

State of Alaska RFP 2013-0200-1396

Answers for: Aetna

Posted: 17:17, 28 Feb 2013 US/Pacific

1 Introduction and Instructions / Product Activation

1.1 Please see the attached Introductions and Instructions document.

Attached Document: [A - SOA - RFP Introduction and Instructions.pdf](#)

1.2 Please indicate the product lines for which your organization intends to provide a bid.

Note: Selecting Yes/No will activate/deactivate the applicable sections.

Medical Claims Administration and Managed Network	Yes
Pharmacy Benefit Management Services	Yes
Healthcare Management	Yes
Dental Claims Administration and Managed Network	Yes

Detail:

Attachments:

2 Medical Claims Administration and Managed Network

2.1 Company Profile

2.1.1 General

2.1.1.1 Describe your company's ownership structure. Explain why your organization is best suited to provide Medical Claims Administration and Managed Network services.

Answer: The ultimate parent of our companies is Aetna Inc., a publicly traded Pennsylvania corporation. Aetna has over 35,000 employees nationally with 15 of those in Alaska.

Aetna is best suited to provide the services the State of Alaska is seeking in this RFP, due in large part to the overall breadth of the Aetna group of companies. The State of Alaska's objectives to transform healthcare in the State of Alaska require an organization that can support this along with all of the State of Alaska's objectives. Aetna's strategic direction, investments and full breadth of the Aetna portfolio will be leveraged to support the State of Alaska. We believe the transformation will take place one member at a time through our support in engagement through the program or method for which that member can be engaged.

The State of Alaska clearly needs an organization that has the full breadth of resources and capabilities to deliver both in Alaska and the lower 48. We are an organization that is not only known for its medical claim and network administration for many of the Fortune 100 and Public entities, but we also have active and retiree fully insured book of business. Our role in the State of Alaska covers each of these and provides the State of Alaska with a partner that will bring other plan sponsors to the table to support the health care transformation.

The Aetna portfolio that will benefit the State of Alaska includes:

Aetna - Aetna is a key player in the push for cost and quality in the health care delivery system in Alaska and the lower 48. We have made material investments in all facets of supporting the consumer and focusing on evidence-based medicine. Aetna is building solutions for today and tomorrow through a health concierge model that will provide the State of Alaska with "My AlaskaCare Single Point of Contact", web and mobile technology to engage every member by providing them with both essential information as well as the level of advocacy critical to behavior change and improved health.

Aetna is a key administrator and insurance carrier in the State of Alaska and throughout the lower 48. Our structure is a single organization that owns and operates a National network and most of the solutions critical to meet the State's needs. Our network resources will work with the State of Alaska to define the optimal strategies to achieve your objectives. We will leverage network contracting, plan design and resources to improve overall effectiveness of the delivery system through our Accountable Care Solutions team. We place extensive rigor on evidence-based medicine across medical, pharmacy, leave and disability, voluntary and dental solutions that will support the State of Alaska's goals to fully impact health care delivery.

ActiveHealth Management an Aetna Company - ActiveHealth is the creator of the Care Engine which is the market leading Clinical Decision support tool. The tool is based on evidence-based medicine and fully connects medical, pharmacy and health assessment information to identify Care Considerations as well as gaps in care. ActiveHealth is a critical facet of our Accountable Care Solutions in delivering the clinical decision support to the Accountable Care Organization through their Care Team platform. Our data warehouse solution is also through Active Health's Health Data & Management Solutions organization.

Medicity an Aetna Company - Medicity is our health information exchange (HIE) and is the leading innovator and largest provider of HIE technology - with more than 750 hospitals, 125,000 physicians and 250,000 end users in its connected ecosystem. Medicity's solutions empower hospitals, physicians and HIEs with secure access to and exchange of health information - improving the quality and efficiency of patient care locally, regionally and nationally. In short, it is the "pipes" that enable an entire delivery system to be connected and operate as an Accountable Care Organization. While critical for an ACO, it can also bring together a delivery system for a plan sponsor such as the State of Alaska to connect the Alaska delivery system.

Aetna's structure fully enables the acquisitions and innovations needed to support the State of Alaska's goals on both a short term and long term basis. It is all based on the Values that guide all of the Aetna companies:

- Integrity - We do the right thing for the right reason
- Excellence - We strive to deliver the highest quality and value possible through simple, easy and relevant solutions
- Inspiration - We inspire each other to explore the ideas that can make the world a better place
- Caring - We listen to and respect our customers and each other so we can act with insight, understanding and compassion

Overall, Aetna is best suited to provide medical claim administration and network services as a direct result of our people. We are an organization built on pushing the next level of solutions and delivering the best service to our members and plan sponsors. In fact, we have developed an entire infrastructure and personnel to support the unique needs of Public and Labor entities. This enables us to deploy the essential resources to focus on your business objectives by bringing all of the Aetna Company resources to the table. We fully understand the needs of large national accounts and Public organizations such as the State of Alaska.

The model we have proposed is focused on supporting health care transformation in Alaska - one member at a time. The My AlaskaCare Single Point of Contact is the member advocate that will support the connection of all the State of Alaska's benefit programs and support navigation through the health care delivery system. This experience is built on the people of Aetna, technology and a comprehensive understanding of the member experience.

Aetna is an organization built to support the development of the State of Alaska's short and long term strategy and more importantly to bring forth and deploy strategies to reduce costs, engage members and improve the overall health of the population. We pride ourselves on developing partnerships to deliver long term success and this will be critical for the State of Alaska's health care transformation.

Attachments: [Executive Summary.pptx](#)

2.1.1.2 Describe how your company meets and exceeds the minimum requirements listed in Section 2.7 of the RFP.

Answer: B. Aetna meets the minimum requirements in Section 2.8 as follows:

(a) Medical Claims Administration and Managed Network - Offeror must have:

- i. provided claim administration for medical, vision and FSA services and managed network services for at least one employer of 6,000 or more employees for at least 5 years
- ii. provided claim administration for medical services and managed network services for at least one group of 20,000 or more retirees for at least 5 years

iii. at least 5 years of experience in processing over 125,000 claims per month for one group
iv. provided claim administration for a government employer or public retirement plan for medical services and managed network services for at least 3 years

- i. We meet this requirement with our customer.
- ii. We meet this requirement with our customer
- iii. We meet this requirement with our customer
- iv. We meet this requirement with our customer

Please find additional supporting information attached on how Aetna meets all the State of Alaska's minimum requirements.

Attachments: [1.a Signed Attachment B - Offeror Information and Certification.pdf](#)
[1.b Attachment B - Offeror Information and Certification.docx](#)
[2. Subcontractor Commitment Letters.zip](#)
[3. Minimum Qualification Question 2.1.1.2 Response- CONFIDENTIAL.doc](#)
[3. Minimum Qualification Question 2.1.1.2 Response- REDACTED.doc](#)
[4. State of Alaska Business Licence.pdf](#)
[5. State of Alaska Certificate of Authority.pdf](#)
[6. Legal Clarifications \(Deviations\).doc](#)
[7. Plan Clarifications.xlsx](#)
[8. Confidentiality Request.docx](#)

2.1.1.3 Provide client references for whom you provide (or have provided) the same services you are proposing to the State that meet the following qualifications. The same reference may be used to meet one or more qualifications but five distinct references must be provided.

- A client with more than 6,000 employee participants for at least 5 years;
- A client with at least 20,000 retiree participants for at least 5 years;
- A client you have processed over 125,000 claims per month for at least 5 years;
- A client you have had for two years or less;
- A client whose contract has ended with you in the last two years; and
- A governmental client for at least 3 years.

Name of client					
Type of business	Retail	State Retirement System	State Government	County Government	City Government
Beginning year of providing service to client	1994	1986	2012	1997	2001
Number of participants (total Lives)	210,000	235,000	30,746	23,800	19,000
Name, address and telephone number of the designated client representative					
Types of coverage or plans provided; and	Medical, Dental, FSA, AGB: ExPats and World	Medical, Dedicated Patient Management & Disease	Self funded medical and pharmacy	Medical	Medical and Pharmacy

	Traveler's, dedicated clinical service and subrogation teams	Management, Direct Bill and COBRA administration			
Reason for Termination (if applicable)	Not applicable	Not applicable	Not applicable	Financial - Discounts	Not applicable

Detail: CONFIDENTIAL - The names, addresses and phone numbers of Aetna active references are confidential. Please see attached confidential file for the contact info.

Attachments:

2.1.1.4 Describe a situation in which you brought a client's healthcare plan trend down. This client should be similar to the State of Alaska in size, as well as in industry.

Answer:

CONFIDENTIAL

Attachments: [2.1.1.4 Harris County Case Study.pdf](#)

2.1.2 Account Management Team

2.1.2.1 Please submit a written narrative providing a thorough description of the proposed account management structure. Your narrative must include the following:

- I. An organizational chart depicting the account management structure.
- II. The individuals who will comprise the account management team.
- III. For each individual on the proposed account management team:
 - a. name
 - b. title
 - c. physical work location where normally based
 - d. years of industry experience
 - e. years with organization
 - f. level of educational attainment
 - g. resume
 - h. years in current position
 - i. level and scope of decision making authority.
- IV. How often the account management team will meet with the Project Director and/or his designee(s) and whether the account management team will meet in person with the State on a quarterly basis in Alaska or other locations to be specified by the State.
- V. Maximum number of accounts assigned to each member of the account management team.
- VI. List other projects and or plans anticipated to be implemented by each member of the account management team during 2013/2014 and evaluate their impact on each member's ability to implement the scope of work set forth in the RFP relative to Medical Claims Administration and Managed Network.

Answer: 1: Attached

Detail:

Options:

1. Attached

2. Not Attached

Attachments: [State of AK - Org Chart.ppt](#)

2.1.3 Organizational Capacity

2.1.3.1 Confirm you, as the Offeror, have reviewed and understand the information presented in the Introduction section of the RFP.

Answer: 1: Confirmed

Detail:

Options:

1. Confirmed
2. Not Confirmed

Attachments:

2.1.3.2 Identify and describe how all aspects of the work for each function identified below will be organized and staffed.

- A. Company Profile
 - a. HIPAA Compliance
 - b. Communications
 - c. Information Technology
 - d. Integration with Other Vendors
- B. Patient Value Chain
 1. Network
 2. Indemnity Vision and Managed Care Network
 3. Eligibility & Enrollment
 4. Customer/Member Services
 5. Utilization Management (UM)
 - i. Concurrent Review
 - ii. Outpatient Review
 - iii. Discharge Planning
 - iv. Approvals/Denials
 - v. Travel Management
 6. Case Management
 7. Claims Processing
 - i. UCR Management
 - ii. Explanation of Benefits (EOB)
 - iii. Coordination of Benefits (COB)
 - iv. Health Flexible Spending Account (FSA)
 - v. Dependent Care Assistance Program (DCAP)
 8. Quality Control
 - i. Performance Guarantees
 9. Appeals
 10. Data Analysis
 - i. Data Collection
 - ii. Reporting
 11. Financial

- i. Subrogation
- ii. Banking
- iii. Direct Bill
- iv. COBRA

State Objectives

- 0. Plan Design
- 1. Policy Development
- 2. Innovation
- 3. Performance Incentives

For each function, please provide the following information:

1. A work flow chart depicting how the work associated with each function will be performed and a narrative describing the processes depicted in each flow chart. In your narrative please specifically address, for each function:
 - i. The role of customer service and communications.
 - ii. Special expertise, if any, that you can provide the State with respect to each function.
 - iii. Your experience and background in performing each specific function.
 - iv. How your system technologies uniquely position you to perform each specific function.
 - v. What innovation you can provide to the State with respect to each specific function.
 - vi. How you will coordinate with other Contractors who may be awarded Contracts under this RFP.
 - vii. If applicable, specify how the process will be different for members outside of Alaska.
2. Whether the specific function will be managed and staffed by you, a subcontractor or joint venturer.
 - i. If the function will be managed and/or staffed by a subcontractor or joint venturer, please identify the subcontractor or joint venturer and identify how long the subcontractor or joint venturer has been providing the service to a client of similar size to the State.
 - ii. If the function will be managed and/or staffed by a subcontractor or joint venturer, explain how communication and coordination occurs between your organization and subcontractors or joint venturers who will provide the functional service.
3. Describe your organization's process for quality oversight of all subcontracted vendors and joint venturers and provide sample corrective actions used if performance needs to be improved.
4. Please include an organizational chart depicting all personnel or positions that will be assigned to accomplish each function.
5. Please identify the geographic location where the work associated with each identified function will be performed, including which functions will be performed exclusively in Alaska.
6. For any function that will not be performed exclusively in Alaska, please identify the total number of positions that will be based in Alaska for each function.
7. Please identify the proposed point-of-contact for each function.
8. Please identify customer service hours of operation for each function. Specify hours of operation by Alaska Standard Time and the applicable time zone where the function will be performed if not in Alaska.

9. Please identify for which functions you will provide onsite support. For example, open enrollment meetings and health fairs.
10. If the Project Team includes the role of a Medical Director, or similar position, please provide the following information:
 - a. The role of the Medical Director in each function.
 - b. A description of how the Medical Director will support the medical management process and assigned staff.
 - c. Whether the Medical Director will be located in Alaska.
 - d. Whether the Medical Director is/will be licensed as a physician in the State of Alaska.
 - e. If the Medical Director is/will not be licensed as a physician in the State of Alaska, is the Medical Director licensed as a physician elsewhere? If so, where?
 - f. Whether the Medical Director will be subject to the review and approval of the Project Director.

Answer: Please refer to the attached "RESPONSE TO 2.1.3.2" document for a complete description of our capabilities to provide each function requested above.

Attachments: [RESPONSE TO 2.1.3.2.doc](#)

[Appeals Resolution Flow Chart.ppt](#)

[Banking Flow Chart.ppt](#)

[Claim Process Flow Chart.ppt](#)

[Enrollment Flow Chart.ppt](#)

[EOB Flow Chart.xls.xls](#)

[Fresno Service Center Organizational Chart.ppt](#)

[Information Technology Flow Chart.pdf](#)

[Network Diagram.pdf](#)

[Northwest Network Org Chart.ppt](#)

[PayFlex Organizational Chart.docx](#)

[UM West Organizational Chart.pptx](#)

[VSP Executive Organizational Chart.ppt](#)

[Case Management Workflow.ppt](#)

[Concurrent Review Workflow.ppt](#)

[Precertification Workflow.ppt](#)

[Retrospective Review Workflow.ppt](#)

[COBRA Flow Chart.pdf](#)

[Subrogation Flow Chart.pdf](#)

[FSA Flow Chart .pdf](#)

[State of AK Organizational Chart.ppt](#)

2.1.3.3 Provide a copy of your standard Administrative Services Organization contract.

Answer: 1: Attached

Detail:

Options:

1. Attached
2. Not Attached

Attachments: [Aetna Sample Master Services Agreement.pdf](#)

2.1.4 Implementation Plan

2.1.4.1 Identify and describe, by function, how you will execute a successful implementation for each aspect of the work set forth in Section 1.04 of the RFP instructions relative to the Medical Claims Administration and Managed Network component. For each function, please provide:

- I. A work flow chart depicting how the implementation work associated with each function will be performed and a narrative describing the processes depicted in each flow chart.
- II. Whether the specific function will be managed and staffed by you, a subcontractor or joint venturer.
- III. If the function will be managed and/or staffed by a subcontractor or joint venturer, please identify the subcontractor or joint venturer and identify how long the subcontractor or joint venturer has been providing the service to a client of similar size to the State.
- IV. If the function will be managed and/or staffed by a subcontractor or joint venturer, explain how communication and coordination occurs between your organization and subcontractors or joint venturers who will provide the functional service.
- V. Describe your organization's process for quality oversight of all subcontracted vendors and joint venturers and provide sample corrective actions used if performance needs to be improved.
- VI. An organizational chart depicting the implementation management team structure.
- VII. Whether you will provide an Alaska-based transition project manager during the term of the transition.
- VIII. The individuals who will comprise the implementation management team.
- IX. For each individual on the proposed implementation management team:
 1. name
 2. title
 3. physical work location where normally based
 4. years of industry experience
 5. years with organization
 6. level of educational attainment
 7. resume
 8. years in current position
 9. level and scope of decision making authority
 10. whether the individual management team member will be exclusively assigned to the transition until completion.
 11. For those individuals not assigned exclusively to the implementation, please identify the amount of time they will be devoted to the transition.
- X. The geographic location where the work associated with each identified implementation function will be performed, including which implementation functions will be performed exclusively in Alaska.
- XI. For any implementation function that will not be performed exclusively in Alaska, please identify the total number of positions that will be based in Alaska for each implementation function.
- XII. The proposed point-of-contact for each implementation function.
- XIII. Timeline for implementation.
- XIV. How often the implementation team will meet with the Project Director and/or his designee(s) and whether the implementation team leader will meet in person with the State on a monthly basis in Alaska or other locations to be specified by the state.

Answer: 1. Please refer to the implementation plan included with this proposal. We have included an implementation plan based upon your timeline of a 7/1/13 effective date and a decision date of 3/29/13. We have the people and processes to continue to support a 7/1 effective date. We would want to work with the State to fully define timing based on key decision dates to ensure a smooth transition. We have included an implementation plan for integrated medical services for the four RFPs and stand alone.

2. The implementation for State of Alaska will be performed solely by Aetna. Other than coordinating with VSP for the managed vision plan, no sub-contractors will be involved.

3. Not applicable.

4. Not applicable.

5. Our process will integrate with the subcontracted vendor just as if it was an Aetna process. They will be part of our ongoing implementation process, quality protocols, and check-ins.

6. Please refer to the implementation organizational chart included with this proposal.

7. The assigned implementation manager, Laura Ocegueda, will serve as the transition project manager. Laura is located in California and will manage the project. The State's account management team will also be an integral part of the implementation process and will be available to meet on-site with Alaska as needed. The primary account management team will be located in Washington and Alaska.

8. Please see below for specific information for each of the implementation team members.

9. Please see below for specific information for each of the implementation team members.

1. Name - Laura Ocegueda

2. Title - Senior Implementation Manager for National Accounts - Public & Labor Plan Sponsor Services

3. Physical work location - Teleworker/California

4. Years of industry experience - 27 years

5. Years with organization - 27 years

6. Level of Educational Attainment - Bachelor's of Science

7. Resume - Please see below

8. Years in current position - 10 years

9. Level and scope of decision making authority - Laura has decision making authority. For anything non-standard she will seek approval either from management or other business partners

10. Whether the individual management team member will be exclusively assigned to the transition until completion. - No. A designated Implementation Manager will be assigned to the transition and will remain engaged for approximately 30-45 days following the effective date. The Account Team and Plan Sponsor Administration team will assume ongoing responsibility for managing your account.

11. For those individuals not assigned exclusively to the implementation, please identify the amount of time they will be devoted to the transition - On average, 35% but may increase based on project scope.

Resume - Laura Ocegueda joined National Accounts Customer Implementation Management Services in July 2002. Her current responsibilities include overall project management for Aetna's new and existing plan sponsors' benefit programs. Her responsibilities include management of all implementation team activities between customers and service personnel relating to the coordination and installation of new and revised services for National Account customers.

Prior to joining CIMS, Laura was an Account Executive in the San Francisco Sales Organization. As an Account Executive she had overall responsibility for client retention, growth, negotiating renewals, and cross selling of new products for her assigned book of business.

Laura is a graduate of California State University at Hayward where she earned a Bachelor of Science degree in Business Administration

1. Name - Sara Kesler
2. Title/function - Sr. Billing Consultant
3. Physical work location - Teleworker/Walnut Creek, CA office
4. Years of industry experience - Please see the included biography for Sara Kesler
5. Years with organization - Sara has been with Aetna since 2006
6. Level of Educational Attainment - High School Diploma
7. Resume - Please see below
8. Years in current position- 6
9. Level and scope of decision making authority - For anything non -standard she will seek approval either from management or other business partners
10. Whether the individual management team member will be exclusively assigned to the transition until completion. - Yes
11. For those individuals not assigned exclusively to the implementation, please identify the amount of time they will be devoted to the transition - Not applicable

Resume: Sara joined the Aetna team in January of 2006. Sara is a Senior Billing Premium Consultant on the National Accounts Team. Sara handles Traditional Premium Billing and Reconciliation.

Sara came to Aetna with many years of experience having been employed in the banking/accounting/bookkeeping field for over twenty five years. Sara was employed initially in the banking field eventually being promoted to Operations Manager and Assistant Vice President. Sara worked for many years for a Certified Public Accountant and was employed prior to joining Aetna as a billing specialist for a firm of attorneys, billing for three locations that included multiple attorneys and paralegals.

Sara has completed several work related classes to assist her in her working environment which includes Excel, Word, Quicken, QuickBooks Pro, Accounting I, Accounting II, Mastering Payroll and Word Perfect.

1. Name - Christina Bryfogle
2. Title- Claim Data Specialist, Christina will install plan sponsor benefits in the claim adjudication system
3. Work Location - Allentown, Pennsylvania. Christina handled the Automatic Claims Adjudication System (ACAS) installation for this plan sponsor in the past and we would like to be able to capitalize on her experience.
4. Years of industry experience - 13 years
5. Years with organization - 13 years
6. Level of Educational Attainment - 12 years plus
7. Resume - Please see below
8. Years in current position - 6 years
9. Level and scope of decision making authority - No direct reports. Will be able to decide if benefits are supportable or not. For anything non -standard she will seek approval either from management or other business partners.
10. Whether the individual management team member will be exclusively assigned to the transition until completion. - Christina will not be exclusively assigned to State of Alaska
11. For those individuals not assigned exclusively to the implementation, please identify the amount of time they will be devoted to the transition - The time amount spent will depend upon the needs of State of Alaska

Resume: Christina began her career with Aetna in May of 1999 as a claims processor. Two years later she was selected to become a Quality Analyst, performing internal quality audits for claim processors.

In this role Christina developed a passion for Quality which is seen in all tasks that she performs. In 2005, Christina was selected to join the Manual Plan Set-up team (MPSU). Christina has been on the MPSU team for 6 years. Her experience and dedication to quality is evident in each customer build she performs on the ACAS.

1. Name - Deborah Smith
2. Title- Automatic Claims Adjudication System (ACAS)Regional Liaison for Public & Labor. Deborah will attend customer installation meetings, verify system supportability of benefits, and monitor case activity through to claim readiness
3. Work Location - Blue Bell, PA
4. Years of industry experience - 14 years
5. Year with organization - 14 years
6. Level of Educational Attainment - 12 years plus
7. Resume - Please see below
8. Years in current position - 5 years
9. Level and scope of decision making authority - No direct reports. Will be able to decide if benefits are supportable or not. For anything non -standard she will seek approval either from management or other business partners
10. Whether the individual management team member will be exclusively assigned to the transition until completion. - Deborah will not be exclusively assigned to State of Alaska
11. For those individuals not assigned exclusively to the implementation, please identify the amount of time they will be devoted to the transition - The time amount spent will depend upon the needs of State of Alaska

Resume: Deborah began her career with Aetna in March 1998 as a claims processor. She became one of the first in the Blue Bell office to be trained to process on the ACAS platform. In 2001 Deborah became a member of the Manual Plan Set-up team actually building the plans on the ACAS platform. In 2007, Deborah became the Regional Liaison, overseeing the implementation process for plan sponsors handled out of the Mid-Atlantic and Northeast Markets. This involved assisting plan sponsors with system support answers for benefits, providing timelines for claim readiness and following up with each area to make sure deadlines were reached. In 2012, Deborah was selected as the Public & Labor Regional Liaison performing the same tasks.

1. Name - Terisita (Tet) Go
2. Title - Plan Set Up
3. Physical work location North Hollywood, California
4. Years of industry experience: 19.5 years
5. Years with organization: 19.5 years
6. Level of educational attainment: 12 years plus
7. Resume: Please see below
8. Years in current position: 10 years
9. Level and scope of decision making authority: Tet will have decision making authority but for anything non -standard she will seek approval either from management or other business partners
10. Whether the individual management team member will be exclusively assigned to the transition until completion: Tet will not be exclusively assigned to State of Alaska
11. For those individuals not assigned exclusively to the implementation, please identify the amount of time they will be devoted to the transition: The time amount spent will depend upon the needs of State of Alaska

Resume: Tet is the Plan Coordination Consultant for the Los Angeles national market.

Tet joined Prudential Healthcare in 1993 as a Claims Examiner for the ASO team. In 1996, Tet was certified as a Plan Description Record Specialist. In 1997, Tet was appointed to do the revalidation of quality reviewed plans. Under Aetna, Tet was the Installation Support Consultant for middle market and was trained as a PCC when the LA center became a national site.

Prior to joining Prudential, Tet held various positions for sixteen years with Carnation Company. The last position she held at the Carnation Company was as a Payroll Administrator.

Tet received an Office Automation Specialist Certificate from Glendale Community College.

1. Name - Sandra Lloyd
2. Title - Benefit Consultant
3. Physical work location where normally based - Pittsburgh, California
4. Years of industry experience: 26 years
5. Years with organization: 11 years
6. Level of educational attainment : 12 years plus
7. Resume: Please see below
8. Years in current position: 7 Years
9. Level and scope of decision making authority: Sandra will have decision making authority but for anything non -standard she will need to seek approval either from management or other business partners
10. Whether the individual management team member will be exclusively assigned to the transition until completion: Sandra will not be exclusively assigned to State of Alaska
11. For those individuals not assigned exclusively to the implementation, please identify the amount of time they will be devoted to the transition: The time amount spent will depend upon the needs of State of Alaska

Resume: Sandy began her career with Aetna in June 2001. She is currently a Work-at-Home Benefit Consultant located in Pittsburg, California (40 miles east of San Francisco). In her current position she is responsible for negotiating contracts and benefit language, drafting Administrative/Master Services Agreements, and drafting benefit plans.

Sandy started her career with Aetna as an Administrative Assistant in Law & Regulatory Affairs, where she was promoted to Paralegal after obtaining her Paralegal certification. Prior to coming to Aetna, she was a Legal Secretary with highly rated law firms in Texas and California that specialized in diverse fields such as: Patent, Trademark and Copyright, Oil and Gas, Estates and Trusts, Business and Corporations, Bankruptcy and insurance defense litigation, and personal injury/property damage insurance prosecution.

1. Name - Barri Frank
2. Title - Eligibility Consultant and ID card consultant
3. Physical work location where normally based: Antioch, California
4. Years of industry experience: 12 years
5. Years with organization: 12 years
6. Level of educational attainment: Bachelor Degree
7. Resume: Please see below
8. Years in current position: 12 years
9. Level and scope of decision making authority: Barri will have decision making authority but for anything non -standard she will seek approval either from management or other business partners
10. Whether the individual management team member will be exclusively assigned to the transition until completion: Barri will not be exclusively assigned to State of Alaska

11. For those individuals not assigned exclusively to the implementation, please identify the amount of time they will be devoted to the transition : The time amount spent will depend upon the needs of State of Alaska

Resume: Barri is a Senior Eligibility Consultant in Walnut Creek, CA. She joined Aetna in August of 2000 and is currently responsible for processing electronic eligibility into Aetna systems. Barri is also involved with the coding of product ID cards which are distributed to Aetna members. In addition, she responds to customer, vendor or claims inquiries for information and/or problem resolution. Prior to joining Aetna, Barri spent three years as a health insurance/benefit analyst for a contract security company in Oakland, CA. In addition to her benefits background, Barri has six years accounting experience.

Barri's professional and consultative customer focus has been recognized numerous times over the years by internal partners, Account Management Teams and Plan Sponsors. She has been formally recognized with two Aetna Ways Excellence Award nominations for her "best in class" service. Barri graduated from the University of Iowa with a Bachelor of Arts degree in English. She also has an associate's degree in accounting.

10. Please see above for specific information for each of the implementation team members.

11. The majority of the implementation functions will be done outside of Alaska, but staff can visit Alaska for any essential activities, if on-site is needed. The State's account team will be an integral part of the implementation and will be available to meet with the State as needed. The account team will be comprised of local resources as well as 4 Alaska-based sales support consultants and an Alaska Advisory Team.

12. A contact list is included in the Implementation Schedule identifying each functional contact involved in the implementation.

13. Please refer to the Implementation Schedule included with this proposal. We have included an implementation plan based upon your timeline of a 7/1/13 effective date and a decision date of 3/29/13. We have the people and processes to continue to support a 7/1 effective date. As the retirees are a 1/1 plan year, we would work with the State and the current administrator for the processes and data feeds needed for a smooth mid-year transition.

14. Our project plan assumes a weekly implementation project call, leveraging all of our project management tools. At a minimum we have assumed the account team will meet in person with the State on a monthly basis. We will work with the Sattu on defining all of the face to face meeting dates based on final notification and implementation date.

Attachments: [State of Alaska Implementation.doc](#)
[State of Alaska Implementation Medical Only.doc](#)
[Implementation Org Chart.ppt](#)

2.1.4.2 Will you provide welcome kits as part of the implementation? If so, please identify and describe all information that will be contained in the welcome kits. If there is an additional cost, please indicate the cost on the rate sheet.

**Answer: 1: Yes: [Our pre-enrollment communication materials include:
- Enrollment forms**

- **Provider directories**
- **Plan brochures**
- **Discount program flyers**
- **Special program flyers**
- **Wellness program brochures**
- **Flyers**
- **Html e-mails promoting our online tools and resources**

In addition, we provide communication materials on other plans and programs available to the member, such as pharmacy and dental flyers, where appropriate. Once enrolled in the plan, members will receive eligibility change forms, ID cards, plan documents, wellness education information and reminders and html e-mails and electronic newsletters on educational, quality and patient safety topics. These communication materials are provided at no additional charge.

]

Detail: Yes, we will provide a welcome kit as part of the implementation.

We are proposing a welcome kit and orientation approach that aligns to the State of Alaska's goal with a focus on consumer engagement. Our My AlaskaCare Single Point of Contact and web and mobile technology are the critical infrastructure components that we want to leverage and engage your members with. As such, our welcome kit is designed in a manner to provide members with an effective overview and contacts, but steer them to a single website for all relevant forms and content and more importantly engage with My AlaskaCare Single Point of Contact.

Finding information on your health plan benefits should be simple, but that is just a portion of the goal for the State of Alaska. We believe engagement with My AlaskaCare Single Point of Contact and the Aetna technology begins through the first interfaces with the resources and tools. We believe engagement occurs one member at a time by meeting the members where they are and through the ideal medium.

Our proposed welcome kit will be designed to provide relevant information and steer the member to the resources. The print material is used to begin the engagement and ensure members are aware of the resources and tools:

IN PRINT

A 8-1/2 x 11 folded six-panel brochure guide that welcomes the member and includes the basic information that member can refer to at their fingertips. The guide provides them an overview of the resources and overview of My AlaskaCare Single Point of Contact. The guide can include:

- Toll-free phone number for My CareAlaska Single Point of Contact
- Information on how to use their plan
- Links to Aetna Navigator, your secure website
- DocFind, our online provider directory
- Print a temporary ID Card
- Link to download claim forms
- Online programs
- iTriage Mobile applications overview

WEB/MOBILE

We will design a custom web page for the State of Alaska. The page will be a single location for all of

the traditional welcome kit material such as links to secure website, claim forms, plan booklets, State of Alaska links, brochure and flyers. The site will also include relevant contact information and an overview of the key resources available to the member to support consumer engagement and provide the member with the Advocacy they need to be effective consumers.

Members will be able to access the site directly as well as through the custom mobile solution, iTriage.

iTriage, a recent Aetna acquisition, provides patients with consumer-facing technology in the form of a mobile phone and web patient engagement platform. This industry-leading mobile application connects patients to medical care by helping them to:

- Process their symptoms
- Research the possible causes of the symptoms
- Identify the appropriate level of care
- Locate the provider best suited for their condition

Our next phase of iTriage will be a AlaskaCare branded site that shows providers in my area specific to the condition or treatment I am seeking. It presents the providers in a customized format designed by State of Alaska and specific to that procedure and condition. iTriage puts critical content at member's fingertips and will also have a plan sponsor link to launch them to the AlaskaCare landing page for relevant information on the plan.

iTriage will replace the entire Aetna mobile application by 2014 and further engage your members. This will be the one stop shop for the member's ID card, benefits information, provider directory and appointment scheduling (registered providers).

We will have the ability to fully customize the AlaskaCare site to contain mutually agreeable content. We will work with the State to balance information that should be on Aetna's site versus content on the State of Alaska Division of Retirement and Benefit site. Additional material can be added to the site:

- Medical, pharmacy, dental and health care management information
- Plan documents
- Wellness education information and reminders and html e-mails
- Electronic newsletters on educational, quality and patient safety topics
- Health Plan Guide
- Aetna standard forms
- All about the benefits program

Options:

1. Yes: [Text]
2. No

Attachments:

2.1.4.3 Offeror must perform comprehensive systems testing and quality assurance audits, with results reported to the State, prior to the contract effective date as part of the base administrative fees with no additional charge to the State. If there are any costs, please detail.

Answer: 1: Yes

Detail: Confirmed. We perform the testing and provide results at no additional cost to the State.

We test all new plans as part of the implementation process. A key tool in this process is the Single Source Document (SSD). We use the document as the basis to build and test the benefit plan. SSD captures major plan changes and serves as a confirmation of the benefits plan.

Eligibility Testing

We recommend sending test eligibility files at least 90 days prior to the effective date. This allows time for any adjustments to the file and subsequent testing prior to sending a full eligibility file. We recommend having a full eligibility file 30 days before the effective date.

Pre-Implementation Testing

We will allow the State or their qualified designated representative the opportunity to conduct pre-implementation testing. Our standard scope of the audit includes:

- On-site access for up to two days
- A review of the benefit grids that are used by customer service representatives when responding to member inquiries
- Use of test claim scenarios to determine our readiness to adjudicate claims according to the State's plan documents
- Completion of auditor's questionnaire (up to 150 questions) by us

A Customer Audit Request form (CARF) is required if live member data is being used.

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

2.1.4.4 Please confirm that you will be able to provide ID cards without Social Security Numbers to all members prior to the effective date of the Contract. If there is an additional cost, please indicate the cost on the rate sheet.

Answer: 1: Confirmed

Detail: We do not use the subscribers' Social Security number as identifier on the ID card. We assign a 12 character identifier to each subscriber and dependent. ID cards will be mailed directly to all members prior to the plan effective date. There is no additional charge for ID cards.

Options:

1. Confirmed
2. Not Confirmed

Attachments:

2.1.4.5 Please confirm that your cost proposal includes the cost of all implementation expenses. If not, please identify all additional costs on the rate sheet.

Answer: 1: Confirmed

Detail:

Options:

1. Confirmed
2. Not Confirmed

Attachments:

2.1.4.6 Please confirm that you will provide run-out administration, including communications and data support for transition to a new Contractor, for a period of 12 months following contract termination. If there is an additional cost, please indicate the cost on the rate sheet.

Answer: 1: Confirmed

Detail:

Options:

1. Confirmed
2. Not Confirmed

Attachments:

2.1.4.7 Within your implementation team, is employee compensation tied directly to performance?

Answer: 1: Yes

Detail: Employee compensation includes a base salary and bonus program. We base annual salary increases and quarterly bonuses on the following:

- Manager assessment
- Individual overall performance

Options:

1. Yes
2. No
3. Partially

Attachments:

2.1.4.8 Please outline your procedures for loading patient payment histories from the prior carrier. If there is an additional cost, please indicate the cost on the rate sheet.

Answer: The implementation manager and account executive will meet with you to discuss the transfer of financial information as soon as we are selected as a benefits partner. This is especially important for the State of Alaska as the retiree plan is being transitioned mid-year. In order to correctly process claims, we request a list of financial accumulators for each employee and dependent. The list may vary based on your needs and can include:

- Coinsurance amounts
- Deductibles
- Lifetime maximums

In order to load this data into our claims system, we ask for the following information:

- Employee's Social Security number
- Claimant's last name
- Claimant's first name
- Claimant's relationship to employee
- Claimant's date of birth (YYYY-MM-DD)

When only one employee/retiree is transferring mid-year, the service center would manually update the accumulators.

FORMAT AND TIMING

We accept the information in both Microsoft Excel® (preferred method) and text delimited formats. We accept these formats through password protected e-mail or via the Internet through secure file transfer protocol.

Because the former carrier continues to process claims during the run-out period, this data can quickly become outdated. To keep data current, we will work with the State on frequency and handling process as a retiree member claims submission impacts accumulators. We will work with the State on the process, communications and call handling by our Health Concierge team.

Attachments:

2.1.5 HIPAA Compliance

2.1.5.1 Confirm your organization is in compliance with and will administer the proposed benefit plan (s) in accordance with all applicable legal requirements, including HIPAA, COBRA, DOL, ERISA, and state and local mandates.

Answer: 1: Confirmed

Detail:

Options:

1. Confirmed
2. Not Confirmed

Attachments:

2.1.5.2 Describe how you maintain confidentiality of patient and plan data.

Answer: We have policies, procedures and technologies in place to protect sensitive information against inappropriate and unauthorized use and disclosure. These include written privacy and security policies, privacy and security awareness training for employees, integrity and access controls, message authentication and/or encryption, firewall and proxy server technologies, etc. We restrict access to protected health information (PHI) to those employees who need it to provide products or services to our members through “role-based access control” (RBAC). We maintain physical, electronic and procedural safeguards to protect PHI against unauthorized access and use. Access to our facilities is limited to authorized personnel, and we protect information we maintain electronically through use of a variety of technical tools.

In addition, as part of our HIPAA Privacy and Security compliance programs, we have identified specific individuals to serve as business area privacy and security managers. These individuals are responsible for day-to-day enforcement of Aetna's privacy and security policies and the procedures that support them. Each privacy and security manager is the “go to” person for business area questions about our privacy and security policies and procedures - in the event these individuals encounter

questions/issues they cannot resolve, they confer with the company's Privacy Office.

Finally, adherence to privacy and security policies and procedures is subject to ongoing monitoring. For example:

- Our Internal Audit Department periodically performs assessments on the company's Privacy policies and procedures. As needed, corrective action plans are developed to address the findings of the Internal Audit reviews;
- Key business areas (e.g., member services) have incorporated review of employee adherence to privacy policies in ongoing quality management efforts; and
- For years, our IT security program has received extremely favorable evaluations from external consultants, including the performance of safeguards to counter efforts to penetrate our IT resources. We will continue relying on reviews by external consultants as part of the ongoing security assessment required by the HIPAA Security Rule.

We do not disclose member health information, except as permitted by law or with the member's consent.

When necessary for a member's care or treatment, the operation of our health plans, or other related activities, we use member health information internally, share it with our affiliates and disclose it to health care providers (physicians, dentists, pharmacies, hospitals and other caregivers). We may also provide the information to other insurers, third party administrators, payors (employers who sponsor self-funded health plans, health care provider organizations and others who may be financially responsible for payment for the services or benefits the member receives under our plan), vendors, consultants, government authorities and their respective agents. These parties are required to keep member health information confidential as provided by applicable law. We train employees who handle member health information regarding our confidentiality privacy policies and procedures.

Aetna and participating providers need access to member health information to fulfill a number of important and appropriate functions, including, claims payment, misuse prevention, coordination of care, data collection, performance measurement, compliance with state and federal requirements, quality management, utilization review, research and accreditation activities, preventive health, early detection and disease management programs.

Our Notice of Privacy Practices, which provides detailed information about our policies concerning disclosure of member information, is available on our website at www.aetna.com/about/information_practices.html.

AETNA.COM WEBSITE

Aetna has adopted and adheres to stringent security standards designed to protect non-public personal information at aetna.com against accidental or unauthorized access or disclosure. Among the safeguards that Aetna has developed for this site are administrative, physical and technical barriers that together form a protective firewall around the information stored at this site. We periodically subject our site to simulated intrusion tests and have developed comprehensive disaster recovery plans.

AETNA NAVIGATOR WEBSITE

Aetna Navigator is a secure site employing secure socket layer (128-bit encryption) which is the industry standard for Internet security.

AETNA MOBILE APPLICATIONS

Authentication methods for Mobile application are consistent with the same as Web application.

AETNA SECURE E-MAIL ENCRYPTION

Attached is our secure E-mail Privacy Practice document.

Attachments: [Aetna Secure Email.pdf](#)

2.1.5.3 Confirm you are currently receiving eligibility files in the HIPAA 834 format.

Answer: 1: Confirmed

Detail:

Options:

1. Confirmed
2. Not Confirmed

Attachments:

2.1.5.4 Are your eligibility and claim systems compliant with recently updated HIPAA regulations?

Answer: 1: Yes

Detail: We are fully compliant with all HIPAA requirements and regulations.

Options:

1. Yes
2. No

Attachments:

2.1.5.5 Please list the dates in which your eligibility and claims systems were reviewed or validated against the updated HIPAA regulations.

Answer: We are in full compliance with the requirements that have been issued to date. This includes review and validation of our eligibility and claim systems. Following is a brief summary:

PRIVACY

As of the April 14, 2003 Privacy Rule compliance deadline, we had taken all steps necessary to comply with the Privacy Rule requirements, including:

- Naming a chief privacy officer and establishing a Privacy Office.
- Implementing new and/or revised company-wide privacy policies and procedures.
- Training impacted personnel.
- Implementing system changes and workflows to provide members with (i) access to their health information, (ii) an accounting of many types of disclosures, (iii) a process for requesting amendments to their health information, and (iv) the ability to request restrictions or have confidential information mailed to an alternative address.
- Delivering a Privacy Notice to full risk subscribers.
- Adopting specific disciplinary procedures and sanctions for employees who violate our Privacy Policies.

TRANSACTIONS AND CODE SETS

As of October 16, 2003, we were positioned to support HIPAA compliant electronic transactions and code sets. We have the flexibility to accept both compliant and non-compliant electronic claims, consistent with guidance provided by the Centers for Medicare and Medicaid Services (CMS).

SECURITY

To prepare for the HIPAA Security Rule, we performed a thorough risk assessment of our systems (including our eligibility and claim systems) and operations and developed and executed a remediation plan. We were compliant with the HIPAA Security Rule as of the April 20, 2005 compliance date.

UNIQUE IDENTIFIERS

Aetna has been compliant with the unique Employer Identifier Number (EIN) requirement since July 30, 2004.

As of May 23, 2007, we were ready to accept and process HIPAA standard electronic transactions that comply with the National Provider Identifier (NPI) regulations. Effective March 16, 2009, to comply with HIPAA regulations, we began rejecting electronic claims and encounters submitted without a billing provider NPI. If a "pay to" provider is identified on a claim, the NPI for that provider must also be included. We continue to work diligently with providers to educate them and bring them into compliance according to the HIPAA regulation.

The Payer regulation is not final. Once finalized, we will have two years to comply.

Attachments:

2.1.5.6 Was an outside auditor/reviewer employed for HIPAA review/validations of these two systems?

Answer: No. We do not employ an outside auditor for HIPAA validation. HIPAA compliance is managed internally and Aetna is in compliance with all required regulations.

Attachments:

2.1.5.7 How soon after the contract award will you provide the HIPAA companion guide for creating eligibility files that load to your system?

Answer: Upon award of contract we will provide the State our HIPAA Companion Guide for creating the eligibility files.

We have provided our Aetna HIPAA 834 Companion Guide.

Attachments: [Aetna HIPAA 834 Companion Guide.docx](#)

2.1.5.8 Confirm your ability to administer HIPAA creditable coverage notices.

Answer: Confirmed.

Attachments:

2.1.6 Communications

2.1.6.1 Confirm that you are able to customize all communication/educational materials to include the AlaskaCare logo as the prominent feature.

Answer: 1: Confirmed

Detail:

Options:

1. Confirmed
2. Not Confirmed

Attachments:

2.1.6.2 Can you provide communication materials in an electronic and editable format for use by the State in their communications? If there is an additional cost, please indicate the cost in the rate sheet.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

2.1.6.3 Please confirm all communications/educational materials will be submitted to the Project Director, or his designee, for review and approval before dissemination to members. If you cannot confirm, please explain.

Answer: 1: Confirmed

Detail: The State is welcome to review our member communication materials and we will work with you to ensure your satisfaction with all communications.

Member communications are provided in simple, easy-to-understand language. The material is produced in compliance with all applicable regulatory requirements and adheres to recommended reading levels. We submit our material to the National Committee for Quality Assurance (NCQA) and adhere to their strict guidelines for writing understandable plan information. We also conduct consumer research to test members' understanding of our material.

Options:

1. Confirmed
2. Not confirmed, please explain: [Text]

Attachments:

2.1.6.4 When are new ID cards generated?

Answer: 4: Other. Please explain: [Our standard is to generate ID cards at initial election.

However, a new card will be generated when information changes during the year. We will send a new ID card when data on the card changes. Below is a list of the data changes that trigger a new card:

- Claim office change
- Unique customer number change, except when we suppress this code on the ID card
- ID number change (employee only)
- Name change (employee and/or dependent)
- New member enrollment (dependent)
- PCP/PCD changes (if applicable)
- Plan changes

After we receive the request, members typically receive replacement cards in approximately 7-10 days. There is no cost for replacement ID cards or revised cards (e.g. change name).

Members can view and print their ID card-level information through the temporary ID feature on Aetna Navigator®, our secure member website at www.aetna.com.

Members can view their medical ID card information directly from their mobile phone.

]

Detail:

Options:

1. At Initial Election
2. Annually
3. At Life Event Change
4. Other. Please explain: [Text]

Attachments:

2.1.6.5 Describe your process for generating and mailing ID cards within 3 days on an ongoing basis as new enrollees are reported eligible.

Answer: Our standard is built around a 3 day turnaround time for mailing ID cards. In 2nd quarter 2012, 93.6 percent ID cards were printed and mailed within 3 calendar days.

When the State sends us updated eligibility information, the eligibility analyst processes the changes in the system. Each night, we process all ID card event triggers and create an output file. The file goes to a secure FTP site. From there, the ID card vendor, Source One Direct, picks up the file and begins production.

Attachments:

2.1.6.6 Are extra ID cards available for a dependent child living away from home? If there is an additional cost, please indicate the cost on the rate sheet.

Answer: 1: Yes

Detail: There is no additional cost.

Options:

1. Yes
2. No

Attachments:

2.1.6.7 Please describe the process that will be implemented to ensure that internal reference source(s) provided to your personnel are consistent with the State's documentation such as employee communication materials, open enrollment information, plan documents, etc.

Answer: We will ensure that all of our Aetna Concierge service staff members are specifically trained on State of Alaska's benefit programs, both internal and external to Aetna, as well as your culture, and other unique requirements. This includes training and prompts for key messages so that our teams can serve as an extension of your benefits team and health program strategy by providing service that is

tailored to your program and personalized for each individual member.

For the State of Alaska, we are proposing a more personal one-to-one member advocate, called the My AlaskaCare Single Point of Contact, who will focus on providing a simplified, seamless member experience to help your members maximize all their available benefits and navigate their individual health care journey. The My AlaskaCare Single Point of Contact service model provides custom-tailored service based on the unique aspects of your health benefits and program offerings.

Think of the My AlaskaCare Single Point of Contact as a health resource consultant with in-depth benefits knowledge and consultative soft-skills that empower them to deliver high-satisfaction service that is personalized within the context of individual member needs for education, guidance, and support. They will help you make the most of your benefits strategy by empowering your members to make better-informed decisions that support program participation and engagement.

The State will have 23 concierge members dedicated to the State of Alaska. They will partner with all State members' connecting you to the right resources across your entire portfolio.

CUSTOMER PERSONALIZATION

My AlaskaCare Single Point of contact concierges will focus on understanding the State's members and how best to provide the service that is right for them. That is why, behind the scenes, the concierges will receive specialized training and State of Alaska-specific certification so they can deliver highly-customized service across the full-spectrum of State of Alaska-provided health benefits and programs. Aetna Strategic Desktop is sophisticated technology that provides each concierge representative with a holistic member view, including personal preferences, call history, and member-specific alerts. Additionally, the Aetna Social Learning tool is a custom-built tool reflecting State of Alaska benefit offerings, program connection triggers, both internal and external to Aetna, as well as key messaging and cultural information specific to the State of Alaska. The concierges use these complimentary tools to cross-reference specific member information with available benefits, resources and programs, in order to provide the right solution at the right time for each individual member.

AETNA SOCIAL LEARNING TOOL

Aetna Concierges use the Aetna Social Learning tool to offer guidance tailored to individual plan sponsors in order to deliver relevant solutions personalized for each individual member. Concierges cross-reference plan details and available benefits, resources, and programs that will provide the right solution at the right time, even if provided by another carrier. They highlight solutions and next steps with an approach that meets the member where they are and provides whatever is needed to ensure that the member is satisfied and empowered. Program connections and referrals are made via warm transfers facilitated by the concierge so that members are never given homework assignments or follow-up numbers to make the most of what's available to them. The My AlaskaCare Single Point of Contact focuses on answering member questions, resolving member issues, and identifying unasked questions, teachable moments, and program referral triggers to provide a more holistic and seamless member experience. They listen, and they personalize. By providing a dedicated Aetna Concierge team, we empower each individual representative to spend the time necessary to deliver first call resolution and make program connections on behalf of members based on identified needs and relevant resources that are available to address those needs. This approach supports more program connections, as well as the program participation and sustained member engagement that leads to improved health behaviors.

More specifically, concierges will be trained and certified on State of Alaska-specific information, offerings and messaging through the use of the Aetna Social Learning Tool. Having a thorough and complete understanding of the State's culture, communications and offerings allows each concierge to

serve as an extension of the State's benefit team. Through the use of First Impression Treatment (FIT) and the Aetna Social Learning Tool, the concierge is empowered to reinforce key messages and ensure that members get connected to relevant programs and resources that are available to them. All connections to internal and external benefit programs are done via warm transfers, which support a simplified, seamless member experience.

FIRST IMPRESSION TREATMENT(FIT)

First Impression Treatment (FIT) involves an Aetna Strategic Desktop (ASD) system trigger that will alert the concierge representative that a member is calling for the first time, resulting in a more comprehensive welcome and overview with Aetna and their specific benefit offerings. Working with the State, we will identify four to five key messages that we will highlight for members during their first call in to the concierge, whether it is a reminder about incentives, an encouragement to establish a relationship with a Primary Care Provider (PCP), or to emphasize specific benefit program features to share during this discussion. We will deliver and reinforce the key messages that support your benefits strategy and member health objectives.

AETNA STRATEGIC DESKTOP (ASD)

All our Concierges use a 360-degree member dashboard to quickly and effectively access information about:

- The member's plan
- Programs in which the member is enrolled or available to join
- Disability and absence management information (if available)
- Available incentive programs

The moment the member contacts the concierge, member information is in our system. The system tracks any tasks or activities performed to resolve the service request from beginning to end.

As an example, your employee receives a doctor bill that was much higher than expected. With Aetna Concierge, the employee can call the number on the back of the ID card and talk to a service professional who will not only explain how the plan works, but can even call the doctor to work out any problems.

We will also ask the member to identify preferred contact method and contact times, and will document the information in the Aetna Strategic Desktop. We will also provide them with an overview of Aetna tools and resources, so that they can become familiar with all that is available to them as an Aetna member. Using this approach, we feel we are able to set the stage for a strong relationship with your members, one that will empower them to maximize their engagement with Aetna and all other available programs.

Attachments:

2.1.6.8 Is the creation, customization, production, and distribution of the materials itemized below included in your cost proposal?

- I. If there is an additional cost for any of the items listed below, please indicate each additional cost on the rate sheet.
- II. Will each of the items listed below be made available online?
- III. Please identify any additional communication and/or educational materials not listed below that are included in your cost proposal, and provide an example of each where possible.

- IV. Please identify any additional communication and/or education materials not listed below that you can provide for an additional fee. Please indicate each additional cost on the rate sheet.

	Can Provide?	Included in Fees? If no, include fee on rate sheet.	Can Customize?
Employee ID Cards	1: Yes	1: Yes	1: Yes
Replacement ID Cards	1: Yes	1: Yes	1: Yes
Claim Forms	1: Yes	1: Yes	1: Yes
Provider Directories	1: Yes	2: No	1: Yes
Summary Plan Descriptions	1: Yes	1: Yes	1: Yes
Summary Annual Reports	1: Yes	1: Yes	1: Yes
Summary of Material Modifications	1: Yes	1: Yes	1: Yes
Annual Benefit Statements	1: Yes	1: Yes	1: Yes
General Letters and Correspondence Sent to Employees	1: Yes	1: Yes	1: Yes

Detail: 1. - Online provider directories are included.

- By Annual Benefit Statement if State of Alaska is referring to Member Benefit Statements, such as Explanations of Benefits, these are included at no additional charge. In addition, members can access plan information such as amounts accrued toward their annual deductible and out of pocket maximum online at Aetna.com.

2. Yes, these are available online.

3. Aetna Navigator®, our secure member website, provides access to health education resources designed to engage members in managing their health care. Other online tools include:

- Personal Health Record (PHR): interactive tool for members and families to improve their health.

Online access to personal information, individual messages and alerts/reminders, and health history

- Aetna Intellihealth: provides members with online tools and resources to help them understand health and wellness topics.

- Healthwise Knowledgebase: user-friendly decision-support tool designed to encourage informed health decision -making and allow members to understand their treatment option.

- Aetna SmartSource: Based on members demographics, the tool searches for the most relevant information to the user i.e., local doctors, medications and treatment plans, estimated cost of care and discounts associated with health topic.

- DocFind: online directory of participating providers (available on mobile devices)

- Women's Health Online: provides age-specific health care resources and interactive tools on a variety of health concerns for women.

Attachments: [Aetna Plan Selection & Cost Estimator.pdf](#)

[Aetna Smartsources Brochure.pdf](#)

[Aetna Informed Healthline Brochure.pdf](#)

[Aetna Mobile App Brochure.pdf](#)

[Aetna Personal Health Record Flyer.pdf](#)

2.1.6.9 What is the average number of work days from placing an order to time of delivery for the following communication materials?

	Average Days to delivery
Employee ID cards	7
Enrollment forms	10
Claims forms	10
Provider Directories	10

	Average Days to delivery
Program Descriptions	10

Detail: The averages provided above are the average number of days for members to receive these communication materials when they request them directly from Aetna. We mail these materials within 2 days of receiving a request from a member. The timeframes listed above are for hard copy communications. Enrollment forms, claim forms, provider directories and program descriptions are all available electronically for members in real-time through our member website. In addition, we can support the State of Alaska's current approach of also having material on their internal site.

Additionally, we can provide the State with a supply of extra materials, such as enrollment forms and claim forms, to give to members immediately upon request.

Attachments:

2.1.6.10 Please attach sample member communication materials, including a sample ID card and sample member welcome letter.

Answer: 1: Attached

Detail: We have attached a sample of our enrollment package, including:

- Aetna Member Welcome Letter
- Aetna DocFind Brochure
- Aetna Enrollment Form
- Aetna Family Style ID Card
- Aetna Alaska Provider Directory
- Aetna Navigator Brochure
- Aetna PPO Plan Product Brochures

Options:

1. Attached
2. Not Attached

Attachments: [Aetna Alaska Medical Provider Directory.pdf](#)
[Aetna DocFind Brochure.pdf](#)
[Aetna Enrollment Form.pdf](#)
[Aetna Family Style PPO ID Card.ppt](#)
[Aetna Navigator Brochure.pdf](#)
[Aetna PPO Product Brochure.pdf](#)
[Aetna Welcome Letter.doc](#)

2.1.7 Information Technology

2.1.7.1 Describe how your company will use its systems technologies to perform each aspect of the work set forth in Section 1.04 of the RFP instructions relative to the Medical Claims Administration and Managed Network.

Answer: Industry leading technology is at the heart of our programs. We will use our advanced technologies and systems to perform each aspect of the State's plan set forth in Section 1-04 to help ensure that the plan runs at the optimal level of efficiency. We will use the following systems, software, and applications in connection with the State's plan:

CLAIMS PROCESSING

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

UNBUNDLING SOFTWARE

We use a customized version of McKesson's ClaimsXten™ software to detect unbundled, upcoded and fragmented provider bills.

We fully integrated ClaimsXten into our claims processing systems. We use this product to address claims in a broad range of services:

- Surgical
- Surgical assistance
- Medical (e.g., office care)
- Diagnostic services (e.g., X-ray, lab)

ClaimsXten is a robust tool as it contains in excess of one million edits.

NETWORK INFORMATION

Provider information is loaded into our Enterprise Provider Database (EPDB), a relational database, which is the single source of provider network information. The EPDB also holds provider credentialing data; however, extensive credentialing and recredentialing data is held in our Enterprise Provider Credentialing (EPC) database. Provider contracts are stored in our Strategic Contract Manager system (SCM), another relational database. Fee schedules and hospital and ancillary rate information are loaded into our Service Code Service Rate system (SCSR), a repository of service codes, rating systems and provider reimbursement rates.

Our claim system reads the EPDB directly for provider matching, and then accesses the SCM or SCSR for provider rate information. Inquiry screens provide information on individual, facility and ancillary providers. Our claims staff can retrieve specific provider information when searching by name, provider identification number or tax identification number.

UTILIZATION MANAGEMENT

eTUMS, our electronic Total Utilization Management System, is a comprehensive information system developed and managed by our Information Technology department. It supports all products and care management activities on one platform, including:

- Inpatient and ambulatory precertification and authorizations
- Concurrent review
- Hospital discharge planning
- Case management
- Behavioral health
- Disability
- Women's Health
- National Medical Excellence Program
- Electronic data interchange for online provider precertification

CUSTOMER SERVICE

We use an online tracking and documentation system called Aetna Strategic Desktop (ASD) for

member and provider contacts including telephone calls, written correspondence, Internet e-mail and walk-in visitors. This system allows us to monitor and follow those inquiries until they are resolved. We document all calls with the exception of transfers or general information questions.

ELIGIBILITY AND BILLING

Member Enrollment Application (MEA) is our billing and enrollment system. We originally developed the system in-house in 1988. We redeveloped the system in 2004 leveraging data and structure in place since 1988. The billing features of MEA interface with the appropriate financial system.

AETNA HEALTH INFORMATION ADVANTAGE

Aetna Health Information AdvantageTM, our new information application software tool created by Aetna Informatics®, makes performance experience data available in real time through the Internet.

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

We have made significant investments into our technology offering. The following describes our recent history regarding technology expenditures.

For 2011, total Information Technology spend was \$1.1 billion, with \$477 million or 43 percent earmarked for “Projects” (new application development and significant enhancements), with Pharmacy/Fulfillment (including mail order integration with CVS-Caremark), Strategic System & Processes Program (multi-year program that migrates applications to a single platform), and regulatory requirements for ICD-10 revisions and Health Care Reform (processing mandated changes and tracking) making up a significant portion of that investment (52 percent, altogether).

2012 Plan currently calls for Total Information Technology spend of \$1.07 billion, with \$403 million or 38 percent earmarked for “Projects”, with about 25 percent being invested in Regulatory activities (Health Care Reform and ICD-10), 17 percent in Integrated Front-End and application simplification, 18 percent to drive medical cost management, and the remaining 40 percent going towards various investments in several areas, including development of mobile applications, improvements in member transaction services, large customer commitments, and Medicare.

Our technology identifies opportunities for improved care by applying clinical rules to the medical information derived from members' medical and pharmacy claims, lab data and health risk assessments. While separate units handle care management, eligibility, member services and claims functions, the data associated with each of these is integrated online. This allows each function to review the others when needed. Through our electronic utilization management system, claims processors, member services and eligibility consultants can view all medical utilization decisions and documentations. These are immediately available in real time after entered by our nurse reviewers. We also continuously integrate information from our pharmacy claims system with other medical claims and eligibility information.

We are delivering on our promise to provide our constituents with the most comprehensive suite of tools and services that today's technology can deliver. Whether it is reducing the time for claim payments to physicians, providing members with 24-hour access to personalized benefits information

or offering the State the ease of online benefits administration, we are taking advantage of technology to enhance the services we provide.

Attachments:

2.1.7.2 Does your automated data processing capability include the ability to interface with the State's health reporting eligibility system when fully operational?

Answer: We work with many customers who use third party enrollment vendors; however, we do not directly interface with their systems. The State can extract data and send our proprietary 2000-byte file layout, our new Consolidated Eligibility Format file or an ANSI 834 standard layout for electronic processing. Because electronic submission tends to be more efficient and accurate, we encourage the State to implement an electronic submission method, regardless of the human resources information system you use. This process is available for initial and subsequent enrollments.

Additionally, our Account Team can establish processes to access the State's systems and we will work with the State to create the optimal process for the member's experience. In addition, we can use your system to check eligibility when it has not yet been loaded into our system.

Attachments:

2.1.7.3 Describe the proprietary software that will be used in administration of this Contract, as well as any services or software purchased or licensed from outside vendors to update your system.

Answer: We will use the following systems, software, and applications in connection with the State's plan:

CLAIMS PROCESSING

We process claims on Automatic Claim Adjudication System (ACAS). We customized ACAS, based on the Dun and Bradstreet system ClaimFacts®, to support our book of business. The system hardware is IBM.

We use a customized version of McKesson's ClaimsXten™ software to detect unbundled, upcoded and fragmented provider bills. We fully integrated ClaimsXten into our claims processing systems. The software includes the following types of edits on facility providers:

- Frequency
- Correct coding guidelines

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

NETWORK INFORMATION

Provider information is loaded into our Enterprise Provider Database (EPDB), a relational database, which is the single source of provider network information. The EPDB also holds provider credentialing data; however, extensive credentialing and recredentialing data is held in our Enterprise Provider Credentialing (EPC) database. Provider contracts are stored in our Strategic Contract Manager system (SCM), another relational database. Fee schedules and hospital and ancillary rate information are loaded into our Service Code Service Rate system (SCSR), a repository of service

codes, rating systems and provider reimbursement rates.

Our claim system reads the EPDB directly for provider matching, and then accesses the SCM or SCSR for provider rate information. Inquiry screens provide information on individual, facility and ancillary providers. Our claims staff can retrieve specific provider information when searching by name, provider identification number or tax identification number.

CUSTOMER SERVICE

We use an online tracking and documentation system called Aetna Strategic Desktop (ASD) for member and provider contacts including telephone calls, written correspondence, Internet e-mail and walk-in visitors. This system allows us to monitor and follow those inquiries until they are resolved. We document all calls with the exception of transfers or general information questions.

UTILIZATION MANAGEMENT

We use the internally developed eTUMS (electronic Total Utilization Management System) platform for our utilization management programs. eTUMS is a mainframe/client server/distributed application. The system platform consists of the following software:

- Web-based user interface (Java) with CICS/COBOL/DB2 backend
- Windows on desktop

ELIGIBILITY AND BILLING

Member Enrollment Application (MEA) is our billing and enrollment system. We originally developed the system in-house in 1988. We redeveloped the system in 2004 leveraging data and structure in place since 1988. The billing features of MEA interface with the appropriate financial system.

AETNA HEALTH INFORMATION ADVANTAGE

Aetna Health Information Advantage™, our new information application software tool created by Aetna Informatics®, makes performance experience data available in real time through the Internet.

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

OWNERSHIP

We own or lease the hardware and software. Where third party software programs exist and are used, appropriate service agreements are in place and, if necessary, vendor personnel are located on-site for maintenance support. The Applications Development Services group provides application programming support for Aetna's primary software applications.

Attachments:

2.1.7.4 Are all data feeds for set-up and on-going maintenance included in your pricing? If not, please include the fees on the rate sheet.

Answer: We have included standard data feeds for the following in our proposed medical fees:

- Rx integration from 3rd party vendor

- Dental Integration from 3rd party vendor
- Biometric Screening integration from 3rd party vendor

Fees for additional data feeds are shown on the rate sheet. Please note these are standard prices. For customized work, for very complex integration efforts or for additional analytics, we may assess additional fees beyond what is quoted.

Attachments:

2.1.7.5 Please indicate any additional charges for any required manual interventions (workarounds) due to system interface incompatibility, file format issues, plan compliance, etc. on the rate sheet.

Answer: We have not identified any manual workarounds necessary to accommodate State of Alaska.

Attachments:

2.1.7.6 Describe your system access security process with members, providers and the State.

Answer: MEMBERS

Aetna Navigator®, our secure member website, complies with all HIPAA privacy rules. Navigator is a secure site employing secure socket layer (128-bit encryption) which is the industry standard for Internet security. If a family member requests that access to his/her information be restricted, or the family member is an adult dependent, that member's information will be filtered out of Aetna Navigator, and will not be visible on the site.

Members can also access our open digital platform, CarePass®. The platform will enable consumers to securely share cloud-based health profile information across mobile applications, sharing information as they specifically permit. With a single secure sign-on, the CarePass platform will enable a consumer to share information across some of the most popular health and fitness apps, and create a personalized, coherent experience to manage their whole health, from getting care to staying well.

We also offer iTriage, the leading mobile application that helps consumers research symptoms and conditions and find the healthcare provider that best matches their needs. It delivers an integrated experience that helps consumers move from researching to accessing care. It offers a symptom checker to help people answer the two most common medical questions: “What condition could I have?” and “Where should I go for treatment?”

By securely connecting iTriage to the CarePass® platform, Aetna is enhancing iTriage's differentiated end-to-end consumer experience and enabling greater personalization for the consumer. Patients can now find the provider that best serves their needs based on services delivered, location, availability, personal preferences, such as gender, language spoke, and years of services.

PROVIDERS

Through Aetna's secure provider website, providers have access to a multitude of transactions and a variety of features. Providers must register through NaviNet where they will receive a secure login ID and password.

Aetna EDI ConnectSM allows providers to submit electronic transactions to Aetna free of charge, without using a third-party vendor. Providers must register through Aetna EDI Connect where they will receive a secure login ID and password. The website is available to all providers whose practice management system can submit files conforming to the American National Standards Institute (ANSI) ASC X12 standards.

STATE OF ALASKA

Aetna Health Information Advantage

The account manager facilitates the registration process with the State's representatives who require access to their plan data through Aetna Health Information Advantage. We will issue a User ID and password and provide registration instructions.

ASD and Employer Secure Website

Access to ASD External View and our Employer Secure Website are granted after all proper individuals have been identified.

Attachments:

2.1.7.7 Describe the advantages of your Internet home page, including access and capability to communicate with the State and members on information regarding:

- a. Claims status
- b. Eligibility (name, address, covered dependents, etc.)
- c. Providers (including name, location, education background and credentials, gender, specialty, languages spoken, standard rates for selected procedures, patient satisfaction levels, etc.); and
- d. Health improvement and education information

Answer: We recognize the increased role that technology plays for the State as many Alaska residents are highly advanced with web and mobile usage. We have extensive technological offerings that are available both on the web and in mobile form.

As one of the nation's leading providers of health and related benefits, we are pleased that national organizations and publications recognize us for our innovations in technology. The following list represents some of the achievements of which we are most proud.

- In 2012, Aetna and Silverlink Communications received a top award in Consumer Innovation at the 2012 TripleTree iAwards for Wireless Health for their text messaging program for members diagnosed with diabetes.

- In 2011, the International Data Group (IDG) recognized us for removing paper from the contracting process. Each year, IDG's InfoWorld Green 15 Awards honor the 15 most innovative IT initiatives that embrace sustainability. We are the first health insurer to offer electronic contract processing to doctors, hospitals and other health care facilities. Using an e-signature solution, we:

- Complete contracts faster and more reliably
- Reduce fax and mail expenses
- Reduce our carbon footprint

- In 2010, Aetna's wholly-owned subsidiary, ActiveHealth Management®, was honored as the 2010 Gold Web Health Award winner in the category of Web Portal/Gateway Site for its personal health portal, MyActive HealthSM. The portal offers personalized resources to help members take action to improve their health.

- In 2010, InformationWeek ranked Aetna number 50 in its annual InformationWeek 500, a list of the top technology innovators in the country. The list identifies companies that harness the power of innovation in information technology, including tools and technology that are redefining the health care delivery system.

MEMBERS

Members are looking for convenient, round-the-clock online tools and information to help them make educated health care decisions and manage their benefits online. Aetna Navigator®, our secure member website at www.aetna.com, offers several online resources which include benefits information, health education, health assessment tools, cost and quality tools and health care decision support.

CLAIM STATUS AND ELIGIBILITY INFORMATION

Aetna Navigator offers secure functionality allowing members to:

- View eligibility for themselves or covered dependents.
- Inquire or view details about the status of a medical, dental and pharmacy claim for themselves or a covered dependent.
- View benefit balances such as deductible and coinsurance maximums.
- View EOB statements.
- Contact Member Services through secure email messaging.

Aetna Navigator member ID information, registration, claim search and Contact Us features are available on a mobile version of the website, allowing for the functionalities to be available in a more user-friendly format, specific to the mobile device being used.

PROVIDER INFORMATION

Members can access DocFind®, our newly redesigned, online directory of participating providers that includes details about providers and facilities as well as links to quality and patient safety information. We maintain and display the following information in DocFind: name, specialties, address, telephone number, provider office number, hospital affiliation, status of practice, education, medical school attended and year of graduation, board certification, language(s) spoken, gender, handicapped accessibility, age bands, provider website addresses, and maps and driving directions. Public DocFind is available for mobile devices.

HEALTH IMPROVEMENT AND EDUCATION INFORMATION

Aetna Navigator assists members in using their health plan and in making informed health choices by providing access to:

- Healthwise® Knowledgebase, a user-friendly decision-support tool designed to encourage informed health decision-making and allow users to better understand their treatment options.
- Aetna SmartSourceSM, an intelligent online search tool available through Aetna Navigator, Simple Steps To A Healthier Life® and our Personal Health Record (PHR).
- Simple Steps To A Healthier Life, a program that offers disease prevention, health education and behavior modification programs aimed at improving the health of our members.
- Credible health information through Aetna IntelliHealth, our online health information subsidiary that provides members with online tools and resources to help them better understand health and wellness.

- Aetna Navigator Hospital Comparison Tool, a tool that allows users access to evidence-based hospital outcome data and quality and safety information on hospitals in their area.
- Estimate the Cost of Care (ECC), a suite of interactive web-based cost tools designed to provide members with cost information they can use to make more informed decisions. Cost information is provided for the most common medical and dental procedures, prescription drugs, office visits, diagnostic test and vaccines and diseases and conditions. The Price-A-Drug tool is available for mobile devices.
- Member Payment Estimator (available in the Fairbanks and Anchorage areas, and many locations in the lower 48 states), allows members to look up certain non-emergency, highly used services for:
 - Physician office services
 - Surgical procedures
 - Diagnostic tests and procedures

The tool allows members to compare costs for up to ten providers or facilities at a time and provides real-time estimates based on the member's actual plan design. It also factors in all applicable deductibles, coinsurance, copayments and plan limits. To highlight the cost savings of getting care within the network, the tool also lets members compare costs between a network and out-of-network physician.

- We also offer iTriage, the leading mobile application that helps consumers research symptoms and conditions and find the healthcare provider that best matches their needs. It delivers an integrated experience that helps consumers move from researching to accessing care. It offers a symptom checker to help people answer the two most common medical questions: “What condition could I have?” and “Where should I go for treatment?”

This year, iTriage will have the ability to customize a plan specific member experience to include provider network information and guide consumers to in-network providers.

We have also introduced Ann, our virtual assistant, to help members navigate the website. In her role as a subject matter expert, she is trained to allow members to ask questions in their own words. When a member asks a question that she does not understand, Ann will ask a clarifying question in order to provide the appropriate answer. Her responses are fast, relevant, and content-specific.

STATE OF ALASKA

While Aetna Navigator is geared toward our members, we offer the State other tools that you can access to view important plan information.

EMPLOYER SECURE WEBSITE

Our Employer Secure Website makes it easy for you to get the information you need, whenever you need it. The site features one-stop benefits administration functions available through single sign on and an easy to navigate home page with links to commonly used resources.

The Employer Secure Website allows you to quickly perform common administrative functions. The State can:

- Check eligibility status.
- Request an ID card.

- Review plan information and link to plan documents.

The home page of the Employer Secure Website provides quick links to the most commonly used customer resources, including:

- Access to reports - You can view our full suite of reports with a single sign on. From utilization reports to claim, banking, medical management and wellness reports, the site provides a convenient way to access data in one place. You can also view ad hoc reports from the site.
- Contact with the account team - The site provides direct e-mail access to the State's account team. This includes the account manager, account executive, eligibility consultant and claim contact.
- The latest news and announcements - From the Employer Secure Website home page, you can catch up on the latest developments at Aetna and in the health care industry as a whole.
- Access to other resources - You can link directly to Aetna Navigator®, DocFind® and our aetna.com home page.
- Requests for site customization - We can provide customer logos, customized DocFind, contact information for the account team, and customized links.

ACCESS TO BENEFIT AND CLAIM INFORMATION

We have the capability to provide the State with access to member eligibility, benefit information and claim information using external access to Aetna Strategic Desktop (ASD). Customers approved for external access to Aetna Strategic Desktop will have the ability to view:

- Detailed member/subscriber information, including eligibility
- Detailed plan information
- COB information on file
- Detailed benefit information, including general policy provision, special programs available, and benefit changes that may have occurred
- Both allowed and remaining accumulator amounts, including deductible, coinsurance amount, office visits (i.e., eye exams)
- Detailed claim history and payment inquiry, including provider name, procedures codes, diagnosis codes, type of service codes and place of service codes. Customers will have read only access to this information and will not have the ability to reprocess claims.

The State will have the ability to create their own notes in ASD, as well as access to view notes that they previously created. Due to privacy issues, you will not have access to call tracking/resolution notes created by our customer service representatives. Our customer service representatives will have the ability to view customer input notes and can use them to assist callers with calls they may have relating to the same issue.

Attachments:

2.1.7.8 Explain your process of providing a secure electronic portal for members and providers to contact you via e-mail for customer service inquiries.

Answer: MEMBERS

Member can use Aetna Navigator to send a written inquiry to member services. Every page on the Aetna Navigator site has a “Contact Us” link, making it simple to send a secure message to member services whenever they have a question or concern.

PROVIDERS

Our secure provider website offers many features to providers, including the ability to submit inquiries to customer service via e-mail.

Attachments:

2.1.7.9 Describe your company’s use of current system technologies to notify customers of issues that relate to them.

Answer: Your account team will be well informed internally about any issues, changes, or items that the State should be aware of and will personally notify you to ensure that any appropriate actions will be taken.

Lynda Gable, your account executive, and Catie Lynch, your account manager, will be the liaisons between the State and Aetna. They are responsible for the plan's day-to-day and strategic activities and are readily available to work with you to ensure all of your needs are met on a daily basis. They can advise and assist you on all facets of your plan including member issues, network information, outages, response to weather events, etc.

Additionally our plan sponsor liaison (PSL), Karri Priddy, will serve as an extension of your account team. Our PSL is located in our Fresno Service Center and will act as a single point of contact in assisting you with service center-related issues. We will also assign an eligibility consultant, Barri Frank, to work with you regarding eligibility file submissions and any eligibility issues that may arise.

We are also offering our My AlaskaCare Single Point of Contact(health concierge) service as well as four locally-based representatives to facilitate the administration of benefits for the State and its members.

The State can also use our Employer Secure Website to contact your account team. The site provides direct e-mail access to the State's account team. This includes the account manager, account executive, eligibility consultant and claim contact. The State can also get the latest news and announcements from the site's home page to catch up on the latest developments at Aetna and in the health care industry as a whole.

Attachments:

2.1.7.10 Describe any on-line comparative reporting tools you make available to assist members in choosing elective care providers and facilities.

Answer: Members and their physicians are the prime decision-makers on when and where care takes place. Physicians often send members to facilities based on familiarity or convenience. Those facilities sometimes cost a great deal more, but may not necessarily provide better care. Fortunately, our price transparency tools and initiatives help take the guesswork out of how much that care costs. We give our members and their physicians the tools and information they need to find out how much health care costs —before that care is given.

Our premier transparency tool is the Member Payment Estimator, which allows members to look up certain non-emergency, highly used services for:

- Physician office services
- Surgical procedures
- Diagnostic tests and procedures

The tool allows members to compare costs for up to ten providers or facilities at a time and provides real-time estimates based on the member's actual plan design. It also factors in all applicable deductibles, coinsurance, copayments and plan limits. To highlight the cost savings of getting care within the network, the tool also lets members compare costs between a network and out-of-network physician.

Our Member Payment Estimator tool is widely available in Alaska, specifically in the Fairbanks and Anchorage areas. We can also expand the tool's availability in other areas of Alaska by expanding our network with the State's support.

In the event the tool can't provide an estimate, we feature several other ways our members can “know before they go,” including:

- Medical Procedure by Facility Cost Tool - shows facility and physician costs for a procedure based on historical claims data
- Estimate the Cost of Care Tool - estimates average costs for approximately 200 medical and dental procedures, tests and office visits, plus overall costs for specific diseases and conditions
- Price-a-DrugSM Tool - includes costs for more than 9,000 prescription drugs

We also offer iTriage, the leading mobile application that helps consumers research symptoms and conditions and find the healthcare provider that best matches their needs. It delivers an integrated experience that helps consumers move from researching to accessing care. It offers a symptom checker to help people answer the two most common medical questions: “What condition could I have?” and “Where should I go for treatment?”

By connecting iTriage to the CarePass® platform, Aetna is enhancing iTriage's differentiated end-to-end consumer experience and enabling greater personalization for the consumer. Patients can now find the provider that best serves their needs based on services delivered, location, availability, personal preferences, such as gender, language spoke, and years of services.

This year, iTriage will have the ability to customize a plan specific member experience to include provider network information and guide consumers to in-network providers.

The app provides consumers with comprehensive health care information on the go and helps them determine what type of health care provider and treatment they need. Through the “Symptom-to-ProviderTM” pathway, users can:

- Look up symptoms and find possible causes
- Based on the causes, guide the consumer to the most appropriate treatment path
- Find the provider that best matches the consumer's needs and preferences
- Locate the closest appropriate health care by location
- In addition to the “Symptom-to-Provider” pathway, the iTriage application provides consumers:

- A nationwide directory of hospital ERs, physicians, urgent care centers and retail clinics
- Information on nurse advice lines
- The ability for consumers to book appointments for select providers and facilities
- Turn-by-turn directions to all provider facilities using either GPS, IP address or any specified location
- Hospital emergency room wait times and a pre-registration feature in select parts of the country

Over 7 million consumers around the globe have downloaded iTriage on their mobile devices and thousands of health care providers use the app to deliver facility and service information to their patients.

Quality and outcomes should be the first priority for more serious care. That's why we offer two tools to help members make smarter decisions about which hospitals and specialists are right for them — not only in terms of price, but also for quality.

- Hospital Comparison Tool -includes information on 157 medical procedures at more than 6,000 hospitals nationwide. It helps members choose a hospital for their inpatient care for certain procedures, conditions and diagnoses. Members can compare hospitals based on treatment outcomes and other quality information, including patient satisfaction. We license the tool from WebMD Health Services.

Our online transparency tools engage our members more than the market average. A 2011 Forrester Research study shows that 58 percent of Aetna members use our online tools compared to 43 percent of the total market. These tools successfully help our members know what they will pay for many services, tests and procedures before they receive them.

Attachments:

2.1.7.11 Indicate services you offer to members and providers via e-mail and electronically.

Answer: We are delivering on our promise to provide our constituents with the most comprehensive suite of tools and services that today's technology can deliver. Whether it is reducing the time for claim payments to physicians or providing members with 24-hour access to personalized benefits information, we are taking advantage of technology to enhance the services we provide.

MEMBERS

Aetna Navigator, our self-service website, empowers members to manage their health benefits and access credible health information online. The site combines customized, credible health information with personalized benefits information including claims status, electronic EOBs, eligibility information, ID card requests, health care decision-making tools, wellness information, and much more. The most popular areas of Aetna Navigator include Who is Covered where members can view eligibility information as well as medical, dental and pharmacy claims status. The health care consumer tools, such as our Aetna Navigator Hospital Comparison Tool and Price-A-DrugSM, are also popular resources for members.

Aetna Navigator also facilitates communications with members by providing push messaging to alert them of certain transactions and features on the site. Members that elect paper suppression will receive an e-mail notification when they have a new EOB or FSA payment to view online. Members who elect to receive e-mails will be sent our monthly e-mail newsletter, Member EssentialsSM. The newsletter promotes the benefits and new features of Aetna Navigator. In addition, members may contact Member Services through secure messaging in English and Spanish at any time.

In addition, Aetna SmartSourceSM, our intelligent online search tool, is available through Aetna Navigator, Simple Steps To A Healthier Life® and our Personal Health Record (PHR). Users simply enter a condition, symptom, medication, test, procedure or other health term and, based on the user's Aetna profile (where they live, their Aetna health plan and more), Aetna SmartSource searches through our vast resources (Aetna Navigator, DocFind, Aetna IntelliHealth, etc.) to bring the most relevant information to the user, including:

- Local doctors and specialists who participate in the user's Aetna health plan
- Medications and treatment options
- Estimated health care costs
- Aetna programs and discounts associated with the health topic
- Easy-to-understand health information and articles
- Aetna Clinical Policy Bulletins

We offer an opportunity for the State to experience Aetna Navigator® through our guest ID. The State can access our guest ID site at www.aetna.com.

User name and passwords are:

- User name: nnmeddentguest1
- Password: nnmeddentguest1

CAREPASS

We recently launched an open digital platform, CarePass® that will seek to improve convenience for consumers in a fragmented health care system. The platform will enable consumers to securely share cloud-based health profile information across mobile applications, sharing information as they specifically permit. We also introduced the updated iTriage® application, the first application connected to the CarePass platform. We are partnering with market leading applications across several health categories (e.g., fitness, nutrition, pharmacy, behavioral health, disease/care management, personal health records) and building a robust ecosystem of health applications that empowers consumers to manage their whole health and live healthier lives.

iTriage provides consumers with comprehensive health care information on the go and helps them determine what type of health care provider and treatment they need. Through the “Symptom-to-Provider™” pathway, users can:

- Look up symptoms and find possible causes
- Based on the causes, guide the consumer to the most appropriate treatment path
- Find the provider that best matches the consumer's needs and preferences
- Locate the closest appropriate health care by location
- In addition to the “Symptom-to-Provider” pathway, the iTriage application provides consumers:
- A nationwide directory of hospital ERs, physicians, urgent care centers and retail clinics
- Information on nurse advice lines
- The ability for consumers to book appointments for select providers and facilities
- Turn-by-turn directions to all provider facilities using either GPS, IP address or any specified location
- Hospital emergency room wait times and a pre-registration feature in select parts of the country

This year, iTriage will have the ability to customize a plan specific member experience to include provider network information and guide consumers to in-network providers.

MOBILE APPS

Nearly 60 percent of our membership has a Smartphone and 40 percent of those members access mobile web at least weekly. In response to this growing popularity of Smartphone technology, we created a free mobile application (app) for the iPhone, iPod touch, iPad, Android™ and Blackberry phones.

Our app provides on-the-go capabilities and lets employees and their families:

- Search for a doctor, dentist, hospital or urgent care facility based on current location and get turn-by-turn directions with the iPhone's built-in global positioning system (GPS)

Call the doctor's office with the tap of a finger

- View a map of the office location
- Transfer the doctor's contact information right to their address books

PROVIDERS

We offer our providers an array of innovative services that provide important information, including patient eligibility, claims status and utilization review procedures.

- Provider website - Our secure provider website offers many features to providers, such as the ability to submit a claim and view claim status, check eligibility, submit a referral and check referral status, view fee schedules, and much more. In addition, the website enables participating physicians to access the medical necessity external review process as members access it.

- Clinical-decision support tools on our secure provider website:

- Electronic Care Considerations - Clinical alerts that identify potential wellness opportunities or safety risks, sent to physicians based on a member's claims history.

- Aetna Personal Health Records - Accessible to a provider with member permission, our Aetna Personal Health Records (PHRs) provide a comprehensive view of a patient's health care treatment and health history. Based on Aetna claim history and self-entered patient data.

- Selected Members' Clinical Information Lists - Provide PCPs with actionable information for reviewing members' treatment and compliance with treatment. The lists profile members in a practice with asthma, diabetes and cardiac disease, and highlight those members who may benefit from an adjustment in their therapy or a review for medication compliance. The lists also identify members with potential drug interactions or evidence of six or more prescriptions dispensed simultaneously that may affect their health.

- Electronic data interchange - Through electronic data interchange (EDI) vendors, participating providers can electronically verify member eligibility and submit referrals, claims and precertifications, as well as check the status of each.

- Provider Payment Estimator - Enables participating providers to determine a more accurate estimate of their provider payment and the member's financial responsibility for services to be performed. The tool is available on our secure provider website and accessible to all participating providers who have registered to use the website. Our Provider Payment Estimator applies to members of our HMO-based and PPO-based medical plans and our behavioral health plans.

- **Clear Claim Connection** - Our Internet-based tool offers physicians and health care professionals comprehensive access to the coding rationale regarding claims payments. Available on our secure provider website, the tool shows how we will handle the billing codes submitted for payment by our claims processing system. Participating physicians may also access their fee schedules on the website.
- **Health Care Professional Toolkit** - Our toolkit, a comprehensive office manual and reference guide, presents providers and their staffs with a thorough overview of our policies, programs, products and procedures along with other essential information. The toolkit is available to primary care and specialist offices and hospitals through our secure provider website, and it can be ordered in a paper version. In addition to the Health Care Professional Toolkit, we communicate with providers regularly with our provider newsletter, Aetna OfficeLink Updates.
- **Personal Digital Assistants** - We also have arrangements with vendors that provide physicians with real-time, point-of-service information and electronic prescribing capabilities. Physicians that subscribe to one of these services use a hand-held electronic device called a personal digital assistant, which provides access to helpful information before prescribing a drug. Information may include a formulary list, precertification and step-therapy requirements, and general published drug-reference information concerning safety topics such as appropriate dosing or drug interactions. Depending on the vendor, physicians may be able to fax prescriptions electronically to a member's retail or mail-order pharmacy or print a copy of the electronic prescription for patients to take to their pharmacies.

Attachments:

2.1.7.12 Describe electronic service methods you use to educate members in accounts you currently manage of similar size to the State of Alaska about health care issues that impact plan costs.

Answer: At Aetna, we believe in promoting wellness and preventive services, and we recognize that the State is concerned about the health of their employee population, and want to do the best thing/the-right thing for your employees. Accounts of similar size to the State of Alaska are optimizing the multiple tools and solutions we have at Aetna to educate members. To a great extent, the goal is to create awareness of the robust tools to support the interaction. However, many of our customers are also using the My AlaskaCare Single Point of Contact (health concierge) as the key point of contact to create greater education when the information is needed. A number of the electronic methods that are included in our solution for the State are below.

WELLNESS WORKS LIBRARY

The Aetna Wellness Works Content Library makes promoting wellness easy, accessible and engaging. Materials are available on a stand-alone basis or soon to be offered through a member focused microsite.

The content library features videos, general health and wellness topics, recipes/cooking demonstrations, turn-key e-campaigns, flyers, e-cards and more.

Sample health and wellness video topics include:

- Cancer care
- Childhood nutrition
- Exercise
- Metabolic syndrome

E-campaigns are instant, self-contained, turn-key marketing campaigns built around a theme. They

feature the videos and other relevant content. All the State needs to do to release the e-campaign is insert their e-mail list and hit the send button.

QUALITY E-MESSAGES

We can deliver educational health information about clinical quality and patient safety to the State and its members as a value-added service. The State can distribute these messages through e-mail to all their employees. The Quality e-Message topics include:

- Cervical Cancer Screening
- Colon Cancer Screening
- Get vaccinated against the flu
- Just what the doctor ordered
- Know when antibiotics work
- Mammography
- Medication Error: Patient safety tips
- Medication Safety
- Numbers to Know
- Over-the -Counter Medications
- Tips for taking medicine
- Your medicine: play it safe
- Ways you can prevent infection

HEALTH HISTORY REPORT

Our Health History Report, available to members through Aetna Navigator, provides a centralized health summary and helps members manage their preventive screening and immunization schedule. The Health History Report includes the member's health-related activity, such as:

- Doctor visits
- Tests
- Treatments
- Prescriptions for medication

The Health History Report organizes information according to health-related category, such as names of doctors, medical care, prescription drugs, dental care, etc.

MEDQUERY

Our MedQuery® program alerts physicians to opportunities for improved patient care by turning our member data into information that can be used to enhance clinical quality, patient safety and financial outcomes. The program analyzes member data, including claim history, current medical, pharmacy and laboratory claims, and demographics, to identify opportunities for improved care and then delivers specific evidence-based treatment guidelines to physicians.

The MedQuery program applies clinical algorithms, according to evidence-based medical research, to identify potential errors or omissions in care. As opportunities for improved care are identified, they are stratified and assigned a severity level. The member-specific opportunities, called Care ConsiderationsSM, are then communicated to the appropriate treating physician. By identifying and communicating opportunities for improved care, the MedQuery program empowers physicians to optimize care and avoid adverse events.

ONLINE TOOLS

Members and their physicians are the prime decision-makers on when and where care takes place.

Physicians often send members to facilities based on familiarity or convenience. Those facilities sometimes cost a great deal more, but may not necessarily provide better care. Fortunately, our price transparency tools and initiatives help take the guesswork out of how much that care costs. We give our members and their physicians the tools and information they need to find out how much health care costs —before that care is given.

Our premier transparency tool is the Member Payment Estimator, which allows members to look up certain non-emergency, highly used services for:

- Physician office services
- Surgical procedures
- Diagnostic tests and procedures

The tool allows members to compare costs for up to ten providers or facilities at a time and provides real-time estimates based on the member's actual plan design. It also factors in all applicable deductibles, coinsurance, copayments and plan limits. To highlight the cost savings of getting care within the network, the tool also lets members compare costs between a network and out-of-network physician.

In the event the tool can't provide an estimate, we feature several other ways our members can “know before they go,” including:

- Medical Procedure by Facility Cost Tool - shows facility and physician costs for a procedure based on historical claims data
- Estimate the Cost of Care Tool - estimates average costs for approximately 200 medical and dental procedures, tests and office visits, plus overall costs for specific diseases and conditions
- Price-a-DrugSM Tool - includes costs for more than 9,000 prescription drugs

Aetna Navigator also assists members in using their health plan and in making informed health choices by providing access to:

- Healthwise® Knowledgebase, a user-friendly decision-support tool that can help users to make more informed health decisions, such as: when to treat a health problem at home, when to call a doctor and what treatment options may be available. Available in both English and Spanish, the Healthwise Knowledgebase offers members access to clinical information on 6,000 health topics, 600 medical tests and procedures, 500 support groups and 3,000 medications. Healthwise Knowledgebase is designed to encourage informed health decision-making, allowing users to better understand their treatment options.

- Aetna SmartSourceSM, our intelligent online search tool available through Aetna Navigator, Simple Steps To A Healthier Life® and our Personal Health Record (PHR). Users simply enter a condition, symptom, medication, test, procedure or other health term and, based on the user's Aetna profile (where they live, their Aetna health plan and more), Aetna SmartSource searches through Aetna's vast resources (Aetna Navigator, DocFind®, Aetna IntelliHealth®, etc.) to bring the most relevant information to the user, including:

- Local doctors and specialists who participate in the user's Aetna health plan
- Medications and treatment options
- Estimated health care costs

- Aetna programs and discounts associated with the health topic
- Easy-to-understand health information and articles
- Aetna Clinical Policy Bulletins

- We acquired iTriage® in 2011 and it was recently named one of “10 Apps That Could Save your Life” in Parade magazine. iTriage is a free mobile health care application for iOS® and Android™ devices.

iTriage is the leading mobile application that helps consumers research symptoms and conditions and find the healthcare provider that best matches their needs. It delivers an integrated experience that helps consumers move from researching to accessing care. It offers a symptom checker to help people answer the two most common medical questions: “What condition could I have?” and “Where should I go for treatment?”

By connecting iTriage to the CarePass® platform, Aetna is enhancing iTriage's differentiated end-to-end consumer experience and enabling greater personalization for the consumer. Patients can now find the provider that best serves their needs based on services delivered, location, availability, personal preferences, such as gender, language spoke, and years of services. This year, iTriage will have the ability to customize a plan specific member experience to include provider network information and guide consumers to in-network providers.

The app provides consumers with comprehensive health care information on the go and helps them determine what type of health care provider and treatment they need. Through the “Symptom-to-Provider™” pathway, users can:

- Look up symptoms and find possible causes
- Based on the causes, guide the consumer to the most appropriate treatment path
- Find the provider that best matches the consumer's needs and preferences
- Locate the closest appropriate health care by location

This year, iTriage will have the ability to customize a plan specific member experience to include provider network information and guide consumers to in-network providers.

Attachments:

2.1.7.13 Provide an overview of your documentation, storage, retrieval and recovery of electronic files.

Answer: Our documentation, storage, retrieval, and recovery policies meet or exceed all requirements.

CLAIMS

Our claims system maintains claims history online indefinitely. This includes detailed claim history for each family member on submitted expenses and processed claims (paid, pending and denied).

We move claims greater than five years old that meet specific criteria into an archive database. These claims are available for recall (in most cases, immediately) and will display all claim details.

We also keep three years of financial data on the claims system that are used during adjudication. Financial data beyond the three years are available for historical view only. This includes the family/member's accumulator information such as plan limits, deductibles and amounts accumulated

towards those limits.

ELIGIBILITY

The eligibility system maintains current plus at least two years of historic eligibility data online. We have found two years to be the optimal period of online retention for our customer and business needs. The claims systems interface with the eligibility systems and edit claims against the data. There is currently no time limit on how long we maintain offline eligibility.

DATA WAREHOUSE

Our vast data warehouse consists of 18 terabytes of integrated claim, membership, product, and provider information. The data warehouse stores all available months from the current year plus 3 previous years. Therefore, 37 months to 48 months of data are available at any given time.

BACK-UP AND RECOVERY PROCESS

System downtime is infrequent. Should a system emergency occur, our integrated claims processing system enables any of our other service centers in the country to provide backup claims processing.

Our first consideration would be to explore whether any capabilities remain on-site; for instance, partial terminal or telephone capabilities, and/or how quickly such capabilities could be restored. We would then look to neighboring Aetna offices which, due to our nationwide integration, can immediately assist. In addition to this alternate office processing capability, we also have complete computer backup for both of our data centers located in Middletown, CT and Windsor, CT.

Attachments:

2.1.7.14 Explain your Computer Disaster Recovery plan. Provide the most recent outside assessment of its readiness.

Answer: Aetna's disaster backup and recovery (DBAR) strategy is to provide and maintain an internal disaster recovery capability. The strategy leverages Aetna's internal computer processing capacity of its two large state of the art and hardened computer data centers, located in both Middletown and Windsor, Connecticut. Both facilities have extensive fire suppression systems, dual incoming power feeds, UPS and backup diesel generators which provide 24x7x365 operations. Physical access is strictly controlled and monitored and access to vital areas is segregated by floor and business function where appropriate. The two data centers house Aetna's computer processing capabilities on 3 major platforms, mainframe (Z/OS), mid-range (Various UNIX versions), and LAN (Windows on X86 processors). The data centers are load-balanced and supplemented by quick ship and capacity on demand contracts so each location can back the other up in the event of a disaster. Contracts with national vendors are maintained to obtain replacement equipment and supplemental capacity as needed to ensure recovery time objectives (RTO) can be met.

Please see attachment "DBAR at Aetna" for a complete summary of Aetna's disaster recovery program.

Regarding outside assessments, Gartner, Inc. performed a Benchmark Assessment of our Disaster Recovery program in 2010. An update will be conducted in 2013. Please refer to the Executive Summary of the Assessment in the attachment entitled "Gartner DR Benchmark Assessment Report - Final - ExecSummary.pdf"

Attachments: [DBAR at Aetna.pdf](#)

[Gartner DR Benchmark Assessment Report - Final - ExecSummary.pdf](#)

2.1.7.15 Does the online system allow the State to assign different levels of access internally?

Answer: AETNA HEALTH INFORMATION ADVANTAGE SYSTEM

Confirmed. There are different levels of access that may be assigned within the Aetna Health Information Advantage System. The State can identify staff members to receive higher and lower access levels as you deem appropriate.

ASD AND EMPLOYER SECURE WEBSITE

The State can identify staff members to receive access to ASD External View and our Employer Secure Website as you deem appropriate. There is only one level of access for these systems.

Attachments:

2.1.7.16 Indicate whether the following web tools are available for the State's use and the members:

Tools Available	Check All that Apply	Comments
Check claim status	1: Available	
Check status of Health FSA and claims	1: Available	
Print a temporary ID card	1: Available	
Request a new ID card	1: Available	
Claims Forms (Electronic)	1: Available	
Find a network doctor	1: Available	
Find a network specialist in my area	1: Available	
Get plan design information	1: Available	
Get estimated cost for a procedure/service	1: Available	Our Member Payment Estimator tool includes the ability to determine specific out-of pocket costs using actual contracted provider rates, member-specific plan design and real-time member deductible, coinsurance, copayments and plan limits.
Review financial information - deductible	1: Available	
Review financial information – out of pocket maximum	1: Available	
Get information about provider quality and/or outcomes	1: Available	
Read provider reviews from other members	2: Not Available	
Contact customer service	1: Available	
View and print my EOB	1: Available	

Tools Available	Check All that Apply	Comments
Summary Plan Description	1: Available	
Summary of Material Modifications	2: Not Available	We will provide the employer with revised booklet materials and/or amendments to the booklet materials for distribution to the employees. We do not produce Summary of Material Modifications (SMMs).
Annual Benefit Summaries	1: Available	

Detail:

Attachments:

2.1.8 Integration with Other Vendors

2.1.8.1 Describe your procedures for implementation of ongoing treatment plans.

Answer: TRANSITION OF CARE

Transition of care coverage is temporary coverage we offer to members when they transition from a prior health insurance carrier's plan to an Aetna medical plan. Our transition coverage policy allows a member who has met certain transition eligibility requirements to continue an active course of treatment:

- with a non-participating provider for a limited time without penalty
- at the new/preferred plan benefit level

The following procedures or services generally apply to members seeking transition of care coverage.

- A member hospitalized in a participating facility on the plan effective date. We will assign a concurrent review nurse to monitor the hospitalization and initiate other care management activities, such as discharge planning.
- A member hospitalized in a nonparticipating facility on the effective date. We will pay for medically necessary services incurred after the effective date while continually monitoring the confinement for appropriate level of care with our medical director. For Medicare Advantage Plans, if the plan before our plan was either federal Medicare or another carrier's Medicare Advantage plan, that plan would cover all acute hospital stays until discharge.
- A member receiving ongoing outpatient treatment for an acute, non-acute or chronic condition requiring specialized management. Examples include chemotherapy or radiation for cancer. A case manager and/or a medical director may evaluate the treatment program and establish contact with the provider. If the member is using a nonparticipating provider, we may attempt to identify participating providers with expertise in the relevant course of treatment to provide care to the member. Alternatively, we may make a determination to provide in-network benefits while the member continues the course of treatment with the nonparticipating provider. In such cases, we attempt to negotiate a cost-effective arrangement with that provider.
- A member in the advanced stages of terminal illness. A case manager and/or a medical director may evaluate the treatment program and establish contact with the provider. If the member is using a nonparticipating provider, we may attempt to identify participating providers with expertise in the relevant course of treatment to provide care to the member. Alternatively, we may make a

determination to provide in-network benefits while the member continues the course of treatment with the nonparticipating provider. In such cases, we attempt to negotiate a cost-effective arrangement with that provider.

- A member who is pregnant and has completed 20 weeks of her pregnancy on the plan effective date. She may continue care with her nonparticipating obstetrician at the preferred level of benefit.

If she has not completed 20 weeks of her pregnancy on the plan effective date and a nonparticipating obstetrician is treating her, she has the option to continue care at a lower benefit or transfer care to a participating obstetrician and receive a higher benefit with the plan.

THIRD PARTY VENDORS

When we are aware of other vendors that provide services to the member, our staff will provide the member with the name of the vendor and their contact number. This information is housed in the plan sponsor tool website to which clinical staff has access. Our staff does not however contact the vendor or exchange member information.

MY ALASKACARE SINGLE POINT OF CONTACT(HEALTH CONCIERGE)

Our My AlaskaCare Single Point of Contact can also connect members to additional resources to help them get the most from their benefits. The health concierge pairs up with a clinical team and organizes clinical support and care for members to help them achieve better health. The concierge may also contact a nurse care advocate to share information with a member on health programs such as disease management.

Attachments:

2.1.8.2 Are you able to accept electronic feeds of data or referrals from other vendor partners? If there is an additional cost, please indicate the cost on the rate sheet.

Answer: 2: Yes, for an additional fee (indicated on rate sheet)

Detail: We have the capability to import external claims data from third-party vendors into selected clinical and reporting applications. For example, we have in-house programs written to accept data from all of the main pharmacy carriers including but not limited to Medco, Caremark, Express Scripts and Walgreens. In addition, we have experience integrating data types such as:

- Disease management activity
- Employee Assistance Programs
- Health Risk Assessment
- Behavioral health claims
- Workman's Compensation
- Disability

We evaluate each request individually to meet the specific needs of our customer. The account manager coordinates the request and facilitates implementation. Costs vary depending on the type of data imported/integrated.

We can accommodate variable file frequencies. The majority of our files are received on a monthly or bi-weekly basis; however, we do receive weekly files for certain programs.

We have included standard data feeds for the following in our proposed medical fees:

- Rx integration from 3rd party vendor

- Dental Integration from 3rd party vendor
- Biometric Screening integration from 3rd party vendor

Fees for additional data feeds are shown on the rate sheet. Please note these are standard prices. For customized work, for very complex integration efforts or for additional analytics, we may assess additional fees beyond what is quoted.

Options:

1. Yes, included in base pricing
2. Yes, for an additional fee (indicated on rate sheet)
3. Yes, for an additional fee IF the number of contracted data feeds are exceeded (indicated on rate sheet)
4. No

Attachments:

2.1.8.3 Are you able to provide electronic feeds of participation data to an outside data aggregator or vendor partners? If there is an additional cost, please indicate the cost on the rate sheet.

Answer: 2: Yes, for an additional fee (indicated on rate sheet)

Detail:

Options:

1. Yes, included in base pricing
2. Yes, for an additional fee (indicated on rate sheet)
3. Yes, for an additional fee IF the number of contracted data feeds are exceeded (indicated on rate sheet)
4. No

Attachments:

2.1.8.4 Are you willing to provide monthly interface with the data integration vendor or other vendors for claims and utilization data? If there is an additional cost, please indicate the cost on the rate sheet.

Answer: 2: Yes, additional cost (indicated on the rate sheet)

Detail: We can transfer data to any vendor that the State designates, with the appropriate confidentiality agreements in place. Aetna Informatics® has more than 30 years of experience in vendor interface. Recipients of our information use it for analytical reporting, auditing, disease management, flexible spending account administration and a host of other health plan functions and services.

We typically disclose processed claim transaction data in our standard Universal File formats. These electronic claims data extracts are available through CD-ROM or electronically on a fee-for-service basis. If the standard format does not meet the State's needs, customized reporting is available. Charges for customized and standard claims data extracts include an initial set-up fee and annual charge. This charge will vary based on frequency. We have included the cost of one regular monthly data feed into our pricing.

We have included at no additional charge one Universal claim file on a monthly frequency basis. All other interfacing would be at an additional cost, which has been outlined on the rate sheet.

Options:

1. Yes, no additional cost
2. Yes, additional cost (indicated on the rate sheet)
3. No

Attachments:

2.1.8.5 Does your program/system have the capability to share data with the following vendors or programs?

Answer: 1: Biometrics,

2: Case Management,

3: Demand Management/Nurse Line,

4: Disease Management,

5: EAP/Behavioral health,

6: Health Advocacy/Health Coach,

7: Health Plans/TPA,

8: Health Risk Appraisal,

9: Healthcare savings/FSA,

10: Labs,

11: Maternity Management,

12: Mental Health / Substance Abuse,

13: Nurse and/or doctor line,

14: On site clinics,

15: PBM,

16: Providers,

17: Utilization Management,

18: Wellness/Lifestyle management,

19: Other, please specify: [We can transfer data to any vendor that the State designates, with the appropriate confidentiality agreements in place. Additional charges may apply depending on the number of vendors and the frequency of the transfers.]

Detail: We have more than 30 years of experience in vendor interface. Recipients of our information use it for analytical reporting, auditing, disease management, flexible spending account administration and a host of other health plan functions and services.

Options:

1. Biometrics
2. Case Management
3. Demand Management/Nurse Line
4. Disease Management
5. EAP/Behavioral health
6. Health Advocacy/Health Coach
7. Health Plans/TPA
8. Health Risk Appraisal
9. Healthcare savings/FSA
10. Labs
11. Maternity Management
12. Mental Health / Substance Abuse
13. Nurse and/or doctor line
14. On site clinics

15. PBM
16. Providers
17. Utilization Management
18. Wellness/Lifestyle management
19. Other, please specify: [Text]

Attachments:

2.1.8.6 Please describe how you will coordinate with other Contractors, if any, to manage functions such as data sharing, eligibility, coordination of benefits and payment of medical, pharmacy and healthcare claims.

Answer: If Aetna is awarded all components of the RFP, we have all of our systems and processes integrated to deliver the seamless experience for the member and the State. If there are other vendors involved, we will work with the State and the vendor to define the necessary coordination.

We work with many national customers that use 3rd parties for which we integrate. Our processes and approach to integrate are based on the customer's goals and the role of each organization and their need for data sharing.

CLAIM DATA SHARING

We can transfer data to any vendor that the State designates, with the appropriate confidentiality agreements in place. Aetna Informatics® has more than 30 years of experience in vendor interface. Recipients of our information use it for analytical reporting, auditing, disease management, flexible spending account administration and a host of other health plan functions and services.

We typically disclose processed claim transaction data in our standard Universal File formats. These electronic claims data extracts are available through CD-ROM or electronically on a fee-for-service basis. If the standard format does not meet the State's needs, customized reporting is available. Charges for customized and standard claims data extracts include an initial set-up fee and annual charge. This charge will vary based on frequency.

We can also import external pharmacy, medical and behavioral health claims data from third-party vendors into selected clinical and reporting applications. In addition, we have experience integrating data types such as:

- Disease management activity
- Employee Assistance Programs
- Health Risk Assessment
- Behavioral health claims
- Workman's Compensation
- Disability

ELIGIBILITY

We work with many customers who use third party enrollment vendors. These vendors can extract data and send our proprietary 2000-byte file layout, our new Consolidated Eligibility Format (CEF) file or an ANSI standard layout for electronic processing.

COORDINATION OF BENEFITS(COB)

We provide COB services as part of our standard offering. We will coordinate benefits using data from our integrated system platforms.

CLAIM PAYMENT

We are offering the State our full administrative services package which includes comprehensive and integrated medical, pharmacy, and health care claims processing services.

While separate units handle care management and claims functions, the data associated with each of these is integrated online. This allows each function to review the others when needed. Through our electronic utilization management system, claims processors can view all medical utilization decisions and documentations, such as non-compliant issues. These are immediately available in real time after entered by our nurse reviewers. This information is provided in a read-only format and can only be edited by authorized staff members.

Attachments:

2.1.8.7 Are you capable of designing exports to the FSA vendor to process FSA claims based off medical claim data that is stored within your system?

Answer: Confirmed. We have assumed as the medical administrator, we would be providing FSA administration. With this arrangement we have a streamlined process of internally integrating claims data; therefore no claims import or export is necessary.

If an external FSA vendor is applicable, we have experience working with several FSA vendors and can provide claims data to your FSA administrators or vendors at your request on a weekly or monthly basis.

Attachments:

2.1.8.8 Please provide examples of FSA data coordination that you have done with other customers.

Answer:

Attachments:

2.2 Patient Value Chain

2.2.1 Network

2.2.1.1 Is your network NCQA accredited?

Answer: Confirmed. We were the first national insurer to hold NCQA Preferred Provider Organization (PPO) Full Accreditation.

Attachments:

2.2.1.2 If your network is NCQA accredited, what was the accreditation date?

Answer: We first obtained our NCQA PPO accreditation in 2007. Our current accreditation date was December 22, 2010.

Attachments:

2.2.1.3 If your network is NCQA accredited, what is the next reevaluation date?

Answer: Our next reevaluation date is December 22, 2013.

Attachments:

2.2.1.4 Please confirm that your network contains sufficient providers to accommodate Employees and Retirees in Alaska and the other 49 states with respect to the following medical services:

- Physician services
- Emergency Room Visits
- Hospitalization
- Home Health Care
- Skilled Nursing Care
- Skilled Nursing Facilities
- Outpatient Procedures
- Radiation
- X-Rays
- Laboratory Tests
- Rehabilitative Care
- Outpatient Preoperative Testing
- Outpatient Ambulatory Surgery
- Anesthetic
- Durable Medical Equipment/Supplies
- Mental Disorder Treatment
- Chemical Dependency Treatment
- Treatment of Spinal Disorders
- Medical Treatment of Mouth, Jaws and Teeth
- Medical Treatment of Obesity
- Plastic, Cosmetic and Reconstructive Surgery
- Mastectomy/Breast Reconstruction

Answer: Confirmed. We typically provide all of these services in our national and Alaska networks. Please note however that Alaska has a smaller number of skilled nursing beds in certain areas.

In the instance that a provider type is not available in network, we have a procedure where a nonparticipating provider can provide care at the participating benefit level. Additionally, network management may pursue contracting initiatives to close the gap. When services are not available in network (e.g. an employee in Hoonah who needs services that are only available in Juneau), the member can work with the My AlaskaCare Single Point of Contact (health concierge) or their case manager to try and arrange the best care possible for the member.

As requested in questions 2.2.1.5 and 2.2.1.6 we have included our PPO provider listings which include information on provider specialty/type.

Attachments:

2.2.1.5 Please provide your in-network provider list for Alaska, including: numeric breakdown by specialty, name and geographic location of each provider.

Answer: 1: Attached

Detail: Please also note that DocFind®, our online provider directory at www.aetna.com, provides information on all our participating providers including physicians, dentists, vision providers, hospitals, and pharmacies.

Options:

1. Attached
2. Not Attached

Attachments: [Additional Providers to join network.xlsx](#)
[PPO- AK.zip](#)

2.2.1.6 Please provide your in-network provider list for the other 49 states, including: numeric breakdown by type, name and geographic location of provider.

Answer: 1: Attached

Detail: Please also note that DocFind®, our online provider directory at www.aetna.com, provides information on all our participating providers including physicians, dentists, vision providers, hospitals, and pharmacies.

Options:

1. Attached
2. Not Attached

Attachments: [PPO- AL thru GA.zip](#)
[PPO- HI thru MD.zip](#)
[PPO ME- NH.zip](#)
[PPO NJ thru SC.zip](#)
[PPO- SD thru WY.zip](#)

2.2.1.7 Please provide your network provider turnover rate for Alaska.

Answer: As of 9/30/2012, the turnover rate in our Alaska PPO network was 2.88 percent.

Attachments:

2.2.1.8 Please provide your network provider turnover rate for the remaining 49 states.

Answer: As of 9/30/2012, our national PPO physician turnover rate (exclusive of Alaska) was 3.4 percent.

Attachments:

2.2.1.9 Describe how your in-network provider list for Alaska has changed in the past five years.

Answer: Our network has grown over the past 5 years. Network fortification has been a key initiative over the past several years in Alaska. The table below illustrates the significant progress made. Aetna is committed to continuing our efforts to expand our network. The chart below reflects our recent growth.

Alaska Provider Composition Trend

2007 Alaska Composition:

- PCPs - 250
- MD/DO Specialists - 198
- Other Specialists - 436
- Total providers - 884
- Hospitals - 8

2012 Alaska Composition:

- PCPs - 377
- MD/DO Specialists - 329
- Other Specialists - 484
- Total providers - 1,190

- Hospitals - 12

2007 - 2012 Alaska Network Growth:

- PCPs - 51 percent
- MD/DO Specialists - 66 percent
- Other Specialists - 11 percent
- Total providers - 35 percent
- Hospitals - 50 percent

Attachments:

2.2.1.10 Describe any anticipated changes to your current in-network provider list for Alaska in the next five years.

Answer: We expect to continue our expansion of our Alaska network while continuing to offer employers the best overall discounts in the market. We are willing to work with the State on adding providers to the network based on mutual goals.

We have attempted to recruit most providers (meeting our participation requirements) in Alaska into the network. However, in many instances, we have been unwilling to meet the excessive rate requests providers are seeking for participation.

We welcome the opportunity to work with the State and expand the network. We can operate in multiple ways:

- Contract for our entire network when providers are willing to accept competitive reimbursement levels and our policies and provisions

- Contract a custom network solution involving the State in the decision making process factoring in the cost implications of meeting the provider rate requests.

Attachments:

2.2.1.11 Explain the efforts you are taking to expand your current list of network providers in Alaska.

Answer: Currently, we have a list of targeted Alaska physicians and facilities we are aggressively pursuing for contracting. Recruiting is based on patient/client demand and ability to procure contracts at affordable rates.

We have committed to increasing the network and will continue to recruit and add providers to our networks. The Aetna network staff is committed to work with the provider community throughout the state of Alaska and throughout the country. We are currently recruiting throughout the state of Alaska with added emphasis on specific areas where providers have historically not been willing to contract like Fairbanks, Juneau, Sitka, as well as other areas as needed, or the opportunity arises.

If awarded the state of Alaska contract, we will work with you to define a total network strategy and determine the deployment timing. That strategy will include the expansion of the existing network, creation of patient centered medical homes, Accountable Care Organizations, and/or telemedicine to meet your needs to address the overall provider delivery system in Alaska. We would anticipate this to be an interactive process that focuses on your goals to achieve the overall strategy and design objectives. We will utilize our network resources to determine the optimal strategy based on each borough within Alaska.

Attachments:

2.2.1.12 Explain the efforts you are taking to expand your current list of network providers in the remaining 49 states.

Answer: We continuously monitor our national PPO network and respond appropriately by addressing local membership needs. When deciding to further develop a local network, we consider:

- Geographic location
- Membership size
- Physician availability

The main objectives of network development are quality of service and appropriate provider access. Our network management staff has been successful in meeting the needs of membership growth by actively seeking out quality physicians to provide services. The popularity of our plans reflects our success in developing and maintaining our broad and robust network.

Our robust national PPO network contains over 244,000 PCPs, 787,000 specialists, and 6,700 hospitals. The disruption analysis submitted with our proposal also demonstrates the strength of our networks in areas of the country where the State's members reside.

Our typical network access standards for determining if we need to expand providers are as follows:

PCPs (e.g., pediatricians, family practice, internal medicine)

- Urban: 2 within 10 miles
- Suburban: 2 within 20 miles
- Rural: 2 within 30 miles

Ob/Gyns

- Urban: 2 within 10 miles
- Suburban: 2 within 20 miles
- Rural: 2 within 30 miles

Specialty care

- Urban: 2 within 10 miles
- Suburban: 2 within 20 miles
- Rural: 2 within 30 miles

Hospitals

- Urban: 1 hospital within 15 miles
- Suburban: 1 hospital within 25 miles
- Rural: 1 hospital within 40 miles

We also consider the effect of local conditions on travel distance and time. This includes:

- Natural geographic boundaries, such as rivers and mountains
- Man-made boundaries, such as bridges and railway tracks
- Road types ranging from interstate highways to rural roads
- Local travel factors, such as periodic traffic congestion

Our local network team is responsible for reviewing the service area at a zip code level.

In addition, we address any provider gaps through network fortification. Our local network staff identifies any provider types that may be lacking in a given network, and then identify specific providers to recruit to close the gap. They work to ensure the network is represented by an appropriate number of quality providers for each provider type that we require in our networks. Members and customers are also welcome to nominate any provider that they would like to see added to our network.

Attachments:

2.2.1.13 Do you wholly own, partially own or lease your network in the State of Alaska?

Answer: We wholly own the core medical network in the State of Alaska. We supplement our core network with an alternative discount arrangement that will provide the State of Alaska additional discounts.

Attachments:

2.2.1.14 If not wholly owned, please provide details of ownership or leased network arrangement(s).

Answer: Our supplemental arrangement is through rental network arrangements. Our program offers access to contracted rates for out-of-network services and case-specific rate negotiation with out-of-network providers. Through several national third-party vendors, we offer access to contracted rates for out-of-network claims that would otherwise be paid at billed charges. These contracted rates can produce average savings of approximately 25 to 30 percent of charges at participating hospitals, facilities and for many physicians' services. Additionally, our agreement with these providers prohibits them from balance billing members.

If a medically necessary service is not available in-network or through a third-party vendor, we contact the non-network provider and negotiate a discount for that particular case if our customer's plan includes our supplemental arrangement.

Our vendors in Alaska are Multiplan, Inc. and Beech Street Corporation.

Attachments:

2.2.1.15 How quickly will the State be informed when there are changes to the network (additions and deletions)?

Answer: Our standard policy is to notify customers at least 30 days prior to any significant network changes, including hospital or large physician group terminations and additions.

We will have a separate process in Alaska as we work with the State to meet its objectives. Regular network meetings addressing network strategy and expansion will be in place to align to cost and quality goals.

Attachments:

2.2.1.16 How quickly will the provider database be updated (additions and deletions) for member reference?

Answer: We update DocFind six times per week. This is available via the web and mobile application.

iTriage will also have our network providers effective March 2013. iTriage provides members with information on both network and non-network providers to ensure providers have a full reference in the event they are traveling and need care. It is updated in real time.

Attachments:

2.2.1.17 Please provide your hospital network for Alaska.

Answer: The hospitals currently participating in our Alaska PPO network are as follows:

ACUTE SHORT TERM HOSPITALS

Anchorage VAMC, Anchorage, AK
Bartlett Regional Hospital, Juneau, AK
Central Peninsula General Hospital, Soldotna, AK
Cordova Community Medical Center, Cordova, AK
Fairbanks Memorial Hospital, Fairbanks, AK
Ketchikan Medical Center, Ketchikan, AK
Maniilaq Health Center, Kotzebue, AK
Mat-Su Regional Medical Center, Palmer, AK
Mat-Su Regional Medical Center, Wasilla, AK
Providence Alaska Medical Center, Anchorage, AK
Providence Kodiak Island Medical Center, Kodiak, AK
Providence Seward Medical and Care Center, Seward, AK
Providence Valdez Medical Center, Valdez, AK
South Peninsula Hospital, Homer, AK
St. Elias Specialty Hospital, Anchorage, AK

PSYCHIATRIC HOSPITALS

North Star Hospital, Anchorage, AK

North Star Hospital-Bragaw, Anchorage, AK

RESIDENTIAL TREATMENT FACILITIES

Cornerstone Emergency Shelter, Juneau, AK
DeBarr Residential Treatment Center, Anchorage, AK
Lighthouse Residential Child Care Facility, Juneau, AK
Miller House, Juneau, AK
Palmer Residential Treatment Center, Palmer, AK
Providence Residential Treatment Center, Anchorage, AK

SUBSTANCE ABUSE FACILITIES

Rainforest Recovery Center, Juneau, AK

NATIONAL ADVANTAGE PROGRAM

The hospitals participating in our National Advantage Program are as follows:

SEARHC Mt. Edgumbe Hospital, Sitka, AK
SEARHC Juneau Medical Center, Juneau, AK
Alaska Native Medical Center, Anchorage, AK
Samuel Simmonds Memorial Hospital, Barrow, AK
Sitka Community Hospital, Sitka, AK
Alaska Regional Hospital - HCA, Anchorage, AK
Angoon Health Center, Angoon, AK
North Star Hospital - Debarr Campus, Anchorage, AK

Attachments:

2.2.1.18 Please provide your hospital network for the remaining 49 states.

Answer: Our national PPO network contains over 6,700 hospitals. Please see our national PPO hospital listing for the other 49 states attached. Within that network, we have isolated Centers and Excellence and Institutes of Quality based on standards met for treatment of transplant care, pediatric congenital heart surgery, infertility, bariatric surgery, cardiac care and orthopedic (total joint replacement and spine) programs.

Attachments: [National PPO Hospital Listing.xls](#)

2.2.1.19 Are in-network services always provided at a reduced fee for covered services (i.e., charge is less than the provider's normal charge)?

Answer: Confirmed. In the State of Alaska we have maintained our standard networking contracting approach which is focused upon both inpatient, outpatient and physician reimbursement approaches aligned to competitive reimbursement levels. According to a highly regarded third party benchmarking study regarding health plan discounts, Aetna has the best discounts in the State. In network services are typically provided at reduced fees. There is only one case where Aetna established a contractual relationship at 100 percent of the provider's charges. This hospital has NO contracts with health plans where they offer their services at a discount. An agreement at 100 percent of charges was considered a first step towards building a relationship with a key delivery system where we can collaborate on managing total cost with an eventual move towards discounted rates. The contract is still subject to our claims edits and policies which will result in a payment that typically results in charges less than normal charges. Please note that all of our provider contracts have our policies and procedures embedded within them to ensure compliance with evidence-based medicine and achieve highest quality and maximum savings for our customers. The savings generated from our policies and procedures may vary by provider but can be up to approximately 3 to 5%.

Attachments:

2.2.1.20 Please describe your contracted network providers' practices with respect to requesting payment from members at time of service.

Answer: Members may be required to pay copayments, coinsurance and/or deductibles for certain covered services, in accordance with their plan design. While copayments represent a fixed amount, the exact amount of a member's coinsurance or deductible cannot be determined until we process the claim.

Providers learn the member's exact amount owed when they submit the claim to us and wait for the explanation of benefits (EOB), which indicates a description of the services provided, the negotiated amount we reimbursed the provider and the amount the member owes, if applicable. Providers benefit from following this process because it eliminates member overpayment and underpayment, which are time-consuming and costly for the provider to resolve.

We do not, however, contractually prohibit providers from collecting member payments upfront. We recognize that some providers are concerned that it may be difficult to collect payment from the member after the date of service and thus seek to fulfill the financial agreement between themselves and the member at the time services are rendered. We believe that these arrangements should be solely between the provider and the patient. Consequently, we will not prohibit providers from requesting a credit card or debit card number at the time of service to facilitate payment as long as the provider informs the member why the information is being requested, the provider agrees to protect the member's card number through encryption or secured access, and the member authorizes the provider to hold the card number. The provider may process the charge of the member's coinsurance or deductible in the event that the member does not pay the amount indicated as the member's responsibility on the EOB.

The provider is never permitted to collect any amounts deemed above the contracted rate. They are only permitted to collect the member's share of costs. In addition, the provider cannot collect any amounts for which our policies and provisions deem not covered. Providers are prohibited from billing patients for services denied or bundled as a result of an Aetna clinical or reimbursement policy unless the provider gets a written approval from the patient in advance. An example of this would be multiple procedure discounts. Aetna reimbursement policy states that when more than one procedure is performed on a patient in the same visit or encounter, the primary procedure is paid at 100 percent of the contractual allowed amount for that service, while subsequent procedures are paid at a lesser rate (e.g. 50 percent). In this case, the provider is prohibited from billing the patient for the 50 percent discount.

Participating providers can also use our Payment Estimator to request estimates prior to or on the day of an appointment. The tool uses the provider's fee schedule and the member's benefit plan, as well as the same decision-making process as our member payment estimator and our claims adjudication processes, to ensure consistency and supply an accurate estimation of Aetna's provider payment and the member's financial responsibility.

Attachments:

2.2.1.21 Describe how you calculate network savings, including discounts and your financial arrangements. Describe all variables included in the calculation.

Answer: Our network discounts and the calculation thereof are determined exclusively by the total billed to the provider, and the amount paid to the provider. The State realizes the full value of these

savings.

Our network fees are a component of the proposed administrative fees to the State of Alaska, and there are no additional fees for network services such as:

- Top sheeting (i.e. another network pricing a claim)
- Network access fees
- Any use of a rental network within the lower 49 states
- Claims adjudication
- Ineligible or denied claims

These would not be reflected in the discount arrangement.

Network Discount savings calculation will be based on a blended total network billed eligible expenses prior to discount for each of the service types, and prior to application of plan design and member cost sharing (copays and deductibles). We will then calculate the actual in-network discount by comparing the non-negotiated provider fee to the negotiated fee within the PPO network by way of the following equation:

$$\frac{\{\text{Provider Discounts (Hospital and Physician) in dollars}\}}{\{\text{Total In-Network (Hosp. and Phys.) Eligible Benefits Billed (before discount)}\}}$$

This measurement would be reported using data from Aetna's Informatics data warehouse. Discounts apply to fee for service claims only with capitations being excluded.

Attachments:

2.2.1.22 What percentage of your physicians are board certified?

Answer: As of 9/30/2012, 73.85 percent of the providers in our Alaska PPO network were board certified, and nationally 75.24 percent were board certified.

Attachments:

2.2.1.23 What percentage of your specialist physicians are board certified?

Answer: As of 9/30/2012, 73.55 percent of the network specialists in our Alaska PPO network were board certified, and nationally 73.65 percent were board certified.

Attachments:

2.2.1.24 How often are your physicians recredentialed?

Answer: Physicians are recredentialed every three years.

Attachments:

2.2.1.25 Please check off those elements that are included in the provider selection process and provide the estimated percentage of network providers that satisfy the following selection criteria elements:

	In Selection Process - Alaska	% of Providers	In Selection Process – other 49 states	% of Providers
Require unrestricted state licensure	1: Yes	100%	1: Yes	100%
Review malpractice coverage and history	1: Yes	100%	1: Yes	100%
Require full disclosure of current litigation	1: Yes	100%	1: Yes	100%
Require signed application and agreement	1: Yes	100%	1: Yes	100%

	In Selection Process - Alaska	% of Providers	In Selection Process – other 49 states	% of Providers
Require current DEA registration	1: Yes	100%	1: Yes	100%
Review adherence to state and community practice standards	2: No	N/A	2: No	N/A
Onsite review of office location	2: No	N/A	2: No	N/A
Review hours of operation and capacity	2: No	N/A	2: No	N/A
Board eligibility	1: Yes	100%	1: Yes	100%
Review practice patterns and utilization results	2: No	N/A	2: No	N/A

Detail: Review adherence to state and community practice standards

Not reviewed during credentialing; however, physicians must meet education/training requirements.

OFFICE VISITS

While we do not make site visits in connection with our initial credentialing process, site visits are made to network practitioners if a member complaint is received regarding physical accessibility (including handicapped access), physical appearance, or adequacy of waiting and exam room space related to the settings in which member care is delivered. This policy is in accordance with both NCQA and Centers for Medicare and Medicaid Services standards.

REVIEW HOURS OF OPERATION

Not reviewed during credentialing; however, physicians must follow our office hour standards once joining our network. Our contracts require network physicians to maintain, at a minimum, the following office hours.

- PCPs must have at least 20 hours of regularly scheduled office hours over a period of at least 4 days per week
- Ob/Gyns must have at least 20 hours of regularly scheduled office hours over a period of at least 3 days per week
- Specialists must be available at least 8 hours per week for scheduled office appointments

BOARD ELIGIBILITY

We require board certification in specialty practice area in connection with our credentialing process. A board certified physician is a physician who is tested and approved to practice in a specialty field by the board of specialists for that field. A board eligible physician is a physician who is eligible to be tested and approved to practice in a specialty field after successfully completing the requirements of the board of specialists (e.g., education, training and practice experience) for that field.

In accordance with medical board practice, we do not recognize the designation “board eligible” during our credentialing process. We require physicians in our networks to meet the appropriate education and training requirements for the specialty in which they wish to be recognized, specified by either the American Board of Medical Specialties (ABMS) for medical doctors or the American Osteopathic Association (AOA) for doctors of osteopathy. If a physician indicates board certification, we verify the information with the AOA, AMA Masterfile, ABMS and certification board. State licensing boards set the requirements for continuing medical education, and we verify current state licensure.

Attachments:

2.2.1.26 What is the average number of weeks from the date of nomination to the date the provider becomes a part of the network?

Answer: We send the first nomination letter with an application request form to the provider within 30 days of the nomination. If the provider does not respond, we will send follow-up letters. The credentialing process begins when the provider returns a completed application request form.

Once we obtain all required documentation, it normally takes 45 to 60 days to credential and add an Alaska physician. Our national average is from 90 to 120 days.

Attachments:

2.2.1.27 Please identify and explain your quality and outcome criteria for network providers.

Answer: We continuously evaluate provider performance as part of our quality management process. Our claim databases allow network managers and local medical directors to analyze trends in provider utilization (both over and under-utilization), with the intent of educating to improve performance, and locate opportunities for improving our delivery of medical services. We combine utilization and unit-cost metrics of performance with clinical effectiveness measures of performance.

We use Episode Treatment Groups software to stratify providers by efficiency. Our data warehouse contains the claims data that we analyze with this efficiency software tool.

Information created by Episode Treatment Groups software is primarily used for medical cost management, quality of care initiatives and physician performance evaluation. We use Episode Treatment Groups software to analyze claims data involving treatment and service utilization for an episode of care across time for an identified health condition. The tool evaluates medical cost and utilization patterns and helps identify efficient providers.

When measuring the actual performance of individual provider offices, we first adjust for patient differences, such as age, gender, market, plan type, pharmacy benefit, year of episode, Episode Treatment Group adjuster and illness severity. Otherwise, the performance of some providers who care for a sicker population might appear below average when calculating the scores. We can evaluate physician performance and generate reports that include rates use by service (utilization), as well as associated patient outcomes.

We can compare treatment continuums for similar cases or conditions to determine the more effective courses of care and those physicians responsible for implementing the more and less effective treatments, based on outcomes. This analytical approach applies to care delivered to members in all our medical plans; unlike an approach of tracking primary care physician (PCP) or specialist referral rates, which would not consider care delivered to members in our many plans that do not require referrals.

This system allows us to compare the cost of patient care by physicians (PCPs and specialists) or hospitals with our average cost of care for similar care/diagnoses. Analyzing medical costs as episodes of care, rather than by isolated provider, helps us to identify patterns of care associated with lower total costs. The system additionally helps us find providers who deliver more efficient care and provides the information we need to assess why their pattern of care costs less. We can analyze, for instance, how a costly medication was used to treat an illness that would otherwise lead to hospitalization.

We evaluate potential quality of care concerns for review and action as appropriate. Also, Aetna Informatics identifies and tracks adverse events, as well as assesses quality, with the Inpatient Performance Measurement System.

Any Aetna unit may identify potential quality of care concerns and report them to the Quality Management (QM) department. Situations may also be identified through mail, e-mail or verbal communication (complaints) by external sources: members, providers, quality improvement organizations (QIOs) or external quality review organizations (EQROs).

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

Examples of situations that may be considered for review:

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

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

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

INPATIENT PERFORMANCE MEASUREMENT SYSTEM

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

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

Aetna Informatics has approximately 30 criteria for evaluating adverse events in the inpatient setting.

Attachments:

2.2.1.28 Do you provide your network providers with incentives or penalties for patient satisfaction results?

Answer: 1: Incentives please describe: [Our national Physician Performance Incentive Program does not include a performance measure for member satisfaction. We previously attempted to include a member satisfaction measure, but member participation in our provider-specific survey tool (no longer available) was too low to support a credible measure. We have elected not to use CAHPS® or other external member surveys, as these typically report combined satisfaction rates for all health plans.

We do participate in the Integrated Healthcare Association (IHA) partnership in California, which includes a member satisfaction measure, as well as measures for clinical performance and technological advances. For member satisfaction, the IHA uses the Patient Assessment Survey, derived from the National Clinician and Group CAHPS survey.

]

Detail:

Options:

1. Incentives please describe: [Text]
2. Penalties please describe: [Text]

Attachments:

2.2.1.29 Please describe and identify any providers identified as centers of excellence or centers of value within your network.

Answer: AEXCEL HIGH PERFORMANCE NETWORK

In partnership with customers, we have developed Aexcel®, an enhanced network option featuring Aexcel-designated specialists. This option is one of a series of industry-leading initiatives from Aetna, designed to address customers' health care challenges and help members make more informed health decisions. We chose to address specialty care in this performance network due to specialty care being more episodic than primary care. Specialty care is driving most of the advances in procedures, pharmaceuticals and diagnostic imaging, and the increases in cost accompanying these advances.

We base the performance network on the designation of specialists and consists of two plan design models: Aexcel (concentric model) and Aexcel Plus (multi-tier model). By leveraging our health information resources to identify specialists from our broader networks, we have developed a network option that aims to provide access to quality care based on a balance of measures of clinical performance and cost efficiency. Described below are the tools and methodology we use in the Aexcel-designation evaluation process.

In select markets, Aexcel and Aexcel Plus feature a subset of our current network of specialists focused on physicians within 12 medical specialty categories: cardiology, cardiothoracic surgery, gastroenterology, general surgery, obstetrics and gynecology, orthopedics, otolaryngology, neurology, neurosurgery, plastic surgery, urology, and vascular surgery. All other network provider types (e.g., PCPs, hospitals, ancillaries), including physicians in other specialty categories (e.g., dermatology, oncology), are also a part of the performance network.

We base Aexcel on a concentric network model and we base Aexcel Plus on a tiered network model. In Aexcel, only designated specialists in the Aexcel specialty categories are considered in network. In Aexcel Plus, both designated and non-designated specialists in the Aexcel specialty categories are considered in network, but coverage for non-designated specialists is provided at a higher level of member cost sharing.

HOSPITAL TIERED NETWORK

We offer a hospital tiered network program, which is designed exclusively for our contracted network hospitals and physician groups that are also providing self-funded benefits for their own employees. Simply stated, these hospitals or physician groups are participating providers as well as customers. This dual role allows us to support a more tailored benefit design to meet the customer's needs.

The first tier of our hospital tiered network plan design is comprised of the employer's own select network of hospitals and providers. When members access care in this tier, they receive a higher reimbursement level (such as zero or low copayment) for their health benefits coverage.

If employees and dependents access care outside the employer's network, but in our participating provider network, that care would be subject to a higher level of cost sharing. Depending on the customer's choice of plan design, coverage for out-of-network benefits may also be provided, subject to deductible and coinsurance limits.

AETNA INSTITUTES

Aetna Institutes facilities are publicly-recognized high quality, high value health care facilities. Our goals are to:

- Recognize facilities with distinguished performance for health services that are critical to members.
- Engage consumers by providing them with information to help make informed choices about facilities with distinguished performance.
- Provide access for our members to high quality, cost-effective care available.

The two major components of Aetna Institutes are:

- Institutes of Excellence (IOE) - A designation for health care facilities that offer highly specialized clinical services to members with complex or rare conditions. Our nurse case managers will nationally coordinate a member's clinical care in these cases. IOEs include transplant care, pediatric congenital heart surgery and infertility.
- Institutes of Quality (IOQ) - A designation for health care providers who offer clinical services for prevalent health conditions to our members served through integrated clinical management at the regional level. IOQs include bariatric surgery and cardiac care and orthopedic (total joint replacement and spine) programs. The orthopedic program started on July 1, 2010. We are also in the process of considering an IOQ for multiple additional strategies related to cancer.

Although we currently don't have any Alaska facilities that are designated, we remain committed to working with local facilities on meeting criteria for participation and we have been in dialogue with Providence Alaska Medical Center. We do have the following facilities in the State of Washington:

IOEs

- Seattle Cancer Care Alliance
(Seattle Children's and University of Washington Medical Center)
Seattle, WA

Adult:

Bone Marrow Transplant - Allo

Bone Marrow Transplant - Auto

Pediatric:

Bone Marrow Transplant - Allo
Bone Marrow Transplant - Auto

- Seattle Children's Hospital and Regional Medical Center
Seattle, WA

Pediatric:

Bone Marrow Transplant - Allo

Bone Marrow Transplant - Auto

Heart

Kidney

Liver

- Swedish Medical Center

Seattle, WA

Adult:

Kidney

- University of Washington Medical Center

Seattle, WA

Adult:

Heart

Kidney

Liver

Lung

- Virginia Mason Medical Center

Seattle, WA

Adult:

Kidney

IOQs

- Deaconess Medical Center

Spokane, WA

Bariatric

- Evergreen Healthcare Hospital

Kirkland, WA

Bariatric

- Northwest Weight Loss Surgery, PLLC

Everett, WA

Bariatric

- Overlake Hospital Medical Center

Bellevue, WA

Bariatric

- St. Francis Community Hospital of Federal Way

Federal Way, WA

Bariatric

A complete listing of IOEs can be accessed at <http://www.aetna.com/docfind/cms/assets/pdf/ioe.pdf>, and a complete listing of our IOQs can be accessed at http://www.aetna.com/docfind/cms/assets/pdf/IOQ_bariatric.pdf.

Attachments:

2.2.1.30 Are in-network providers allowed to balance bill? If so, explain.

Answer: No. Network providers contractually agree to hold members harmless and we prohibit them from balance billing for covered services. Our standard provider contracts contain hold harmless provisions that do not allow providers to seek reimbursement from our members for covered services outside of applicable copayments, coinsurance or deductibles, in accordance with the plan design. This includes, but is not limited to, in the event of payment failure, delay, denial or reduction due to our network policies or provisions, Aetna insolvency, provider insolvency, or breach of the provider contract.

Our standard provider contracts state that the medical provider may bill the member only in the following circumstances.

- Applicable copayments, coinsurance or deductibles were not collected when the covered services were rendered
- A self-funded customer becomes insolvent or otherwise fails to pay the provider in accordance with applicable federal law or regulation, provided that the provider has first exhausted all reasonable efforts to obtain payment from the customer
- The member's plan provides and/or we confirm that specific services are not covered, the member was advised in writing prior to the services being rendered that the specific services may not be covered services, and the member agreed in writing to pay for such services after being so advised

Attachments:

2.2.1.31 Can you administer the plan so that network physicians are responsible for any precertification requirements and the member will not be penalized if the physician does not follow the proper procedures?

Answer: Confirmed. Our network contracts require network physicians to start the precertification process for the member for the defined Aetna procedures requiring precertification. The plan may penalize the provider if they fail to comply. We do not penalize the member when our network physician does not precertify.

We welcome the opportunity to review all procedures and conditions requiring precertification. We can share both clinical data and incidents to support the State in the assessment of all precertification requirements.

Attachments:

2.2.1.32 What performance standards must your providers adhere to for urgent appointments (timeframes)?

Answer: 3: 12 to 24 Hours

Detail: Our PCP urgent appointment waiting time standard is within the same day or within 24 hours. Additionally, My AlaskaCare Single Point of Contact (health concierge) can assist a member who is unable to schedule an appointment in obtaining a same day appointment when necessary.

Options:

1. 0 to 8 Hours
2. 8 to 12 Hours
3. 12 to 24 Hours
4. 24 to 48 Hours
5. Greater than 48 Hours

Attachments:

2.2.1.33 What performance standards must your providers adhere to for routine appointments (timeframes)?

Answer: 1: 1 to 2 weeks

Detail: My AlaskaCare Single Point of Contact (health concierge) can assist a member who is unable to schedule an appointment in obtaining an appointment when necessary.

Options:

1. 1 to 2 weeks
2. 2 to 3 weeks
3. 3 to 4 weeks
4. 4 to 6 weeks
5. 6 to 8 weeks
6. Greater than 8 weeks

Attachments:

2.2.1.34 Describe your method that providers use to check patient eligibility.

Answer: Providers can verify patient eligibility in the following ways:

- Provider website - Our secure provider website offers many features to providers, including the ability to check the eligibility status of members.
- Electronic data interchange - Through electronic data interchange vendors, participating providers can electronically verify member eligibility.
- Provider Service Centers - Provider can contact our call center staff by email or by using our toll-free number to verify eligibility.
- Aetna Voice Advantage - Providers can also use our interactive telephone system to verify member eligibility.

Attachments:

2.2.1.35 How are network claim payments disbursed?

Answer: We age and bulk provider checks on a schedule. This allows delivery within 24 days of the claim received date. We send the majority on either a weekly or biweekly schedule, and on a consistent day of the week. A provider EOB accompanies each provider draft. The EOB breaks down the payment by patient and gives pertinent information about the payment and non-covered expenses.

All payments are made direct by Aetna even if a custom or rental network is being used.

Attachments:

2.2.1.36 What is your primary reimbursement method for Primary Care Physicians?

Answer: Nationally, our most common reimbursement arrangement is a physician fee schedule. 90 percent of our Alaska PPO providers are reimbursed using a negotiated fee schedule, and remaining 10 percent on a discounted fee for service basis.

Attachments:

2.2.1.37 In the upcoming year, do you anticipate any significant changes in the following reimbursement policies?

Outpatient Hospital Reimbursement Policy	2: No
Inpatient Hospital Reimbursement Policy	2: No
Laboratory Services Reimbursement Policy	2: No

Detail: We do not anticipate any significant changes in our outpatient, inpatient, or laboratory reimbursement policies.

Aetna has a robust process of monitoring, analyzing and understanding cost drivers with the goal of controlling cost increases either through implementing new policies and programs or by enhancing current policies and programs. In addition, Aetna monitors emerging technologies and therapeutic interventions not only for medical appropriateness but also to ascertain the overall cost impacts to our business partners and constituents. In total, we have over 200 payment policies.

An effective claims edit system delivers increased savings to our customers and a greater likelihood of successful health outcomes through:

- Comprehensive, vigilant processes that let us develop, update, and seamlessly administer clinical policy bulletins (CPBs) which are formulated from evidence-based medicine. Our CPBs are available online for public viewing at www.aetna.com.
- Enhanced programming that allows us to rapidly deploy these updated policies in our claims and administrative systems. In 2010, our claims edit policy savings was approximately \$1.3 billion.
- Industry-leading fraud and abuse recovery capabilities that show results. In 2010, our internal fraud unit recovered approximately \$160 million.

Attachments:

2.2.1.38 If you answered yes to any of the above, please describe the nature and scope of the anticipated change in policy.

Answer: Not applicable as we do not anticipate any significant changes in our reimbursement policies.

Attachments:

2.2.1.39 Confirm you have completed and uploaded the requested GeoAccess reports based on the criteria listed below for urban/suburban:

- General Medicine provider within 15 miles
- Internal Medicine provider within 15 miles
- Family Practice provider within 15 miles
- Pediatrician within 15 miles
- OB/GYN within 15 miles
- Psychiatrists and Psychologists (combined) within 15 miles

- Masters Level Clinicians within 15 miles
- PhD Level Clinicians within 15 miles
- Other Specialists (excluding OB/GYNs) within 20 miles
- Outpatient Mental Health and Substance Abuse providers within 20 miles of Alaska's top 5 locations.
- Inpatient Mental Health and Substance Abuse providers within 20 miles of Alaska's top 5 locations.
- Hospital within 20 miles of Alaska's top 5 locations

Answer: Confirmed. Please refer to the Medical GeoAccess reports included with this proposal.

Attachments: [GeoAccess Report PPO SI Actives Top 5.pdf](#)

[GeoAccess Report PPO SI Actives.pdf](#)

[GeoAccess Report PPO SI Retirees.pdf](#)

[GeoAccess Reporta PPO SI Retirees Top 5.pdf](#)

2.2.1.40 Confirm you have completed and uploaded the requested GeoAccess reports based on the criteria listed below for rural:

- General Medicine provider within 25 miles
- Internal Medicine provider within 25 miles
- Family Practice provider within 25 miles
- Pediatrician within 25 miles
- OB/GYN within 25 miles
- Psychiatrists and Psychologists (combined) within 25 miles
- Masters Level Clinicians within 25 miles
- PhD Level Clinicians within 25 miles
- Other Specialists (excluding OB/GYNs) within 30 miles
- Outpatient Mental Health and Substance Abuse providers within 30 miles of all other locations.
- Inpatient Mental Health and Substance Abuse providers within 30 miles of all other locations.
- Hospital within 30 miles of all other locations

Answer: Confirmed. Please refer to the Medical GeoAccess reports included with this proposal.

Attachments: [GeoAccess Report PPO SI Actives Top 5.pdf](#)

[GeoAccess Report PPO SI Actives.pdf](#)

[GeoAccess Report PPO SI Retirees.pdf](#)

[GeoAccess Reporta PPO SI Retirees Top 5.pdf](#)

2.2.1.41 Confirm you have completed and uploaded the requested GeoAccess reports based on the criteria listed below for the top 5 State of Alaska locations, which includes Juneau, Anchorage, Fairbanks, Kenai/Soldotna and Wasilla / Palmer (details provided on census):

- General Medicine provider within 15 miles
- Internal Medicine provider within 15 miles
- Family Practice provider within 15 miles
- Pediatrician within 15 miles
- OB/GYN within 15 miles
- Psychiatrists and Psychologists (combined) within 15 miles
- Masters Level Clinicians within 15 miles
- PhD Level Clinicians within 15 miles
- Other Specialists (excluding OB/GYNs) within 20 miles

- Outpatient Mental Health and Substance Abuse providers within 20 miles of Alaska's top 5 locations.
- Inpatient Mental Health and Substance Abuse providers within 20 miles of Alaska's top 5 locations.
- Hospital within 20 miles of Alaska's top 5 locations

Answer: Confirmed. Please refer to the Medical GeoAccess reports included with this proposal.

Attachments: [GeoAccess Report PPO SI Actives Top 5.pdf](#)
[GeoAccess Report PPO SI Actives.pdf](#)
[GeoAccess Report PPO SI Retirees.pdf](#)
[GeoAccess Reporta PPO SI Retirees Top 5.pdf](#)

2.2.1.42 Confirm you have completed and uploaded the requested GeoAccess reports based on the criteria listed below for the top 5 State of Alaska locations, which includes Juneau, Anchorage, Fairbanks, Kenai/Soldotna and Wasilla / Palmer (details provided on census):

- General Medicine provider within 25 miles
- Internal Medicine provider within 25 miles
- Family Practice provider within 25 miles
- Pediatrician within 25 miles
- OB/GYN within 25 miles
- Psychiatrists and Psychologists (combined) within 25 miles
- Masters Level Clinicians within 25 miles
- PhD Level Clinicians within 25 miles
- Other Specialists (excluding OB/GYNs) within 30 miles
- Outpatient Mental Health and Substance Abuse providers within 30 miles of all other locations.
- Inpatient Mental Health and Substance Abuse providers within 30 miles of all other locations.
- Hospital within 30 miles of all other locations not stated as key locations in the Plan Background section of this RFP.

Answer: Confirmed. Please refer to the Medical GeoAccess reports included with this proposal.

Attachments: [GeoAccess Report PPO SI Actives Top 5.pdf](#)
[GeoAccess Report PPO SI Actives.pdf](#)
[GeoAccess Report PPO SI Retirees.pdf](#)
[GeoAccess Reporta PPO SI Retirees Top 5.pdf](#)

2.2.1.43 Which type of liability insurance do you require of your providers?

Answer: 2: Per occurrence

Detail: We maintain Professional Liability insurance (also known as an Errors and Omissions policy), which provides coverage for Aetna's legal liability arising out of an act, error or omission in the performance of our services in connection with the ownership, operation or management of a managed care service organization.

Our participating providers and hospitals are required to maintain general and professional liability (malpractice) and other insurance policies, or a comparable program of self insurance at minimum levels. We verify and monitor compliance with minimum acceptable professional liability insurance limits for all network providers through our credentialing process.

For general liability insurance, the typical minimum standard is \$1 million per occurrence/\$1 million

annual aggregate for most provider types, regardless of the state.

For professional liability insurance, hospital requirements generally range from \$1 million per claim/\$3 million annual aggregate.

Professional liability for non-hospital facilities (e.g., skilled nursing facilities, surgery centers, urgent care centers) is generally \$1 million/\$1 million.

Individual provider requirements are generally \$1 million/\$1 million but can vary greatly because of damage caps, patient compensation funds, regional norms and state insurance requirements.

Options:

1. Per professional
2. Per occurrence
3. Other: [Text]

Attachments:

2.2.1.44 How much notice is a provider contractually required to give if they elect to terminate a contract with your network(s)?

Answer: 3: 90 days

Detail: Our standard provider contract requires the provider to generally give at least 90 days advance written notice prior to withdrawing from the network. Our standard hospital contract requires a facility to generally give 180 days advance written notice of termination. All participating providers are required to continue to provide covered services to members receiving active treatment until treatment is completed or we can make appropriate arrangements to have another provider render the service.

Options:

1. 30 days
2. 60 days
3. 90 days
4. 120 days
5. Other [Text]

Attachments:

2.2.1.45 Indicate your procedures for removing a provider from your network involuntarily.

Answer: 1: Specific outcome of any malpractice claims,

2: Specific number of malpractice claims,

3: Based on review of irregular claims,

4: Based on review possible claims "abuse",

5: Based on medical/dental outcomes,

6: Based on licensing issues,

7: Failure to meeting contracting requirements,

8: Other: [Please see the description below for other procedures utilized to terminate a provider from our network.]

Detail: We consider numerous factors when evaluating the termination of a participating physician:

- Breach of contractual terms

- Quality of care issues that could put our members at risk
- Contracts that do not produce the values that are expected by our customers

We subject physician participation in our networks to at least two levels of regular review: recredentialing and ongoing monitoring.

RECREREDENTIALING

The recredentialing process, which evaluates the qualifications of individual participating physicians every three years, includes a complete review of the physician's performance in several areas:

- Compliance with administrative features of our contract
- Compliance with utilization and quality management programs
- Service levels provided to members
- Observed clinical quality issues
- Malpractice history
- Disciplinary actions by public agencies

We will terminate a physician from our network for failure to maintain acceptable levels of performance in one or more areas. The termination process involves problem identification and assessment, direct contact with the physician to provide advice and counseling on performance improvement, peer review, and committee disciplinary action, subject to appeal and review.

ONGOING MONITORING

We systematically monitor clinical care and service activities, and locally based quality management programs identify clinical quality issues during provider interactions or as a result of member complaints. The medical director promptly reviews serious quality issues, and immediate disciplinary action may be considered appropriate in some cases. Occasionally, disciplinary action includes termination of the provider's participation.

Common reasons for termination:

- Failure to comply with utilization management programs
- Documented patterns of practice that are inconsistent with community standards of care
- Non-compliance with the administrative terms of our contract; such as inappropriately balance billing patients or failing to provide appropriate after-hours coverage

In addition, professional competence and conduct issues that adversely (or could adversely) affect the health or welfare of a member may be submitted to a peer review committee for consideration at any time between recredentialing cycles. We formally monitor these issues at least every six months between recredentialing cycles for practitioner-specific trends and take appropriate action when we identify poor quality.

We also terminate contracts with network providers whose licenses are suspended by the state board authority or who are listed on the Office of Inspector General (OIG) sanction report or Office of Personnel Management (OPM) debarment list. We review these reports each month.

Options:

1. Specific outcome of any malpractice claims

2. Specific number of malpractice claims
3. Based on review of irregular claims
4. Based on review possible claims "abuse"
5. Based on medical/dental outcomes
6. Based on licensing issues
7. Failure to meeting contracting requirements
8. Other: [Text]

Attachments:

2.2.1.46 What has been your rate of removal of providers involuntarily from your network?

Answer: 1: Under 5% in prior calendar year

Detail: As of 9/30/2012, the involuntary turnover rate in our Alaska PPO network was 2.19 percent.

Options:

1. Under 5% in prior calendar year
2. 5% -- 10% in prior calendar year
3. Over 10% in prior calendar year

Attachments:

2.2.1.47 If a member needs care while in an area where you have a network (but the network is not part of the employer's plan), can the plan benefit from the discounts?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

2.2.1.48 If there are providers or specialists that are not available in your medical networks in the service areas where there are plan participants, please explain what provisions are made for plan participants requiring these services.

Answer: In the instance that a provider type is not available in a network, we have a procedure where a nonparticipating provider can provide care at the participating benefit level. Additionally, network management may pursue contracting initiatives to close the gap.

Additionally, we are proposing a travel management program for the State's members that require care outside of their local service area. Our customer service concierge team assigned to the State of Alaska will be trained on the details of the travel program included with the State of Alaska's medical plan. The training will include a detailed review of the conditions for which travel may be reimbursed, as well as what specific expenses are eligible for reimbursement. The concierge team will serve as the initial contact for a member who is requesting pre-authorization of travel. We have included a complete description of the travel management program in section 2.2.5.6 of our proposal response.

Attachments:

2.2.1.49 Describe how your in-network and out-of-network allowances vary nationally along with the structure and number of rating areas.

Answer: IN-NETWORK

Physicians

We pay physicians, including PCPs and specialists, on a negotiated fee schedule. The fee schedule compensates physicians at the lesser of their usual charge or the negotiated fee. Each of our networks has a unique fee structure. We have 196 local PPO networks across the country. We base our fees on market factors specific to each network and the federal government's Resource Based Relative Value Scale (RBRVS) methodology with adjustments made at the local level. We adjust fees geographically and they may also vary among providers in the same geographical area as determined by market considerations.

Hospitals

We have a variety of financial arrangements with hospitals. Reimbursement structures may include a combination of per diems, case rates, percentage of charges or other payment methodologies for services covered by the health plan. We base the majority of our negotiated hospital agreements on per diems for inpatient care and fee schedules, where appropriate, for outpatient services. In addition, there are instances (e.g., open-heart surgery and transplants) where we negotiate specific case rates. Fee structures for outpatient care include case rates, fee schedules and percentage of charge arrangements. Our standard hospital contracts provide for the lesser of the eligible billed charge or the contracted amount to be paid.

OUT-OF -NETWORK

We typically reimburse out-of-network providers in accordance with the appropriate reasonable and customary (R&C) schedule. For R&C based benefit determinations we consult an external database. We use the FAIR Health Benchmarks database produced by the non-profit entity FAIR Health.

We use the FAIR Health expense area groupings. There are 492 expense areas and the State of Alaska is broken down into three areas.

The standard value for the recognized amount is the 80th percentile of the R&C database with a \$10 liberalization corridor for professional medical and surgical benefits.

Attachments:

2.2.2 Indemnity Vision & Managed Care Network

2.2.2.1 Explain whether or not you use telephonic verification via toll-free phone lines to verify coverage for vision care participants and describe this service.

Answer: VSP

VSP offers a streamlined authorization process whereby our preferred providers contact VSP via the Internet or telephone to obtain verification to provide services. This approach makes accessing the plan easy and direct for VSP members as they need only contact a VSP preferred provider to schedule an appointment. VSP and the preferred provider handle the rest including:

- Eligibility and plan verification
- Authorizing services
- Direct claim payment

Their members can also verify coverage and eligibility by contacting our customer service representatives at VSP's toll-free telephone number, 800.877.7195. Callers have the option of speaking

directly to a customer service representative or using the Interactive Voice Response (IVR) system, which provides personalized information on:

- Eligibility
- Plan coverage
- VSP preferred providers
- Affiliate and open access providers

INDEMNITY

Eligibility is verified by the provider at time of service. The provider has access to a real-time eligibility application, thus a call to verify coverage is not required.

Attachments:

2.2.2.2 Describe how your organization works directly with suppliers and manufacturers to obtain reduced costs for vision services and/or supplies and explain these arrangements.

Answer: VSP

As a not-for-profit company, all of VSP's investments are designed to improve and grow the business while delivering a cost effective benefit to their clients. They continue to develop industry leading and price-competitive benefit programs to further support their clients' health and wellness strategies.

Disease Management

You'll receive innovative solutions that help reduce healthcare costs through VSP's exclusive Eye Health Management Program® - included with their proposed plan at no additional cost. Their common goal with the State and your employees in mind - to help you reduce overall healthcare costs and improve your employees' health. VSP is the only vision provider using Smart Data ManagementSM and Smart Patient OutreachSM to help clients manage rising healthcare costs. As part of their Eye Health Management Program® VSP providers participate in HIPAA-compliant medical data sharing on every VSP patient and indicate whether they have any of the following conditions:

- Diabetes
- Diabetic retinopathy
- Hypertension (high blood pressure)
- High cholesterol
- Glaucoma
- Macular degeneration

Early management and treatment of these conditions is critical to helping the State achieve long-term cost savings and better health outcomes for your employees. A recent independent study by Human Capital Management Services (HCMS) confirms that VSP preferred providers are often the first to detect early signs of conditions that may have otherwise gone unnoticed and untreated until more advanced symptoms compelled the patient to seek medical attention. VSP is the only vision provider able to provide meaningful comprehensive data sharing exchange with health plans and disease management vendors, as well as reporting that helps our clients bend the trend of rising healthcare costs.

Lab Savings

Due to their size and buying power, they negotiate effectively with our labs for the best prices on the most products and services. They work with about 230 of the most qualified full-service optical labs across the country to provide local service. They own five labs located in California, Ohio, Florida, Texas, and Washington. They also have partnered in joint ventures with optical labs in San Diego, California; Tampa, Florida; Warwick, Rhode Island; Waterbury, Connecticut; and Augusta, Maine.

Additional Discounts

VSP's preferred providers offer direct-from-manufacturer incentives such as rebates, coupons or other special offers. Eyeglass cases are typically supplied by the frame company and included with the purchase of glasses. They also offer valuable discounts on additional pairs of prescription glasses, contact lens services, and retinal screening as follows:

- 30% off the preferred provider's U&C fees for additional complete pairs of prescription and non-prescription glasses, including sunglasses.
- 15% off the contact lens professional services (materials not subject to discount).
- Optomap® retinal imaging guaranteed price of \$39 or less

Your employees will also be able to save on hearing aids through TruHearing®. TruHearing is a discount medical organization that contracts with a national network of audiologists and hearing instrument specialists for aggressive discounts on state-of-the-art digital hearing aids. All VSP members and their covered dependents have free access (\$108 value) to the TruHearing MemberPlus® Program to enjoy up to 50% savings on some of the most popular digital hearing aids on the market. Plus, they can sign up extended family members for a VSP-exclusive rate of \$71 each to enjoy the same great savings. Best of all, this special offer can be combined with a member's existing hearing aid benefit to maximize savings and reduce their out-of-pocket expense.

INDEMNITY

We have contracted national member discounts with our vision vendor, EyeMed, which is automatically included with the health plan at no additional cost.

This program offers savings on eye exams, glasses and contact lenses at participating locations. The Aetna Vision discount program helps members save on many eye care products, including:

- Eyeglasses
- Contact lenses
- Nonprescription sunglasses
- Contact lens solutions
- Other eye care accessories

Members may also receive up to a 15 percent discount off standard prices (5 percent off promotional prices) on LASIK surgery (the laser vision correction procedure).

Members can schedule an appointment with a participating professional and receive an eye exam at the discounted rate. The EyeMed Select Network includes thousands of providers in all 50 states including Alaska.

Attachments:

2.2.2.3 Describe both your Alaska indemnity and managed care vision service provider networks, if different, noting the locations and number and type of providers.

Answer: VSP

Preferred Providers - Best Value and Preventive Care

VSP offers a unique and innovative approach that gives your employees the freedom to choose any provider. For the best value, their program includes 80 preferred providers in 47 offices. That's 96 points of access statewide, providing access to over 30% of the state. And State employees agree with 92% of covered employees utilizing a VSP preferred provider over the last 12 months. While they pay claims in all 50 states, below highlights the number of locations in the most utilized cities:

- Anchorage 39

- Eagle River 3
- Fairbanks 13
- Homer 2
- Juneau 8
- Kenai 2
- Ketchikan 4
- Kodiak 4
- Palmer 1
- Petersburg 1
- Seward 1
- Sitka 1
- Soldotna 1
- Wasilla 16

Affiliate Providers - Added Convenience and Retail Locations

In addition, they've contracted with Costco Optical and others as affiliate providers. Costco Optical includes over 400 locations across the country. Whether your employees choose a preferred or affiliate provider, they will receive a covered-in-full benefit experience. Your employees are only responsible for any plan copayments and/or non-covered options they select.

Through secure systems, their providers check member eligibility and bill VSP directly on behalf of your employees. And it's easy for your employees and their families to find providers near them as both preferred and affiliate providers are included in our provider directories.

VSP Open AccessSM - Freedom to Choose Any Provider

Through VSP Open AccessSM your employees and their families always have the freedom to choose any provider. VSP's plan includes a generous reimbursement schedule for services obtained from other providers - including any local or national chains. All providers can contact VSP directly to check eligibility and submit claims to them on behalf of your employees. In fact, they have a national arrangement with Wal-Mart and Sam's Club that makes it simple for your employees to use their VSP benefits at any Wal-Mart Vision Center and Sam's Club Optical Center location.

INDEMNITY

The vision discount program operates the same for all products.

Attachments:

2.2.3 Eligibility & Enrollment

2.2.3.1 Can you accommodate an account code structure in the eligibility file that will allow the State to identify trends in claim activity information broken down by different organizational units?

Answer: Yes. We will work with the State to set up an account code structure that will allow the State to identify trends for each organizational unit. We will work with the State to establish the structure that optimizes reporting for all of the Aetna administered programs.

Attachments:

2.2.3.2 Explain whether or not your proposal includes on-line access by the State to view eligibility files. If yes, describe this arrangement, and whether or not this access includes the ability for the State to update member data on an ad hoc basis.

Answer: Yes. We have systems in place to allow the State to view on-line eligibility and make updates as appropriate. We will also provide the State with Aetna resources in Alaska and on the

Account Team who can make eligibility updates on an ad hoc basis or review the State's eligibility system.

Attachments:

2.2.3.3 How will eligibility data be transferred from the State to the Contractor?

Answer: We can accept eligibility data in all of the following formats:

- Internet-based Eligibility Transfer Solutions - The State can use a UNIX server or web-based transfer solutions to transmit eligibility files to us during open enrollment and as updates are needed. SecureTransport, which uses customer software, is our preferred method of receiving eligibility through the internet.

- Electronic Transport Method - The State can submit enrollment through any number of electronic transport methods including secure Internet FTP, VAN or mainframe-to-mainframe connections, using ConnectDirect and EDI ANSI X12 formats. If the EDI ANSI format is used, the only connectivity options available are SecureTransport or VAN.

- e.Listing - An e.Listing is an Excel spreadsheet populated with eligibility data. The spreadsheet is scanned into our systems and mirrors an electronic file, eliminating manual intervention. The e.Listing functionality increases the timeliness of eligibility updates so that members can access care quickly.

- Enrollment Forms - The State can submit paper enrollment forms that will be input manually.

Attachments:

2.2.3.4 Please confirm your ability to accommodate the electronic transfer of eligibility from the State's system.

Answer: Confirmed. We can accept the State's 834 eligibility layout.

Attachments:

2.2.3.5 How often is eligibility electronically updated? Confirm that you will accept a daily eligibility file.

Answer: We can accept a daily file, but we recommend transaction only or full-inforce files twice per week. This would ensure that we have the most accurate and up-to-date file submissions possible. We find this process beneficial in minimizing disruption in eligibility files for customers. Once we upload the eligibility file to our mainframe system, the State's eligibility consultant reviews an edit of the file online. If there are no other data quality concerns, we update the system. If there are any errors or issues, the eligibility consultant will work with the State to resolve these prior to updating the system.

While we recommend twice weekly files to allow this eligibility verification process to take place, we can accept daily files for an additional charge.

Updated information appears in our eligibility system immediately and in the claim system within approximately 24 hours. If the State grants access, our Health Concierges and Alaska Team can review any questions on eligibility in the State's eligibility system. We can have standard processes to address any emergency eligibility issues in that manner to ensure no issues with coverage.

Attachments:

2.2.3.6 How often is eligibility electronically updated by any subcontractors or joint venturers?

Answer: We will establish automated eligibility extracts once per week to VSP. We can also discuss any other subcontractors that the State may require Aetna to interface with for eligibility.

Attachments:

2.2.3.7 Please confirm you can receive and send FTP files or have other secure methods of transmission.

Answer: Confirmed. We offer the following secure methods of transmission:

- Internet-based Eligibility Transfer Solutions - The State can submit eligibility using our web-based transfer solution called SecureTransport.
- Electronic Transport Method - The State can submit enrollment through SecureTransport using an electronic transport method. We support transfers in:
 - Explicit SSL (FTPs)
 - SSH (sFTP)
 - AS2 protocols
 - EDI ANSI X12 formats
 - Connect Direct with secure+ encryption.

Attachments:

2.2.3.8 Can you accept eligibility via paper, as well as by electronic feed?

Answer: Yes.

Attachments:

2.2.3.9 Do you allow online access to the client's staff for real-time eligibility updates?

Answer: Yes. We have systems in place to allow the State to view on-line eligibility and make updates as appropriate. We will also provide the State with Aetna resources in Alaska and on the Account Team who can make eligibility updates on an ad hoc basis or review the State's eligibility system.

Attachments:

2.2.3.10 Indicate how dependent eligibility information is stored. Is it part of the member record, or a separate record?

Answer: We store dependent eligibility information as a separate record but attached to the employee ID.

Attachments:

2.2.3.11 What is the standard turnaround time for an eligibility file upload?

Answer: 1: Within 24 hours

Detail:

Options:

1. Within 24 hours
2. By Next Business Day

3. Within 5 Business Days
4. Other: [Text]

Attachments:

2.2.3.12 Are you able to administer 90 day retroactive enrollment adjustments?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No
3. Other: [Text]

Attachments:

2.2.3.13 Are you able to make exceptions to the 90 day retroactive enrollment to allow for longer periods than 90 days?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No
3. Other: [Text]

Attachments:

2.2.3.14 Clearly state your company's timelines and deadlines for Open Enrollment (system updates due to plan changes or file formats, new divisions, manual work-arounds, dates for the last pre-OE updates, OE file updates, etc.).

Answer: We will work closely with you to develop an Open Enrollment schedule based on the State's enrolled employees, chosen products, programs and services. Our Account Team will assist in identifying tasks, needed resources and schedule key milestone dates that work best for the State and their members.

Key milestones dates include:

- Kick-off Strategy Call - 4/1/13
- Begin Implementation - 4/8/13
- Implementation meeting - 4/8/13
- Confirm eligibility 6/14/13
- Confirm ID cards mailed - 6/21/13
- Effective date - 7/1/13

Please refer to the attached Implementation Schedule for all of our implementation dates.

Attachments: [State of Alaska Implementation.doc](#)

2.2.4 Customer/Member Services

2.2.4.1 Will you provide the State with unit(s) dedicated to customer service? Please describe each function supported by these customer service unit(s).

Answer: Yes, we will provide the State with a dedicated customer service unit. We are committed to transforming health care one member at a time, and this begins with providing exceptional service to each member how and when they need it.

We are proposing our Aetna Concierge service model, which we are calling “My AlaskaCare Single Point of Contact”. The Aetna Concierge service model builds on the strong foundation of Aetna's standard member service experience with a more consultative approach that focuses on making every member call a more tailored and personal benefits experience.

My AlaskaCare Single Point of Contact is each member's concierge to navigate through their health care path. They help each member understand the barriers associated with health care, and access the resources and programs they have available to them. This personalized interaction enables a truly heightened level of engagement and creates an experience that opens the door to future personalized interactions and advocacy for the member.

CUSTOMER SERVICE REPRESENTATIVES

Our designated Customer Service Representatives assist members with inquiries that generally fall into the following categories:

- Benefit inquiries that address available coverage, preferred and nonpreferred benefit levels, and plan limitations and requirements.
- Claim settlement inquiries that address how to file a claim, claim status, Explanation of Benefits and payment information, and pending or denied claims.
- Eligibility inquiries that address eligibility requirements, enrollment of a new family member and coverage continuation resulting from a layoff, leave of absence, divorce, etc. and ID card requests.
- Network inquiries that address how the program works, how to access care through a PCP, preferred and nonpreferred care and benefits, provider directory requests and PCP changes.
- Patient management inquiries that address precertification and referrals. We direct case management inquiries to our nurse consultant staff.
- Requests for member information and plan materials that include replacement ID cards, EOBs, benefit booklets and provider network directories.

Aetna Concierges receive special training to support the member across the total State of Alaska benefit offering. They are fully empowered by the Wiki Site that is a 360 degree view of member and provides the concierge with necessary information to understand “who the member is and where they are.”

This enables them to fully support all areas of consumer engagement critical to the State of Alaska. They are knowledgeable on Aetna's online tools, including Aetna Navigator, our secure member website. They provide guidance on how to use the Member Payment Estimator (MPE) transparency tool, which provides members with point-in-time cost estimates based on individual member benefits, deductibles, and cost-share (coinsurance) specific to each individual member and their unique claims experience at any given point-in-time. The use of Aetna's MPE transparency tool supports the

informed decision making that leads to appropriate utilization of in-network care and health care services in appropriate care settings.

Aetna Concierge also connects members to additional resources to help them get the most from their available benefits. Aetna Concierge supports improved collaboration and connectivity to your Aetna clinical team by supporting relevant connections to clinical resources that will help members manage acute and chronic conditions and get the care they need. Aetna Concierge uses Aetna Strategic Desktop to quickly and efficiently access summaries of clinical program enrollment, disability and absence management information, as well as available incentive programs.

WARM TRANSFERS

Concierges are available to answer questions and connect members to relevant programs through internal warm transfers and external transfers to benefits provided by other carriers in order to simplify and provide a more seamless member service experience. Concierges also ensure members have an opportunity to become more informed and empowered through the identification of “teachable moments” that provide opportunities for member guidance and education.

Additionally, richer staffing ratios that support designated teams allow for longer, more relevant conversations with members. This allows the Concierge to build a rapport with each member so that they better understand how to “meet the member where they are” in their health care experience and on the health and wellness continuum, thereby enabling a more relevant and value-added service experience for each member.

Having a better understanding of each member enables the Concierge to use their consultative skills and benefits expertise to find relevant solutions that meet varying and unique individual member needs. The Concierge focuses on keeping the member at the center of everything they do, while also working as an advocate to remove the member from the middle of the complexity and uncertainty that can come with navigating the health care system and making appropriate use of available health care and wellness benefits and programs.

Concierges also focus on member advocacy by ensuring that all member issues are resolved in a timely manner. In the event a member issue requires follow-up, the Aetna Concierge will complete applicable follow-up tasks and provide notification to the member via their communication channel of preference, including a return phone call, email, or outbound text message, in order to inform the member that their issue has been resolved. Concierges never give members homework assignments.

E-MAIL AND CHAT CAPABILITIES

Members can reach the Concierge via live Aetna Navigator-based web chat and communicate directly with them. In the event a Concierge needs additional detail from a member during a chat, they will call the member at a number that is convenient for the member in order to continue the conversation.

Example of Aetna Concierge Model

The concierge will listen to each member and support you as if you were one of their own family members. A member is scheduled to have surgery at hospital one hour away from their home. The customer service representative can only provide member with location of the hospital and the time member needs to be there.

The concierge will check in with you a few days before surgery to confirm that you have taken any pre-op testing required and if you have any concerns prior to surgery. They will provide you complete directions to the hospital, parking costs or if there is a designated spot for surgery patients. If you have

someone going with you to the hospital, the concierge will provide information about the hospital amenities, such as cafeteria to get food or if there is a place to wait until the surgery is over. Based on the member demeanor or conversation when they talk to the member, the concierge may have suggestions that the member may have not thought to ask his doctor or caregiver.

ALASKA BASED SALES SUPPORT CONSULTANT

In addition to My AlaskaCare Single Point of Contact, there will be four sales support consultant positions (SSC) for the State of Alaska. Two will be in Juneau and two will be in Anchorage. The representatives can meet with members either on-site or over the phone to assist with any provider or claim issues they may be experiencing. These four SSCs will have the same training as the concierges.

These representatives will have access to all Aetna systems and resources to support your members and any escalated issues from the State of Alaska team. We will work with the State of Alaska on the process to hand off member questions or issues to support resolution. The sales support consultant will also work closely with the State's team as well as Aetna's Field Account Management team.

Attachments:

2.2.4.2 Where will the dedicated offices(s) be located and will those offices be dedicated to customer service, claims processing or both?

Answer: The State's dedicated team of claims processors and customer service representatives will be located in our Fresno Service Center to provide member services and claims processing. The Fresno Service Center is located at 1385 E. Shaw Avenue, Fresno, CA.

There will also be four sales support consultants for the State. Two will be in Juneau and two will be in Anchorage. The sales support consultant will interface directly with State employees and their dependents regarding health benefits offered through the State's benefit program.

Attachments:

2.2.4.3 List how many customer service representatives will be dedicated to the State's plans.

Answer: The State will have 23 concierge members dedicated to you. They will partner with all State members, connecting you to the right resources across your entire portfolio. In addition, the four sales support consultants will be fully dedicated to the State of Alaska.

Attachments:

2.2.4.4 Describe your training program for customer service employees.

Answer: The My AlaskaCare Single Point of Contact service model is supported by a robust training curriculum. We staff our Aetna Concierge teams with a mix of new and existing customer service professionals who possess the knowledge and aptitude to deliver a best-in-class member service experience.

The My AlaskaCare Single Point of Contact training aims to strengthen active listening skills that enable the Concierge to deliver truly personalized service to deliver the seamless "wow" (won over wonderfully) and high-satisfaction member experience ensuring that member will view their Aetna Concierge as a valuable resource and advocate who is available to support their ongoing needs.

COMPREHENSIVE TRAINING

Comprehensive training provides Concierges with information about State of Alaska-specific benefits and employer culture to assist members within the context of the plan sponsor's organization, and enables the Concierge to serve as an extension of the State's culture, communications strategy, and HR

benefits team.

High-touch, one-on-one support for Aetna Concierge representatives is provided by Aetna's Learning and Performance trainers and the Aetna Concierge leadership team throughout the comprehensive Aetna Concierge training curriculum. Aetna Concierge training is structured in such a manner that the concierge will obtain and build upon in-depth product knowledge, consultative soft-skills, and plan sponsor-specific benefit, program, and cultural information in distinct modules and sections. Once one section is learned, the Aetna Concierge representative is placed in a live phone environment for two weeks to allow them to use their new knowledge in real-time. During these two separate two-week timeframes that the concierge is in the live environment, they will have the support of their trainers for feedback and mentoring. This allows our training team to begin building rapport while directing the concierge down the path to success. Many members still prefer person-to-person phone contact to resolve their inquiries and issues, as such, our concierge are trained to answer questions and resolve issues on the first call, thereby delivering high levels of first call resolution. We give them the tools they need to find answers and access the relevant resources and information that will address individual member needs.

Concierge training has an added emphasis on soft-skills that supports a consultative approach to members with additional focus on understanding unasked questions and implicit needs. This ensures that concierges are aware of underlying opportunities to guide, educate, and empower members through the teachable moments. This comprehensive training builds on the designated staffing model to provide a truly differentiated member service experience that is customized for each plan sponsor, and personalized for each individual member using a simplified, seamless approach.

Lastly, a robust certification and performance assessment process ensures that each Aetna Concierge representative is equipped with the necessary skills to deliver concierge-level service to Aetna members upon completion of their training program.

MEMBER EXPERIENCE

The concierge is able to provide a differentiated member service experience through the use of the First Impression Treatment (FIT), which uses an ASD system alert to notify a concierge when a member calls in for the first time. Concierges are able to discuss key topics, as identified by the Plan Sponsor, with a first-time caller to ensure that members are maximizing their available benefits, and promote awareness on topics that are key from the perspective of the plan sponsor.

Concierges connect members more seamlessly through the use of internal warm transfers to Aetna clinicians, and programs that are available to them. They also serve as a single point of contact by transferring members to external 3rd party vendors and service providers. Outbound text messaging is an added capability that allows concierges an additional way to personalize the experience by following-up with members via the communication channel they prefer, whether it is by phone, email, or text.

CUSTOMER SERVICE TRAINING PROGRAM

In addition to our in-depth Aetna Concierge training program, our concierges are placed in a 12 to 14 week foundational customer service training program. The training is delivered through classroom lecture and computer-assisted instruction. The training program covers:

- Benefit determination
- Claim review
- Eligibility information
- System navigation and documentation

- Communications and soft skills

Additionally, 4 weeks of in-depth product and integration training, as well as consultative soft-skills training builds upon the foundational customer service training to ensure that the concierges have an elevated level of expertise and skill in delivering concierge-level service. Ongoing management oversight and mentoring focuses on skills refinement and proficiency to support continuous skills development and improvement.

We review all new hire training content weekly and incorporate changes to policy, product or systems within 5 working days.

Trainees study previously recorded calls and mock-up call scenarios. They also meet with seasoned customer service representatives (CSRs) to listen to and watch real calls.

Trainees only graduate when they can demonstrate they can consistently handle calls with a quality level that meets or exceeds our standards.

ONGOING TRAINING AND AUDITING

Each month our concierges and CSRs receive policy, legislative, or system updates. In most cases, we deliver this training electronically. This lets the CSRs train during periods that have the least impact on production. We record program completion in our internal, online training resource. This is to make sure all CSRs take the required training specific to their job functions.

CUSTOMER SPECIFIC TRAINING

We want our team to know that the State members are important to us and we address this through cultural training. When a member calls with a question or concern, our service center staff will be trained and well educated on not just your plans and other vendors, but on your culture.

We will take the State of Alaska through an elaborate implementation process to ensure collection of all relevant information to support the Concierge team. We will use our experience and both collect the critical information from the State of Alaska as well as our network and clinical teams to populate both the tools as well as determine critical culture training.

We will work with the State of Alaska to define your role in the cultural training process. We see tremendous value in the State of Alaska delivering the cultural training to support a clear understanding of the State of Alaska's culture program goals, vendor partners and other key features.

The service center staff will review your benefit program, special administrative issues and other unique requirements. We will provide copies of the State's employee benefit booklets, announcements, other communications and any materials that you recommend, to provide our staff with a clear understanding of your program. This provides a smooth transition for responding to employee inquiries, as well as claim settlement.

Attachments:

2.2.4.5 Explain any incentive programs you employ to retain competent customer service employees.

Answer: We conduct performance reviews for our customer service staff and determine pay increases annually. We recognize and reward them for their performance and team outcomes.

These outcomes include:

- Customer focus

- Contact documentation adherence
- Quality call/correspondence review results
- Teamwork
- Schedule adherence
- Service excellence innovation (Keeping the Commitment)
- Telephone service factor
- Attendance

Managers consider these elements in the annual performance merit review.

In addition to their base salary, eligible customer service representatives (CSRs) take part in an incentive program that permits them to earn more monies on a quarterly basis.

We designed the Customer Service Incentive Program to keep and motivate CSRs. It also encourages a higher level of performance by providing meaningful financial rewards to those who excel in specific quality, productivity and teamwork goals.

We subject final bonus eligibility and bonus amounts to plan maximums and managers' discretion.

Attachments:

2.2.4.6 What is the average years of experience for your customer service staff?

Answer: The average years of experience of our customer service staff in the Fresno Service Center is 7.13 years.

Attachments:

2.2.4.7 What is the average length of employment for your customer service staff?

Answer: The average length of employment for our customer service staff in the Fresno Service Center is 10 years.

Attachments:

2.2.4.8 Describe your plan for maintaining at a minimum, offices in Juneau and Anchorage to provide dedicated customer service to members and providers served under the AlaskaCare Plans.

Answer: Juneau and Anchorage offices will have two Aetna service representatives dedicated to the State. These representatives will act as an extension of State of Alaska and will be available for member service issues, plan benefit questions, support for the State's staff, coordination of program and services, and various other needs as they arise. Along with the account team, these individuals will primarily be responsible for ensuring a cohesive integration of all resources and programs.

The Anchorage representatives will be located in our Aetna offices and we will establish a lease for the Juneau representatives.

Attachments:

2.2.4.9 How many dedicated toll-free phone lines will be made available to answer member and provider inquiries?

Answer: The State will have one dedicated 800 number with prompting for members and providers. When a State employee uses the member prompt on the 800 number, their call is handled by the My AlaskaCare Single Point of Contact team which handles member calls exclusively. When providers use the provider prompt 800 number, their call is geographically routed to be handled by representatives in our Provider Service Center which handles providers' calls exclusively.

Members can also reach the Concierge via live Aetna Navigator-based web chat. In the event a Concierge needs additional detail from a member during a chat, they will call the member at a number that is convenient for the member in order to continue the conversation.

PROVIDER INQUIRIES

Provider services are geographically aligned to one of eight Provider Service Centers. All work (e.g. calls, claims, correspondence) is systematically routed from central addresses/phone numbers to provider's local service center. Provider Service Center locations are:

- Allentown, PA
- Arlington, TX
- Bismarck, ND
- Blue Bell, PA
- High Point, NC
- Jacksonville, FL
- New Albany, OH
- Walnut Creek, CA

Attachments:

2.2.4.10 How many dedicated toll free phone lines for the hearing impaired will be made available to answer member and provider inquiries?

Answer: Members and providers who are hearing impaired can call Aetna's TDD line for specialized service communication over telephone lines.

Attachments:

2.2.4.11 During what hours/days of week will toll free phone lines be staffed?

Answer: The State's members will have access to their My AlaskaCare Single Point of Contact team from 8:00 a.m. to 6:00 p.m., in their local time zones. The dedicated My AlaskaCare team will handle all of the State of Alaska member calls from 8:00 a.m. to 7:00 p.m. pacific standard time with support team handling call for members in eastern, central and mountain times prior to 8:00 a.m. pacific.

Members may also obtain customer service information through Aetna Voice Advantage, our self-service telephone system, and Aetna Navigator, our secure member website, which are both available 24 hours a day, 7 days a week.

Attachments:

2.2.4.12 Provide an explanation of how you define "after-hours." How are calls "after-hours" of operation handled?

Answer: We define "after hours" as outside of our normal business hours, which are Monday through Friday, 8:00 a.m. to 6:00 p.m. Members that are located in a different time zone will have access to our standard 10 hours of phone coverage through call routing to another office. Standard customer service hours consist of 8:00 a.m. to 6:00 p.m. local time to the member.

Members may also obtain customer service information through Aetna Voice Advantage, our self-service telephone system, and Aetna Navigator, our secure member website, which are both available 24 hours a day, 7 days a week.

OUTSIDE OF NORMAL BUSINESS HOURS

For inquiries outside of normal business hours, members have the option of using Aetna Voice Advantage, our self-service telephone system or Aetna Navigator, our secure member website.

INTERACTIVE VOICE

The Aetna Voice Advantage® interactive telephone system is available 24 hours a day. Members speak as they normally do and the system helps guide them to the information they are seeking in a clear, conversational way.

Using the self-service features, members can request an ID card, get claim payment information or obtain fund balances, when applicable.

AETNA NAVIGATOR

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

Members can send a written inquiry to member services. Every page on the Aetna Navigator site has a “Contact Us” link, making it simple to send a secure message to member services whenever they have a question or concern.

Attachments:

2.2.4.13 Is there a voice mail system or capability for callers to leave messages after normal business hours? During after-hours?

Answer: The Aetna Voice Advantage® interactive telephone system is available 24 hours a day, 7 days a week to provide information for members when they need it. The easy-to-use tool determines the reason for the call as members talk and finds the information they need.

Callers who exit/opt out of Aetna Voice Advantage after the service center has closed will hear the following message:

“If your call is regarding an emergency, please contact your primary care physician or seek care immediately. Our business hours are Monday to Friday, 8:00 a.m. to 6:00 p.m., local time.”

After-hours, members can be connected with Informed Health® Line, our 24 hour nurseline, for urgent issues.

Attachments:

2.2.4.14 Do members reach a live representative or an interactive voice response unit (IVR) when calling customer service?

Answer: When members call customer service, they are first greeted by Aetna Voice Advantage, our telephone self-service system.

Members are able to request to speak to their My AlaskaCare Single Point of Contact at any time during the call by speaking 1 of the more than 150 synonyms for concierge that the system is programmed to recognize. When a member requests to speak to a concierge, their validated member information automatically presents to the concierge receiving the call.

Our state of the art IVR system, Aetna Voice Advantage (AVA), fully supports our service model with complex call routing designed to support the multi-product customer. Only one toll-free-number is required and the AVA integrated product menu, along with the speech recognition technology, will get the member to the right area.

All information provided by the member to the AVA system will be available to the concierge, eliminating the need to repeat information.

E-MAIL AND CHAT CAPABILITIES

Members can reach the Concierge via live Aetna Navigator-based web chat and communicate directly with them. In the event a Concierge needs additional detail from a member during a chat, they will call the member at a number that is convenient for the member in order to continue the conversation.

MEMBER ENGAGEMENT

The concierge uses a 360-degree member dashboard to quickly and efficiently access summaries of clinical program enrollment, disability and absence management information, as well as available incentive programs.

The concierge can also:

- Update member preferences
- Respond to system alerts
- Transfer live calls to product specialists
- Work with clinicians who coordinate care across all clinical programs
- Schedule appointments
- Return phone calls through expanded support of outbound call activity

The concierge engages members to improve health outcomes with more than 50 triggers that allow program-to-program referrals, as well as notes and alerts that improve collaboration between program staff, other Aetna departments and external vendors.

For example, an unable to reach alert notifies the concierge that a caller is eligible for a care management program and has not returned introductory phone calls. The alert gives concierges an opportunity to explain to members the benefits of the program and offer to warm transfer the caller to a specialist.

Attachments:

2.2.4.15 Are all calls logged into your tracking system?

Answer: Yes. We use an online tracking and documentation system called Aetna Strategic Desktop (ASD) for member and provider contacts including telephone calls, written correspondence, Internet e-mail and walk-in visitors. We track events in the system from the moment a member contacts us. The system tracks any tasks or activities performed to resolve the service request from beginning to end.

Attachments:

2.2.4.16 If no, what percentage of calls are logged into your tracking system?

Answer: We record 100 percent of calls to support quality improvement processes.

Attachments:

2.2.4.17 Please check all items below which pertain to calls handled by the customer service representatives:

- Answer:** 1: All calls are recorded,
2: Customer service representatives document all calls,
5: Calls are documented in summarization

Detail: A key feature of our member services system is a quick way for the concierge to document an event by either clicking a checkbox or simply following a specific workflow that will document the task by capturing which screens the concierge visited in ASD. This greatly reduces the need to type manual notes in support of call documentation thus reducing overall call time and improving reporting capabilities.

Options:

1. All calls are recorded
2. Customer service representatives document all calls
3. Customer service representatives can make adjustments to claims during a call
4. Calls are documented verbatim
5. Calls are documented in summarization

Attachments:

2.2.4.18 If your customer service unit uses a dedicated on-line call tracking and documentation system, identify whether the following characteristics are tracked:

Answer: 1: Date of initial call,
2: Date inquiry closed,
3: Representative who handled the call,
4: Call status,
5: If and where issue was referred for handling,
6: Reason for call,
7: What was communicated to member

Detail: Auto documentation is a key feature of ASD. This is a quick way for the concierge to document the event by either clicking a checkbox or simply following a specific workflow that will document the task simply by capturing where the concierge went in ASD. This will greatly reduce the need to type manual notes in support of call documentation thus, reducing overall call time and improve reporting capabilities.

Options:

1. Date of initial call
2. Date inquiry closed
3. Representative who handled the call
4. Call status
5. If and where issue was referred for handling
6. Reason for call
7. What was communicated to member

Attachments:

2.2.4.19 What other methods of contacting customer service representatives, besides telephone, are available for members to use?

Answer: With My AlaskaCare Single Point of Contact, members can contact Aetna via live Aetna Navigator-based web chat. This capability allows Concierges an additional way to personalize members experience by following-up with members via the communication channel they prefer, whether it is by phone, email, or text.

If the concierge needs additional detail from a member during the web chat, the concierge will call the

member directly at the member's convenience to continue their conversation.

Members may also use Aetna Navigator, to send a written inquiry to member services. Every page on the Aetna Navigator site has a "Contact Us" link, making it simple to send a secure message to member services whenever they have a question or concern. Our goal is to respond to e-mail inquiries within one business day.

The representatives in Juneau and Anchorage will have access to the same systems and information as the concierge team and will be able to assist members who visit those locations.

Attachments:

2.2.4.20 Do customer service representatives handle both member calls and provider calls?

Answer: Customer service representative do not handle provider calls.

Providers and their staffs have a unique phone number separate from the phone number members would call. Our Provider Service Centers are available between 8 a.m. and 5 p.m. local time to answer their questions. Our automatic call distribution system quickly directs each call to a local service center based on the area code from which the call is placed.

Attachments:

2.2.4.21 Can customer service representatives access claims status on-line in real-time?

Answer: Yes. Our concierges have online access to claims information. Should a claim payment adjustment be needed, our concierge will forward to our claim department for further handling. All departments access the system and the member is not required to reach out directly for claims assistance.

Attachments:

2.2.4.22 Identify the typical work and training experience required of your customer service and claims processing supervisors and/or managers.

Answer: We provide extensive training to both our Aetna Concierge teams and our claims processing teams.

DIVISION MANAGERS

Division managers are responsible for coordinating the team activities that support our customer's benefit plans. The call teams are led by customer service supervisors who report to the division managers. Call supervisors have total responsibility and accountability for the prompt and proper response to members' questions and problems. Their roles and responsibilities are:

CALL OR CLAIM MANAGERS

These managers are assigned three to five teams of either claims administration or customer service staff. They are also responsible for the day-to-day operations of their team within the service center. Other responsibilities include maintaining working relationships with assigned customers and oversee training and promote continuous learning for the customer service representatives and claim processors.

SUPERVISORS

A supervisor oversees a team of 20 employees, either claim processors or customer service representatives and manages the assigned accounts assigned to their team. They have the responsibility to develop and monitor performance of their team. The most important role for the

supervisor is our customers. Keeping costs down by explaining and promoting cost management programs to members.

The Fresno Service Center has a career path established leading to supervisory positions. They identify individuals interested in supervision and provide them with opportunities to learn these functions in their current positions by such assignment as working with trainees, filling in for supervisor during absences, etc. They work with them during the course of the temporary assignment to provide guidance, feedback, etc.

There is ongoing training for supervisory and management staff. This training consists of seminars, direct broadcast, and mandatory attendance at Home Office leadership schools. Each supervisor/manager is required to participate yearly to update their skills.

HEALTH CONCIERGE TRAINING

Concierges receive a much broader training that provides a thorough understanding of all products, services and clinical programs. We include information about the State's culture, preferences and benefit offerings, even if offered through another carrier, in our training curriculum.

We hire a different caliber of people for the concierge role because they'll be expected to know more and actively listen for triggers to unearth the unasked questions on every call. Training is also done differently to ensure that the concierge can realistically apply their knowledge and actively listen throughout. There is one on one support offered by the trainer throughout the comprehensive training.

The training is structured in such a manner that the concierge will learn their materials in two sections. Once one section is learned, the concierge is placed in a live phone environment for two weeks to allow them to use their new knowledge in real time. During these two separate two week timeframes that the concierge is in the live environment, they will have the support of their trainer as well as our Aetna One Quality team. This allows our Quality team to begin building rapport while directing the concierge down the path to success.

Attachments:

2.2.4.23 What is the current ratio of customer service representatives to supervisors and managers?

Answer: The State of Alaska will have 1 dedicated supervisor and 23 dedicated Customer Service Representatives in their team.

Typically, a supervisor may have approximately 18-20 CSRs in their team. A manager may have approximately 6-7 supervisors reporting to them.

Attachments:

2.2.4.24 What is the ratio of customer service representatives to covered lives in your organization's programs?

Answer: HEALTH CONCIERGE

The ratio of concierges to members is about 1:4,500. For the State of Alaska, My AlaskaCare Single Point of Contact concierges will be a team of 23.

A number of factors affect actual staffing levels. These include both the complexity and number of plans available to employees, and the service level requirements of the customer.

We use workforce management tools to forecast call volume and to schedule appropriate customer

service representative coverage. Service center managers continually monitor staffing and call volume to maintain quality standards and service targets.

Attachments:

2.2.4.25 Describe when and how a caller's recurring or unresolved issue is elevated to a supervisor/manager for resolution. Explain how you measure the success of this process over time.

Answer: Our goal is to provide our concierge staff with the optimum level of training, system access and online information to promptly and accurately respond to virtually any type of inquiry. In addition, we empower the concierges to take all actions to resolve the issue and support the member.

CONCIERGES PROVIDE ULTIMATE GUIDANCE

We recognize that there will be situations, due to the nature of the inquiry, when it will be appropriate for another department to resolve a member's concern. One example of this would be a patient management inquiry, when we would connect the member to a nurse consultant for assistance.

Where an inquiry requires additional research, the concierge will document the information concerning the outstanding inquiry. Our systems will then electronically direct the request to the appropriate department for review and resolution. Once resolved, we will reach out to the member to advise them of the resolution.

If an answer lies in a different department, the concierge introduces the member to the new representative, explains the circumstances and gets everyone involved on the same page immediately. The concierge will point out benefits your employee might not even know they had and explain the way the benefit works.

If a caller would like to speak to a member of management, the concierge will gather all relevant information and transfer the caller to a team leader. When the team leader is not available, the concierge will try to locate another member of management. If the caller is unable to hold, the concierge offers to take the pertinent information and have a member of management return the call. Management's goal is to return the call within one business day.

Attachments:

2.2.4.26 Provide the turnover rate of your call center representatives for the past three calendar years.

Answer: The call staff turnover rate for our Fresno Service Center for the past three calendar years is:

- 2010: 13.60%
- 2011: 10.20%
- 2012: 10.48% (as of 9/30/2012)

Our turnover rate is tracked on the overall call staff.

Attachments:

2.2.4.27 Using current calendar year data, please provide the following information for each customer service office that will have responsibility for this account:

- Answer Speed
- Wait Time
- Abandonment Rate

- ID Card Issuance (timeliness)

Answer: As of 9/30/2012, our Fresno Service Center achieved the following results:

Answer Speed: 26 seconds

Wait Time: 78.30% of calls were answered within 30 seconds.

Abandonment Rate: Less than 1.10%

ID Card Issuance (book of business: 7-10 business days).

Members have the capability to print temporary ID cards through the temporary ID feature on Aetna Navigator®, our secure member website at www.aetna.com.

Attachments:

2.2.4.28 Describe other dedicated or customized customer services you are prepared to offer the State.

Answer: As one of the nation's leading providers of health and related benefits, we are pleased that a national organization recognizes us for world-class customer service. Several years ago, Aetna decided to revolutionize the member experience. The result was a model that JD Power has certified as "an outstanding customer service experience." For the fourth year in a row, Aetna's concierge customer service call center has been recognized by J.D. Power and Associates for providing "An Outstanding Customer Service Experience."

We are offering My AlaskaCare Single Point of Contact concierge services to the State.

This provides highly-skilled benefits experts to serve as single-points-of-contact to simplify and streamline the member experience.

Our system also recognizes members who are making their first contact with us, and alerts the concierge. This enables the concierge to provide a service experience specific to the needs of a first time caller, including a welcome type message and even more emphasis on education about our self-service tools.

Every question from every member is answered in total context because the concierge always has a complete portrait of each member's unique need in view.

Using a consultative approach to address member needs, Aetna Concierges:

- Answer questions about all of a member's Aetna benefits, as well as any non-Aetna employer-sponsored benefits that may be available
- Transfer the member's call to a different area when necessary and remain on the line to make sure the connection is made
- Help the member learn about our online tools and health information resources, and provide guided support, as necessary
- Let members know when another one of our programs is trying to reach them, such as disease management, and offer to connect them
- Listen holistically to fully understand the member's needs, including triggers for clinical engagement opportunities, unasked questions and implicit needs the member may have, and teachable moments that afford our concierges the opportunity to educate and empower them
- Focus on opportunities to make the right connection at the right time ensuring members are linked to relevant resources when they need them most.

All of our concierges use a 360-degree member dashboard to quickly and effectively access information about:

- The member's plan
- Programs in which the member is enrolled or available to join
- Disability and absence management information (if available)
- Available incentive programs

EXAMPLES

The concierge answers questions, offers proactive suggestions and connects members to resources they may not have been aware of. If a member has a question the health concierge cannot answer, the call is transferred to a specialist. The concierge remains on the line until the transfer is complete and the specialist is able to view all information gathered before the call was transferred.

The scope of assistance provided in a single phone call is unprecedented. For example, a newly pregnant woman seeking assistance with identifying an obstetrician also may learn about her maternity benefits, connect to EAP to find child care resources in her area, enroll in the maternity program, learn how to enroll her child after the birth, and explore her short-term disability and Family Medical Leave options.

Here is another example that the concierge is your advocate and provides the support and one-on-one assistance. Your employee receives a doctor bill that was much higher than expected. With Aetna Concierge, the employee can call the number on the back of the ID card and talk to a service professional who will not only explain how the plan works, but can even call the doctor to work out any problems.

Additionally, all Aetna Concierges use the Aetna Social Learning Tool. This tool is customized for the State and regularly updated to reflect specific information on all benefit and clinical programs that are available to your employees. Aetna Concierges use this tool to deliver personalized service that is tailored to meet the unique needs of your employee population based on the products, programs, and services that are available to them at Aetna and through any employer-sponsored third-party vendors.

Because Aetna Concierge teams are staffed more richly, concierges are empowered to spend the necessary time with each member to deliver relevant, meaningful interactions that deliver high levels of member satisfaction. Concierges focus on educating and empowering members to become better informed and better equipped to maximize their available benefits and navigate the health care system effectively.

Support provided by the concierge extends to promoting the use of Aetna Navigator, finding in network providers, estimating the cost of care using Aetna's Member Payment Estimator (MPE), supporting member steerage to Institutes of Quality (IOQs) and Institutes of Excellence (IOEs) for specific types of procedures, and even working with members to schedule physician's appointments, as necessary.

Their focus is providing whatever support is needed for the member given their specific needs, while also taking advantage of “teachable moments” that afford an opportunity for the concierge to educate members on their benefits and the myriad resources that are available to them through their plan sponsor.

The goal of the Aetna Concierge program is to provide accessible service that is simple and seamless,

and to also deliver best-in-class member support, guidance, and education leading to sustained member engagement, better informed decisions, and healthier outcomes

Attachments:

2.2.5 Utilization Management (UM)

2.2.5.1 Utilization Management (UM) - General

2.2.5.1.1 Please identify and describe the services you provide through your utilization management program.

Answer: We want our members to enjoy their best level of health. Our nurses work together to get members the care they need. We do this by using our care team approach and applying clinical expertise, technology, and evidence-based guidelines throughout our care management program.

Program components

PRECERTIFICATION

The precertification staff confirms eligibility and collects information before inpatient admissions and selected ambulatory procedures and services.

Two components of precertification are:

- Notification - This process is the registration of a request for services or supplies included on a precertification list.
- Coverage determination - This process reviews plan documents and may include a review of clinical information to determine whether clinical guidelines/criteria for coverage are met. The coverage determination process takes into account:
 - Individual needs of the member
 - Characteristics of the local delivery system
 - The member's benefit plan

By focusing on high cost or over/under-used procedures, precertification provides an entry point for acute care utilization management. It also provides a referral point for complex case management and special programs. These help reduce medical expenses and improve the member's quality of life.

The precertification process helps communicate a coverage decision to the treating practitioner and/or member in advance of the procedure, service or supply. We can receive precertification requests:

- Electronically through an electronic data interchange or Internet solution
- By telephone
- In writing by fax or mail

Our Precertification department also reviews the use of providers who do not participate in our networks. This includes:

- Members in certain plans who must initiate precertification themselves when seeking out-of-network care

- Members who are referred to out-of-network providers for covered medical services that are not available within our network

We can also provide precertification for the services listed as requiring precertification in your plan documents.

We also have 630 clinical policies (CPBs) in place today that are based on evidence based medicine. We have an annual review process and work with providers identifying new evidence in the development of policies. Our policies are embedded in our network contract requirements and claims payment typically resulting in savings ranging from 1 - 3 percent across providers.

CONCURRENT REVIEW

With the exception of normal maternity admissions, we register all inpatient admissions in our medical management system for review in accordance with the member's benefit plan. Our clinical staff uses evidence based clinical guidelines from nationally recognized authorities and the terms of the member's benefit plan to guide utilization management decisions for inpatient utilization, continued stay review and discharge planning, as well as for precertification and retrospective review.

We use on-line guidelines from the following sources:

- Milliman Care Guidelines® (Seattle, WA: Milliman USA)
- Our internally developed Clinical Policy Bulletins (CPBs)
- National and local Medicare coverage policies
- Other Aetna recognized criteria
- Applicable regulatory guidelines

Not all of the inpatient admissions require a clinical review for medical necessity (for example routine admissions with a short length of stay). We review outpatient procedures using the same criteria or guidelines as inpatient procedures. Licensed and experienced clinicians and professionals make decisions based on the above criteria as well as the individual needs of the member.

DISCHARGE PLANNING

Assessment for discharge planning begins at the time of notification of admission. Once we identify post discharge needs, we begin to coordinate them during the hospital stay. It involves a proactive approach to work with providers and members to develop a transition plan from one level of care to the next. The discharge plan considers:

- The member's age
- Prior level of functioning
- Significant past medical history
- Anticipated discharge location
- Current medical condition and level of functioning
- Family/community support
- Psychosocial issues
- Barriers to discharge planning

Discharge planning may include internal and external referrals. Examples of internal referrals are:

- Case management
- Disease management

- Behavioral health
- The National Medical Excellence transplant program

Examples of external referrals are:

- Skilled nursing facilities
- Rehabilitation facilities
- Home health care agencies
- Community support groups
- Durable medical equipment and supplies
- Social work services

RETROSPECTIVE REVIEW

Retrospective review is the process to determine coverage after an inpatient stay or an outpatient service. We perform retrospective reviews after we confirm the member was eligible and had benefits at the time of service. We use clinical guidelines and criteria to support our process.

Retrospective review is available when:

- The member met precertification/notification requirements at the time of service, but the service dates do not match the submitted claim
- We convert from secondary payer to primary payer at the time of inpatient claim adjudication.

BEHAVIORAL HEALTH INTEGRATION

We are strengthening our current care management program by expanding our behavioral health identification and support for all medical members.

We have seen the impact our motivational interviewing has had on member engagement since we introduced it several years ago. We have also gathered specific claims evidence that proves that medical costs per claimant dramatically rise when complicated by a behavioral health condition. Through our behavioral health/medical integration initiative, we are training our entire care management staff to assess, identify, triage and support routine behavioral health issues. This can:

- Improve identification of behavioral health comorbidities to enhance overall quality of care across all products and populations
- Improve effectiveness of medical interventions by addressing behavioral drivers of medical outcomes
- Improve member well-being and engagement in their medical management
- Have a positive impact on cost savings for the State

Using motivational interviewing skills and a new behavioral health screen tool, care management clinicians go beyond depression screening to now identify other BH conditions such as anxiety, eating disorders, bi-polar disorders or substance abuse that may impede a member's medical management.

The nurse who is handling the member at that time will identify and address “routine” issues, such as feeling:

- Stressed
- Overwhelmed
- Irritable
- Nervous
- Anxious
- Worried

To help our care management nurses support these members, we have now assigned a behavioral health specialist to their specific team. The behavioral health specialist provides guidance to the nurse in coordinating the member's care. If we identify members with more complex needs, we will refer them to appropriate resources that are included in their benefit plan.

Attachments:

2.2.5.1.2 How many years has your organization provided UM services?

Answer: We have provided utilization management services for 27 years, since 1985. Aetna was one of the few organizations that never deviated from the value of utilization management. We believe this is an essential component of health care delivery and is designed to ensure the right care in the right setting. Our policies are established to support appropriate care, which is based on evidence based medicine.

Attachments:

2.2.5.1.3 How many total covered lives does your UM program support?

Answer: We currently provide UM services to 17,818,931 members.

Attachments:

2.2.5.1.4 How many clients do you currently service in your UM program?

Answer: We currently provide UM services to 117,769 customers.

Attachments:

2.2.5.1.5 What is the size of your target client?

Answer: Our target client for large group Public Sector and Labor customers typically has in excess of 3,000 employees. However, we are a full service national carrier who provides services to employers of all sizes. We have customers with populations ranging from a handful of employees to large, complex populations with over 300,000 members.

Attachments:

2.2.5.1.6 What is the average caseload for each utilization manager?

Answer: The average daily caseload for each utilization review nurse is between 25 and 50 cases.

Attachments:

2.2.5.1.7 What percentage of your utilization management staff has a clinical degree?

Answer: For clinical determination and medical necessity review, 100 percent of staff have a clinical degree. 69 percent of our total medical management staff has a clinical degree. This includes RNs, MDs, and LPNs. 31 percent of our total medical management staff is non-clinical and include administrative support, care management associates and intake queue associates.

Attachments:

2.2.5.1.8 Will the utilization management program be available to members for at least 8 hours during Alaska Standard Time? Indicate the hours of operation.

Answer: Confirmed. The standard hours of operation for our utilization review staff are 7 a.m. to 4 p.m. Alaska Time, and 8 a.m. to 5 p.m., local time for the lower 48 states. Callers for our UM program receive a message after hours advising them to call back during regular business hours. The after-hours message also gives information on how to handle emergencies. For provider urgent utilization requests we have 24/7/365 coverage by both precertification nurses and medical directors across the country.

Attachments:

2.2.5.1.9 Which days of the week is your utilization management program available?

Answer: Our utilization review staff is available Monday through Friday. Please note that precertification is the responsibility of our network providers when members seek care from our in-network providers. Callers for our UM program receive a message on weekends advising them to call back during regular business hours. The after-hours message also gives information on how to handle emergencies. For provider urgent utilization requests we have 24/7/365 coverage by both precertification nurses and medical directors across the country.

Attachments:

2.2.5.1.10 What percentage of UM calls are monitored?

Answer: We record 100% of all UM calls. This enables us to review any call whether regarding appeals, questions or other inquiries surrounding that interface. Approximately 30 calls per nurse per quarter go through a rigorous review process. We review these calls for continuous quality improvement opportunities.

Based on our contractual agreements with providers, the majority of UM calls are between network providers and Aetna UM nurses.

Attachments:

2.2.5.1.11 What was your UM organization's average speed of answer for last year?

Answer: In 2011, our average speed to answer was 82 seconds.

Network providers are responsible for obtaining precertification, and therefore average speed of answer only affects members when they use out of network providers.

Attachments:

2.2.5.1.12 What was your UM organization's abandonment rate for last year?

Answer: In 2011, our abandonment rate was 3.4 percent.

Network providers are responsible for obtaining precertification, and therefore the abandonment rate only affects members when they use out of network providers.

Attachments:

2.2.5.1.13 What was your UM organization's call wait time for last year?

Answer: In 2011, callers waited an average of 82 seconds before their call was taken. 60 percent of the calls were answered within 30 seconds.

Network providers are responsible for obtaining precertification, and therefore call waiting only

affects members when they use out of network providers.

Our plan designs can administer varying levels of penalties resulting from noncompliance of utilization management activities. The plan may penalize providers if they fail to comply. We do not penalize the member when a participating physician does not precertify.

Attachments:

2.2.5.1.14 Indicate any accreditations you currently hold SPECIFIC to your utilization management program.

Answer: Our health plans are accredited by NCQA under the accreditation for health plan standards. This includes review of our utilization and management program. We do not have separate accreditation for our utilization management program.

The NCQA health plan accreditation standards include extensive requirements related to case management, including the following:

- Annual assessment of the characteristics and needs of its member population and subpopulations, and how the organization updates processes to address member needs.
- Identifying members eligible for complex case management using seven required data sources, such as claims data, pharmacy data, providers and purchasers.
- Processes for staff to receive referrals from six required sources such as informed health line, caregivers and providers.
- Use of case management systems that support evidence-based clinical guidelines, automatic documentation of the case management interactions and automated prompts for follow-up.
- Processes to assess the needs of each member requiring case management that include 15 required components.
- An annual evaluation of the case management program that includes a member satisfaction survey and complaint analysis.
- Measuring the effectiveness of the case management program using three measures. For each measure, quantitative analysis is required, goals must be established and opportunities for improvement identified. Corrective action must be taken on at least one of these and re-measurement performed.

We were the first national insurer to hold NCQA PPO Full Accreditation, which we obtained in 2007. Our most recent review was in 2010, when we underwent a renewal and achieved a 3-year accreditation designation. This accreditation is effective December 22, 2010 through December 22, 2013.

Attachments:

2.2.5.1.15 Explain the clinical criteria or guidelines used to determine medical necessity, length of stay and level of care. Provide examples.

Answer: MEDICAL NECESSITY

We use Milliman Care guidelines for our concurrent review program.

LENGTH OF STAY

We use the goal length of stay (GLOS) definition contained in the Milliman Care Guidelines® Optimal Recovery Guidelines. It is a goal and not a rule. The GLOS is the number of days that uncomplicated patients usually require to recover to a point for a safe discharge or transition to a less acute level of care.

LEVEL OF CARE

For level of care, we use Milliman Care Guidelines for Inpatient and Surgical Care.

All of these are built into our claim payment policies.

Attachments:

2.2.5.1.16 Explain the clinical criteria or guidelines used to determine experimental treatment vs. standard of care. Provide examples.

Answer: Our Clinical Policy Bulletins (CPBs) define our policy regarding the experimental and investigational status of medical technologies that may be eligible for coverage under our medical plans. This includes medical and surgical procedures, devices, pharmaceuticals, biological products, behavioral health interventions, and the organizational and supportive systems within which such care is provided. We use the CPBs in conjunction with the terms of the member's benefit plan and other Aetna-recognized criteria to determine health care coverage for our members.

We base our CPBs on:

- Evidence in the peer-reviewed published medical literature
- Technology assessments and structured evidence reviews
- Evidence-based consensus statements
- Expert opinions of health care providers
- Evidence-based guidelines from nationally recognized professional health care organizations and government public health agencies

We consider the following criteria in evaluating medical technologies:

- Whether the medical technology has final approval from the appropriate governmental regulatory bodies
- Whether the scientific evidence permits conclusions about the effect of the medical technology on health outcomes
- Whether the medical technology improves net health outcomes
- Whether the medical technology is at least as beneficial as any established alternatives
- Whether the medical technology is more costly (taking into account all health expenses incurred in connection with the medical technology) than any equally effective established alternatives
- Whether improvements are attainable outside of investigational settings

You can find a complete index of published CPBs on our public website at www.aetna.com/cpb/cpb_menu.html. Please also find a sample CPB attached to our submission.

Questions about the experimental and investigational status and medical necessity of a medical technology can arise from our network providers. We may conduct an assessment of current or newly proposed CPBs at the request of our network providers.

Attachments: [Sample Clinical Policy Bulletin.doc](#)

2.2.5.1.17 Explain any clinical criteria imbedded within the care management system to facilitate consistent interpretation and use of criteria by staff members.

Answer: eTUMS, our electronic Total Utilization Management System, is a comprehensive information system that supports all products and care management activities on one platform. eTUMS consolidates all data into a common technology platform across all product lines. eTUMS also embeds the Goal Length of Stay (GLOS) contained in the Milliman Care Guidelines Optimal Recovery Guidelines and the level of care Milliman Care Guidelines for Inpatient and Surgical Care. In addition, the system links to national medical criteria and internal guidelines, and interfaces with Aetna Navigator®, our secure member website.

While separate units handle care management, claims functions, and provider contracts, the data associated with each of these is integrated online. This allows each function to review the others when needed. Through our electronic utilization management system, claims processors can view all medical utilization decisions and documentations, such as non-compliant issues. These are immediately available in real time after entered by our nurse reviewers. This information is provided in a read-only format and can only be edited by authorized staff members.

When the associated claim is submitted and processed, the claims adjudication system automatically flags the claim and alerts the claim processor to review the member's care management file for payment instruction. Our system enables care management nurses and claims representatives to toggle from care management screens to claims screens as needed. The use of claims screens, in addition to formal, daily communication between care management nurses and claim representatives is an integral part of our care management process.

Attachments:

2.2.5.1.18 Explain the documentation standards in place to assure the consistent collection of clinical information.

Answer: eTUMS supports all products and care management activities on one platform. Our nurse reviewers collect/document information regarding the member's physical condition, plan of treatment and clinical findings in the system. They also scan the member's recent history in the system to identify earlier hospital admissions and significant diagnostic-related information. If necessary, they can also review claim history screens. If the nurse reviewers cannot get all the necessary medical information from the caller, they may telephone the attending physician's office and note their findings in our system.

Data accessed or collected by our utilization management system falls into several categories. Our single system platform provides consistency in the overall administration of our plan by maintaining a holistic view of each member's health.

MEMBER DATA

Includes demographic, eligibility, benefits and other coverage information

PROVIDER DATA

Includes provider name, identification number, addresses, provider type (physician, acute care hospital, etc.), credentialing information, utilization history, network participation status and provider flags that identify specific providers for whom special utilization and claim review is needed

CASE DATA

Includes the diagnosis and other information that describe the member's condition and the services under review

UTILIZATION REVIEW DATA

Includes the name and ID number of the nurse and physician reviewers, the review determination, the criteria or rationale used to arrive at the review determination, member discharge plans

Attachments:

2.2.5.1.19 What clinical criteria are used to determine medical necessity of proposed care?

Answer: Our clinical policy bulletins (CPBs) define our policy regarding medical necessity and the experimental and investigational status of medical technologies that may be eligible for coverage under our medical plans. This includes medical and surgical procedures, devices, pharmaceuticals, biological products, behavioral health interventions, and the organizational and supportive systems within which such care is provided. We use the CPBs in conjunction with the terms of the member's benefit plan and other Aetna-recognized criteria to determine health care coverage for our members.

We base our CPBs on evidence in the peer-reviewed published medical literature, and technology assessments and structured evidence reviews. We also based them on evidence-based consensus statements, expert opinions of health care providers, and evidence-based guidelines from nationally recognized professional health care organizations and government public health agencies

We define medical necessity as health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, treating or rehabilitating an illness, injury, disease or its associated symptoms, impairments or functional limitations in a manner that is:

- In accordance with generally accepted standards of medical practice
- Clinically appropriate in terms of type, frequency, extent, site and duration
- Not primarily for the convenience of the patient, physician, or other health care provider

It must be widely accepted professionally in the United States as effective, appropriate, and essential based upon recognized standards of the health care specialty involved.

In no event will we consider the following to be necessary:

- That part of the cost that exceeds any other service or supply sufficient to safely and adequately diagnose or treat the individual's physical or mental condition.

Our rationale for using medical necessity criteria is to support the development and use of clinical guidelines and clinical protocols to improve the quality of medical care. We have designed our process to adopt appropriate guidelines relevant to the membership for the provision of preventive, acute, chronic and behavioral health services.

Attachments:

2.2.5.1.20 Is a formal policy/process in place to guide staff regarding Medical Director referrals?

Answer: Confirmed. Our nurse reviewers refer all cases to a medical director when:

- The available clinical information does not meet decision-making guidelines
- The length of stay exceeds guidelines
- If based on their clinical acumen they have questions on the treatment plan, concern for any reason about the quality of care and/or to request our physicians call the treating physician directly for additional information and/or clinical discussions

If necessary, the medical director may also ask another physician of the same or similar specialty to review.

All staff have system access to our Policies and Procedures and clinical criteria and have the ability to 'task' the referral through the system to the medical director reviewer.

Attachments:

2.2.5.1.21 What percentage of inpatient admissions was referred for Medical Director determination or clinical input during the most recent calendar year?

Answer: In 2011, our nurses referred 14,794 requested precertifications/admissions to a medical director. We are unable to track the actual percentage of precertifications/admissions sent to a medical director because we are not notified of all admits prior to the admission. However, we track the total number of requested and non-requested admissions, which is 403,809. This translates to a 3.66 percent referral rate.

Attachments:

2.2.5.1.22 Describe the guidelines in place that require non-clinical staff to refer cases for clinical staff to review. Describe the types of cases referred.

Answer: We follow guidelines for staff functions set forth by our National Care Management policy and procedure manual.

Clinical support staff perform administrative functions such as, eligibility verification, intake screening and data collection. They also have access to licensed clinicians for questions, concerns and guidance regarding how to handle a coverage request for a particular procedure or service. They create a record of the request for certification along with demographic information in eTUMS. The system then tasks the record to our nurse reviewers.

Generally, all inpatient non-surgical admissions and all out-of-network admissions require medical review by clinical staff. However, our non-clinical staff can perform registration of activities in our medical management system for services we do not designate for medical review in accordance with the member's benefit plan. Some examples are hysterectomy and laparoscopic cholecystectomy. Our rationale is these are elective admissions where length of stay is less than three days.

Attachments:

2.2.5.1.23 What percentage of reviews are performed by non-clinical staff?

Answer: Zero percent. Non clinical staff do not perform reviews. Reviews can only be done by clinical staff. Non-clinical staff can perform registration only.

Attachments:

2.2.5.1.24 Identify each location in Alaska where you will staff onsite nurses?

Answer: We currently have one nurse located in Homer, Alaska. We are willing to explore hiring an additional nurse that meets our employment criteria in Alaska.

Attachments:

2.2.5.1.25 Briefly describe your process for handling pre-certification requirements, including intake method, eligibility and benefits verification, system tracking and notification to claim processing staff, communication to members and providers, etc.... Explain whether the process differs for emergency, urgent care v. elective procedures.

Answer: The following steps outline our precertification review process:

- Phone call to precertification unit

Our inbound queue associates check basic eligibility, benefit information, COB, and create a record of the request for certification along with demographic information in eTUMS, our electronic Total Utilization Management System. The system then tasks the record to our nurse reviewers.

- Check of eligibility and discussion of plan of treatment

Our nurse reviewers check the eligibility benefit information and collect/document information regarding the member's physical condition, plan of treatment and clinical findings. They scan the member's recent history in the system to identify earlier hospital admissions and significant diagnostic-related information. If necessary, they can also review claim history screens. If the nurse reviewers cannot get all the necessary medical information from the caller, they may telephone the attending physician's office.

- Application of decision-making criteria

Based on medical information collected, the nurse reviewers apply clinical criteria or other policy guidelines as applicable for medical necessity review.

APPROVALS

If certification meets our criteria, the nurse reviewers verbally inform the caller and document the information in eTUMS. Upon specific request, we may fax or mail a confirmation of certification of services to any provider. When the member precertifies, we generate a confirmation of approved services to the provider/facility including approved length of stay for inpatient services if mandated by state law or upon request.

POTENTIAL DENIALS

If the information obtained by the nurse reviewers does not meet the established criteria, they refer the case to the medical director. The nurse reviewers cannot deny services based on medical necessity. If upon review, the medical director determines the care meets the criteria outlined within established guidelines, we certify the services and inform the requestor. If the medical director determines the care does not meet the established guidelines, we deny certification. We will send a denial letter to all parties at that time. The letter will include the reason for the denial, the availability of clinical rationale used to support the decision and the process for filing an appeal.

INTERNAL INTEGRATION

Separate units handle care management, eligibility, member services and claims functions. However, the data associated with each of these is integrated online. This allows each function to review the others when needed. Through our electronic utilization management system, claims processors, member services and eligibility consultants can view all medical utilization decisions and documentations, such as non-compliant issues. These are immediately available in real time after

entered by our nurse reviewers. This information is provided in a read-only format and can only be edited by authorized staff members.

EMERGENCY, URGENT AND ELECTIVE SERVICES There is no difference during the precertification/notification process for emergency, urgent and elective services. However, our notification timeliness standards vary for emergent/ urgent and non-urgent procedures. They are in compliance with applicable federal regulatory and accreditation requirements. Applicable state laws or regulations that mandate a more stringent response time supersede the national standards.

NON-URGENT (INCLUDES ELECTIVE) PRECERTIFICATION APPROVALS AND DENIALS

We make non-urgent precertification decisions within 15 calendar days, or mandated state law, from the receipt of the request. Once we make the determination, we communicate the non-urgent precertification approval by telephone to the attending physician or other ordering provider/facility on the day of the determination, not to exceed 15 calendar days. We provide written notification when state mandated or when requested from the physician, facility or the member.

We communicate non-urgent precertification denials by telephone to the attending physician or other ordering provider/facility on the day of the determination, not to exceed 15 calendar days. We send written notification for denial to the physician, facility and the member within 3 days of the initial determination.

URGENT/EMERGENT PRECERTIFICATION APPROVALS AND DENIALS

Based on health care reform requirements, we make urgent precertification decisions within 72 hours from the receipt of the request. We communicate the coverage determination verbally or by fax within 72 hours of receipt of the request. We send written notification for approvals when required by state law and for all denials within 3 calendar days of the verbal notice unless state law requires a more stringent turnaround time.

The written denial notice includes the type of service and dates involved, the reason for the denial, the date denial was made, a statement about discussing alternatives with the member's physician, directions on how to obtain a copy of the clinical criteria used for the denial. The provider's notice also contains appeal information including timeframes and an address to send the request to and an offer to speak with medical director to further discuss the case within 14 days of the determination or state regulated peer-to-peer timeframe. The member's notice includes ERISA state-specific language, a right to file civil action, privacy directives if appealing, links to some websites about patient safety, a link to report suspected fraud, and directions to contact Member Services for any questions or clarifications.

PARTY RESPONSIBLE FOR INITIATING PRECERTIFICATION

For hospital admissions and select ambulatory procedures and services, members are responsible for starting the precertification process when they use a non-network provider. When the member chooses an in-network provider, the network physician is responsible for starting the precertification process. Either the member, a representative for the member, or the attending physician can start the precertification process by calling a toll-free number on the member's ID card. For continued stays, the member does not need to contact us. The attending physician will contact us or our utilization management staff will contact the facility on the expected date of discharge to verify discharge or obtain clinical information.

Attachments:

2.2.5.1.26 Describe your procedures for promoting clinically appropriate alternatives to hospitalization.

Answer: All non-maternity admissions are reviewed for medical necessity. Some members can be safely managed in a non-inpatient facility including a hospital observation department, skilled facility, long term care facility or home with appropriate support.

DISCHARGE PLANNING

Assessment of potential discharge planning needs begins at the time of notification of admission, and continues throughout the hospital stay.

The discharge planning process may include the hospital reviewer/case manager or other alternate care provider, other health care providers, the treating practitioner, the member and the member's family.

Our discharge planning program encourages providers to develop a plan that provides an appropriate transition from one level of care to the next appropriate level of care. It also facilitates the delivery of cost-effective, quality care.

The utilization management nurse consultant (UMNC) is responsible for managing the discharge planning needs through that member's continuum of care, including:

- Inpatient assessment, evaluation and monitoring
- Consultation with the medical director on an as-needed basis in determining coverage decisions

If we identify and accept a member for case management while in the hospital, the case manager will collaborate with the UMNC to perform the discharge planning. The case manager follows the member throughout the continuum of care and is responsible for the assessment and coordination of the member's discharge planning needs.

The discharge plan may include having the member use a variety of services and benefits upon discharge from an inpatient stay. Based upon the physician's discharge plan, the UMNC or the case manager may contact alternative care facilities to arrange for the member's admission. In addition, they may approve and coordinate the delivery of home care services and arrange for outpatient services as well. Goals include:

- Timely provision of requested services and supplies
- Facilitate timely discharge to the appropriate setting
- Promotion of optimal recovery
- Prevention of hospital readmission
- Delivery of care in a safe, appropriate setting
- Continuity of care
- Cost-effective utilization of resources
- Identification of members for referral to case management or other Aetna specialty programs

Case managers and UMNCs work on teams together and monitor all services authorized through the discharge planning process to their conclusion to promote continuity of care and proper utilization of resources. This promotes collaboration and a smooth transition for members in the case management

program.

OTHER METHODS

In 2011, all utilization management staff began using a tool to identify participating providers and their unit costs. This provides members with the most cost effective home care vendors available in their area. It applies to all products; however, we cannot provide this steerage when we have specific arrangements in place. Examples of arrangements include our exclusive provider arrangement with CSI in Ohio or CareCentrix in Florida or if the hospital has its own home care provider.

We review requests for certain scope procedures to determine where the provider has privileges among various facilities in the area. Through that, we look for cost-effective options. Members receive a written communication with suggested facilities that are more cost effective, when an opportunity exists. We also attempt to contact members via automated phone calls to inform them of the potential cost savings if they change to a different facility. The doctor also receives a copy of the member letter with the alternate facilities given to the member. However, the selection of any particular facility is voluntary at this time. The member or doctor can still elect to use the original facility.

AETNA INSTITUTES

Aetna InstitutesTM facilities are publicly-recognized high quality, high value health care facilities. The two major components of Aetna Institutes are:

- Institutes of ExcellenceTM (IOE) - A designation for health care facilities that offer highly specialized clinical services to members with complex or rare conditions. Our nurse case managers will nationally coordinate a member's clinical care in these cases. IOEs include transplant care, pediatric congenital heart surgery and infertility.
- Institutes of Quality[®] (IOQ) - A designation for health care providers who offer clinical services for prevalent health conditions to our members served through integrated clinical management at the regional level. IOQs include bariatric surgery and cardiac care and orthopedic (total joint replacement and spine) programs. The orthopedic program started on July 1, 2010. We are also in the process of considering an IOQ for multiple additional strategies related to cancer.

Attachments:

2.2.5.1.27 Describe your protocol specifying that certain procedures must be performed on an outpatient basis. Describe how the protocol standards are determined, and how they are enforced.

Answer: We base outpatient coverage determinations on plan documents and nationally recognized guidelines or criteria. These include:

- Aetna Clinical Policy Bulletins
- Centers for Medicare & Medicaid Services guidelines
- Milliman Care Guidelines[®]

We review and update precertification criteria annually for recommendations by our quality committees to reflect the most current versions of Milliman[®] Care Guidelines and Medicare national coverage decisions.

To enforce protocol standards, we perform internal quality reviews using standardized processes and tools. These are composed of role specific critical competencies to:

- Define consistent performance expectations

- Measure compliance with regulatory requirements and accreditation standards
- Provide consistent comparisons and measurements of the execution of our programs across all regions and offices
- Support consistent interpretation of policy and procedure

Our standard provider contracts include language requiring providers to comply with our utilization management policies and procedures, including all outpatient coverage determination requirements.

Attachments:

2.2.5.1.28 Describe other ways your organization promotes alternatives to hospitalization.

Answer: Our Surgery Decision Support (SDS) program, powered by Welvie™, helps participants make informed choices for upcoming medical procedures through an online tool. SDS helps participants understand procedures, tests and surgeries for conditions that have more than one clinically appropriate treatment. It also helps them select the appropriate treatment based on their understanding of these options. Too often, surgical decisions are made with little to no consideration to what alternatives might be available first. Preference sensitive surgery, also referred to as elective surgery, represents 77 percent of all surgeries and more than 30 percent of total health care cost.

SDS helps participants:

- Get the right diagnosis
- Find the best doctor
- Make the right treatment decision
- Research hospitals
- Prepare for surgery
- Recover at home

SDS is a curriculum-based, structured online program developed by surgeons, leading theorists and experts in consumerism. It uses a multimedia-rich application, which allows users to work at their own pace as the program gently guides them through the process of making a surgical decision. Users may access this program through our Aetna Navigator website. The program includes content for all elective surgeries.

SDS guides participants through a personalized, interactive curriculum that focuses on decision-making for currently proposed or future surgery. Videos, quizzes and content show them how to:

- Talk and work effectively with providers to obtain an accurate diagnosis
- Choose the most appropriate treatment based on risk, belief and desired outcomes

The program also helps participants understand and evaluate all treatment options and alternatives, as well as identify inherent risks and benefits.

SDS does not diagnose a patient's condition or favor one treatment over another. Through SDS, we help participants realize that surgery is just one option among several. We also help them understand that such an important decision requires discussion, thought and preparation.

COMPASSIONATE CARE

We worked with a team of experts in the field to develop the Aetna Compassionate CareSM program. This program helps members and their families better handle the difficult and emotional issues involved in taking care of a person at the end of life. We provide various programs and services to both the person who is sick and the caregiver. The enhanced program covers hospice with curative care. In addition, it provides respite care and bereavement care services. The program also provides tools and information to encourage advance planning for the kind of issues often associated with end-of-life care.

The enhanced hospice benefit package includes:

- The option for a member to continue to seek curative care while in hospice
- The ability to enroll in a hospice program with a 12-month terminal prognosis
- The elimination of the current hospice day and dollar maximum plan limits

Our nurse case managers coordinate end-of-life care as part of their job. We worked with the National Hospice and Palliative Care Organization (NHPCO) to further develop their training. NHPCO is America's oldest and largest nonprofit membership organization.

Attachments:

2.2.5.1.29 Explain how, if at all, your top UM program(s) improved quality of care and/or produced a shorter length of stay.

Answer: Our UM programs work to lower costs by identifying inappropriate procedures and by managing members effectively — both in and out of the hospital.

Precertification helped our customers avoid \$195 million of unnecessary costs. This saved members from inappropriate admissions and procedures*.

Concurrent review helped us lead all major competitors in reducing inpatient hospital days**.

- Aetna: 238.7 days per 1,000
- Competitors averaged: 274.4 days per 1,000

With this level of attention, we can spot opportunities for a change in the level of care. We can let doctors know, for example, of coverage for home health care. This simple step can allow a safe, earlier discharge from the hospital.

IOQ BARIATRIC SURGERY FACILITIES

Our IOQ bariatric surgery facilities meet all Medicare certification requirements and demonstrate annual mortality rates within 30 days of surgery at 1 percent or less. Less than 10 percent of cases are readmitted within 30 days. In many cases, the readmission rates are below 5 percent. All programs provide 12 months or more of after-care, and have a minimum of 75 percent track record.

In addition, we conducted a longitudinal study of our bariatric surgery cases. The average medical cost reduction for medical costs 12 months after a member receives bariatric surgery compared to the 12 months prior to surgery is approximately 3 percent. Bariatric surgery cases in designated IOQ facilities had a 15 percent decrease in medical costs in the 12 months after surgery compared to the non-designated IOQ facilities which had a 4 percent increase.

COMPASSIONATE CARE PROGRAM

Our case management results show a 47 percent reduction in inpatient admissions for members

seeking end-of-life care, due to doubling the use of hospice services.

*Aetna Precertification Analysis 2010 - Javitt, JC; Rebitzer, JB; Reisman, L. Information technology and medical missteps; evidence from a randomized trial. Journal of Health Economics, 5/08; 27(3): 585-602

**2009 Health Leaders data

Attachments:

2.2.5.1.30 Describe your proposed procedures for authorizing inpatient hospital stays.

Answer: Our network providers are responsible for obtaining precertification. Our precertification staff confirms eligibility and collects information before inpatient admissions. The two components of precertification are:

- Notification - This process is the registration of a request for services or supplies included on a precertification list.
- Coverage determination - This process reviews plan documents and may include a review of clinical information to determine whether clinical guidelines/criteria for coverage are met. The coverage determination process takes into account:
 - Individual needs of the member
 - Characteristics of the local delivery system
 - The member's benefit plan
 - Medical necessity review

The precertification process helps communicate a coverage decision to the treating practitioner and/or member in advance of the procedure, service or supply. We can receive precertification requests:

- Electronically through an electronic data interchange (EDI) or Internet solution
- By telephone
- In writing by fax or mail

All inpatient confinements require precertification excluding normal maternity admissions. Normal maternity admissions include vaginal and Caesarean deliveries, which do not require notification or medical review.

Inpatient confinements include:

- Surgical and non-surgical confinements, excluding vaginal or Caesarean deliveries
- Skilled nursing facility
- Rehabilitation facility
- Inpatient hospice

Our precertification unit provides soft steerage on the benefits of using designated Institutes of Quality® (IOQ) for cardiac and orthopedic services/procedures. We developed a new tool called the IOQ Locator Tool to identify IOQs located in the members' area. We have not completed steerage for Medicare members, California IPAs and plans with tiered benefits or custom networks, or plans on the Group Exclusion list.

We require notification of outpatient surgical scopes to encourage the use of cost-effective facilities. This currently includes:

- Colonoscopy
- Upper gastrointestinal endoscopy

We review requests to determine where the physician has privileges among various facilities in the area. Through that, we look for cost-effective options. Members receive a written communication with suggested facilities that are more cost effective, when an opportunity exists. We also attempt to contact members via automated phone calls to inform them of the potential cost savings if they change to a different facility. The physician also receives a copy of the member letter listing the alternate facilities. The selection of any alternate facility is voluntary at this time. The member or physician can still elect to use the original facility.

Attachments:

2.2.5.1.31 Describe your procedures for handling after-hours and week-end calls.

Answer: Our network providers are required to initiate precertification for our members. Callers for all our care management programs receive a message after hours advising them to call back during regular business hours. The after-hours message also gives information on how to handle emergencies. For provider urgent utilization requests we have 24/7/365 coverage by both precertification nurses and medical directors across the country.

If the request cannot wait until the next business day, the call center staff member will document all information received in the case. They will advise the caller that "Clinical information will need to be provided so that a coverage decision can be made" (regardless of case type) and that they will receive a determination from a clinician. If the caller has clinical information to provide, the call center staff will connect the provider to the appropriate urgent voice mailbox.

If the caller does not have clinical information to provide, the call center staff will leave a voicemail for the appropriate clinical area on the designated urgent voice mailbox to include the following information:

- The number assigned to the case
- Subscriber ID number
- Patient's Name
- Type of urgent request (SNF, Rehab, extension, etc.)

Attachments:

2.2.5.1.32 Describe the qualifications of staff involved in the various stages of pre-admission authorization.

Answer: We maintain professional licensure and certification records for each nurse. Other qualifications are:

- UM Nurse Consultant:

- RN with current unrestricted state licensure
- Three to five years clinical practice experience, preferably in acute care, in a hospital setting
- Utilization Management Nurse Associate
- LPN/LVN with unrestricted active license
- Two years managed care experience
- Two plus years clinical experience required

The educational and experience requirements for our medical director are:

- M.D. or D.O. degree
- Board certification in a recognized specialty, including post-graduate direct patient care experience
- Active and current state medical license without encumbrances
- 2-3 years of experience in Health Care Delivery System such as Clinical Practice and Health Care Industry
- Demonstrated appreciation of cultural diversity and sensitivity towards target populations

Attachments:

2.2.5.1.33 Describe your proposed procedures for ensuring an appropriate length of inpatient hospital stays.

Answer: With the exception of normal maternity admissions, we register all inpatient admissions in our medical management system for review in accordance with the member's benefit plan. We base the maximum length of stay that a nurse can approve on the criteria found in the Milliman Care Guideline® for that specific procedure/service. If the physician requests a length of stay that is greater than the maximum stated in the Milliman Care Guideline, the nurse refers the case to a medical director for review.

Not all inpatient admissions require a clinical review for medical necessity (for example routine admissions with a short length of stay). Licensed and experienced clinicians and professionals make decisions based on the above criteria as well as the individual needs of the member.

When applicable, our concurrent review nurses will:

- Obtain necessary clinical information from facility staff, practitioners, and providers.
- Use this clinical information to determine benefits coverage. Our nurses consider the unique characteristics of each member when using the guidelines and apply their own clinical judgment and experience.
- Notify facility staff, practitioners and providers of coverage determinations in the appropriate manner and time frame.

Any hospital stay that exceeds the length approved during the precertification process is not paid, as our claim system is fully integrated with our utilization management system.

Attachments:

2.2.5.1.34 Describe the basis your organization uses to establish length of stay criteria.

Answer: We use the goal length of stay (GLOS) definition contained in the Milliman Care Guidelines® Optimal Recovery Guidelines. It is a goal and not a rule. The GLOS is the number of days that uncomplicated patients usually require to recover to a point for a safe discharge or transition to a less acute level of care.

Licensed and experienced clinicians and professionals make decisions based on the above criteria as well as the individual needs of the member.

Attachments:

2.2.5.1.35 For all cases other than maternity, describe the length of hospitalization after which cases are reviewed.

Answer: The first request for concurrent review clinical information occurs within the first 24 hours of receipt of the case. For those admissions that require ongoing review, we base the frequency on the severity or complexity of the member's condition or on necessary treatment and discharge planning activity.

We comply with applicable federal regulatory and accreditation requirements for national timeliness standards for making and notifying members and providers of coverage decisions. National timeliness standards are the maximum time frames (minimum standards).

NEONATAL INTENSIVE CARE UNIT

We created the Neonatal Intensive Care Unit (NICU) program in 2006 to ensure that all babies admitted to the NICU receive care management services including:

- Review during the inpatient setting for leveling of care
- Focused discharge planning
- NICU follow-up calls
- Continual assessment for focused case management needs

An NICU case manager follows all babies admitted to either the NICU or a Transitional Nursery Unit.

Attachments:

2.2.5.1.36 Describe your administrative procedures in the event of pre-existing conditions and ongoing treatment plans.

Answer: Transition of care coverage is temporary coverage we offer to members when they transition from a prior health insurance carrier's plan to an Aetna medical plan. Transition of care coverage applies only to health care professionals including:

- Doctors
- Physical therapists
- Occupational therapists
- Speech therapists
- Agencies that provide skilled home care services such as visiting nurses

It does not include facilities or hospitals. When we approve the request, the health care professional must use a facility or hospital in the Aetna network.

Our transition coverage policy allows a member who has met certain transition eligibility requirements to continue an active course of treatment:

- With a non-participating provider for a limited time without penalty
- At the new/preferred plan benefit level

Our Precertification department completes transition of care reviews. They will:

- Review the coverage request to verify that the correct department received it for processing.
- Record receipt of the transition of care coverage request in our care management system when member eligibility becomes available.
- Verify member eligibility.
- Verify that the forms are complete and signed.
- Verify that the service is not a plan exclusion.
- Determine whether we can approve the transition of care coverage request based upon the information submitted or whether we need additional information.
- Document the transition of care request decision.
- Provide notification of the decision.

The following procedures or services generally apply to members seeking transition of care coverage.

- A member hospitalized in a participating facility on the plan effective date. We will assign a concurrent review nurse to monitor the hospitalization and initiate other care management activities, such as discharge planning.
- A member hospitalized in a nonparticipating facility on the effective date. We will pay for medically necessary services incurred after the effective date while continually monitoring the confinement for appropriate level of care with our medical director. For Medicare Advantage Plans, if the plan before our plan was either federal Medicare or another carrier's Medicare Advantage plan, that plan would cover all acute hospital stays until discharge.
- A member receiving ongoing outpatient treatment for an acute, non-acute or chronic condition requiring specialized management. Examples include chemotherapy or radiation for cancer. A case manager and/or a medical director may evaluate the treatment program and establish contact with the provider. If the member is using a nonparticipating provider, we may attempt to identify participating providers with expertise in the relevant course of treatment to provide care to the member. Alternatively, we may make a determination to provide in-network benefits while the member continues the course of treatment with the nonparticipating provider. In such cases, we attempt to negotiate a cost-effective arrangement with that provider.

- A member in the advanced stages of terminal illness. A case manager and/or a medical director may evaluate the treatment program and establish contact with the provider. If the member is using a nonparticipating provider, we may attempt to identify participating providers with expertise in the relevant course of treatment to provide care to the member. Alternatively, we may make a determination to provide in-network benefits while the member continues the course of treatment with the nonparticipating provider. In such cases, we attempt to negotiate a cost-effective arrangement with that provider.
- A member who is pregnant and has completed 20 weeks of her pregnancy on the plan effective date. She may continue care with her nonparticipating obstetrician at the preferred level of benefit.

If she has not completed 20 weeks of her pregnancy on the plan effective date and a nonparticipating obstetrician is treating her, she has the option to continue care at a lower benefit or transfer care to a participating obstetrician and receive a higher benefit with the plan.

We also approve transition of care coverage for members who have completed 14 weeks of pregnancy or greater and are receiving care from an Aetna provider who becomes inactive because of non-quality reasons. However, the inactive provider must agree to our reimbursement schedule, our utilization review process and use a participating obstetrical facility for delivery.

PRE-EXISTING CONDITIONS

Some plans may currently include pre-existing limitations. If so, these limitations will be eliminated for members under age 19 and we will administer coverage in accordance with The Patient Protection and Affordable Care Act and applicable regulatory guidance. Effective September 23, 2010, as new plans renew pre-existing is waived for members under the age of 19. Once pre-existing is waived for the member under age 19, it continues to be waived going forward even after their 19th birthday.

When pre-existing limitations are applicable, the claims system will edit expenses incurred within 12 months of the member's effective date. The claim processor initiates an investigation to determine whether the condition existed prior to the member's original effective date.

We place a notice in the claims system when we begin the investigation. This will serve to flag subsequent claims for review.

We follow-up in writing with physicians, hospitals and/or other health care providers who may have examined or treated the patient. We ask the following questions:

- The date of the onset of symptoms
- The date initially examined and/or treated
- The dates of subsequent examinations and/or treatments
- The names and addresses of providers known to have examined or treated the patient; we may then contact these providers with the same questions

As the investigation progresses or is resolved, we update the system notice accordingly.

EXPANDING CURRENT NETWORKS

We intend to work with the State on expanding network provider participation as well as specific procedures for maternity.

Attachments:

2.2.5.1.37 Provide your 2011 book of business utilization statistics for the following measures (Do NOT exclude outliers):

- Inpatient admissions per 1000 members
- Bed days per 1,000 members
- Emergency room encounters per 1,000 members
- Ambulatory surgical procedures per 1,000 members

Answer: Our 2011 PPO book of business data is as follows:

- Inpatient admissions per 1000 members: 59.67
- Bed days per 1,000 members : 248.3
- Emergency room encounters per 1,000 members: 213.2
- Ambulatory surgical procedures per 1,000 members: 45.66

Attachments:

2.2.5.1.38 Describe how you will obtain network provider information from a third party network and give utilization management staff on-line, real-time access to that data.

Answer: We are offering our Aetna PPO network. All provider information will be available to our UM staff through our integrated systems.

If a rental or custom network is used, the same information is loaded into our systems and made available to our nurses. The network, clinical and claim system are all connected to ensure payment is also in alignment with contract and clinical decisions.

Attachments:

2.2.5.1.39 Describe how UM managers have access to the claims payment information either internally or by data feed from the claims payer to view member activity and costs.

Answer: We are a full service carrier who will provide comprehensive claims processing services in connection with our administrative services offering.

While separate units handle care management and claims functions, the data associated with each of these is integrated online. This allows each function to review the others when needed. Through our electronic utilization management system, claims processors can view all medical utilization decisions and documentations, such as non-compliant issues. These are immediately available in real time after entered by our nurse reviewers. This information is provided in a read-only format and can only be edited by authorized staff members.

When the associated claim is submitted and processed, the claims adjudication system automatically flags the claim and alerts the claim processor to review the member's care management file for payment instruction. Our system enables care management nurses and claims representatives to toggle from care management screens to claims screens as needed. The use of claims screens, in addition to formal, daily communication between care management nurses and claim representatives is an integral part of our care management process.

Attachments:

2.2.5.1.40 Can utilization managers refer eligible members to the following programs? (Please check all that apply)

Answer: 9: Other, please specify: [Our utilization managers can refer eligible members to all of the programs above. We can also refer eligible members to our National Medical Excellence transplant program.]

Detail:

Options:

1. Disease management programs
2. Mental Health / Substance Abuse
3. EAP
4. Behavioral health
5. Case Management Programs
6. Health coaching programs
7. Maternity management programs
8. Wellness programs
9. Other, please specify: [Text]

Attachments:

2.2.5.1.41 Is a formal process in place to communicate with the plan sponsor regarding notification of potential large claimants or adverse determination?

Answer: Confirmed. When case management is aware of a potentially large claim, our case manager notates the member's file with a "Forecasted High Dollar" heading in the care management system. The system then sends the notification electronically to the High Dollar Forecast Database which your account team monitors.

Additional ways in which an account team will receive large claim notification:

- When our claims unit processes a claim over \$50,000, the plan sponsor liaison notifies the account team by e-mail.
- The account team runs large claim reports sporadically (monthly or quarterly) to check on large claims.

Once the account team is aware of a potentially large claim, they will notify the State.

Attachments:

2.2.5.1.42 What percentage of inpatient admissions was referred for Medical Director determination or clinical input during the most recent calendar year?

Answer: Our nurses referred 14,794 requested precertifications/admissions to a medical director. We are unable to track the actual percentage of precertifications/admissions sent to a medical director because we are not notified of all admits prior to the admission. However, we track the total number of requested and non-requested admissions, which is 403,809. This translates to a 3.66 percent referral rate.

Attachments:

2.2.5.1.43 How frequently can you export utilization management files to vendor partners?

Answer: 1: Daily

Detail: Our systems can support frequency options of daily, weekly, every other week, or monthly. Please note however, that all of our internal systems are integrated and no export files are required.

Options:

1. Daily
2. Weekly
3. Monthly
4. Cannot export UM data

Attachments:

2.2.5.2 Concurrent Review

2.2.5.2.1 Describe your organization's procedures for reviewing inpatient hospital stays while they are occurring.

Answer: With the exception of normal maternity admissions, we register all inpatient admissions in our medical management system for review in accordance with the member's benefit plan. Our clinical staff uses evidence-based clinical guidelines from nationally recognized authorities and the terms of the member's benefit plan to guide utilization management decisions. Licensed and experienced clinicians and professionals make decisions based on our criteria as well as the individual needs of the member.

The first request for concurrent review clinical information occurs within the first 24 hours of receipt of the case. For those admissions that require ongoing review, we base the frequency on the severity or complexity of the member's condition or on necessary treatment and discharge planning activity.

When applicable, our concurrent review nurses will:

- Obtain necessary clinical information from facility staff, practitioners, and providers.
- Use this clinical information to determine benefits coverage. Our nurses consider the unique characteristics of each member when using the guidelines and apply their own clinical judgment and experience.
- Notify facility staff, practitioners and providers of coverage determinations in the appropriate manner and time frame.
- Identify continuing care needs at the beginning of the inpatient stay with re-assessment throughout the stay to facilitate discharge planning activities. The utilization management staff determines the timetable or frequency of review and follow-up on a case-by-case basis depending on the severity of the member's condition and clinical progression.
- Identify members for referral to covered specialty programs including case management, disease management, behavioral health, National Medical Excellence Program®, and women's health programs, such as the Beginning Right® maternity program and our Neonatal Intensive Care Unit .

We use our electronic Total Utilization Management System (eTUMS) to record, monitor and track ongoing review and discharge planning activities for inpatient admissions, when applicable.

DISCHARGE PLANNING

Discharge planning is an integral part of utilization review and not viewed as a discrete function. Assessment of potential discharge planning needs begins at the time of notification of admission, and continues throughout the hospital stay.

The discharge planning process may include the hospital reviewer/case manager or other alternate care provider, other health care providers, the treating practitioner, the member and the member's family.

Our discharge planning program encourages providers to develop a plan that provides an appropriate transition from one level of care to the next appropriate level of care. It also facilitates the delivery of cost-effective, quality care.

The utilization management nurse consultant (UMNC) is responsible for managing the discharge planning needs through that member's continuum of care, including:

- Inpatient assessment, evaluation and monitoring
- Consultation with the medical director on an as-needed basis in determining coverage decisions

Attachments:

2.2.5.2.2 Describe the criteria that must be met to begin concurrent review.

Answer: We conduct concurrent review on all non-maternity admissions that exceed 2 days in length.

Our clinical staff uses evidence-based clinical guidelines from nationally recognized authorities and the terms of the member's benefit plan to guide utilization management decisions.

We use on-line guidelines from the following sources:

- Milliman Care Guidelines® (Seattle, WA: Milliman USA)
- Our internally developed Clinical Policy Bulletins (CPBs)
- National and local Medicare coverage policies
- Other Aetna recognized criteria
- Applicable state and federal guidelines

Not all inpatient admissions require a clinical review for medical necessity (for example routine admissions with a short length of stay). We review outpatient procedures using the same criteria or guidelines as inpatient procedures. Licensed and experienced clinicians and professionals make decisions based on the above criteria as well as the individual needs of the member.

Attachments:

2.2.5.2.3 Describe when discharge planning begins.

Answer: We assess potential discharge planning needs at the time of notification of admission, and continue throughout the hospital stay. Discharge planning is an integral part of utilization review and not viewed as a discrete function.

In some instances discharge planning begins even before a member is admitted to the hospital. We consider all of the needs for each individual member, including:

- The member's age
- Prior level of functioning

- Significant past medical history
- Anticipated discharge location
- Current medical condition and level of functioning
- Family/community support
- Psychosocial issues
- Barriers to discharge planning

When unique needs are identified by the UM nurse, we get a case manager involved to assist and coordinate care for the member, such as follow-up care and transitioning to a home environment.

Attachments:

2.2.5.2.4 Describe how you measure, report or use information reviewed to assess the quality of inpatient services.

Answer: We monitor potential quality of care concerns and identify them for review and intervention. We also monitor clinical effectiveness and efficiency as part of our national Hospital Performance Incentive Program and Aetna Informatics® identifies and tracks adverse events, as well as assesses quality, with the Inpatient Performance Measurement System.

QUALITY OF CARE CONCERNS FOR PHYSICIANS AND FACILITIES

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

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

INPATIENT PERFORMANCE MEASUREMENT SYSTEM

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

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

The IPMS has approximately 30 criteria for evaluating adverse events in the inpatient setting, including:

- Sepsis
- Meningitis
- Skin infection
- Wound disruption
- Coagulation complication
- Hemorrhage
- Pneumonia
- Transfusion reaction

- Embolism/thrombosis
- Postoperative decubitus ulcer
- Ulcer or gastrointestinal bleeding
- Surgical complication
- Urinary complication
- Respiratory complication
- Fluid or electrolyte complication
- Gastrointestinal complication
- Anesthesia complication
- Renal complication
- Neurologic complication
- Acute myocardial infarction
- Cardiac arrest
- Other cardiac complication
- Birth canal injury
- Other medical complication
- Other infection complication

HOSPITAL PERFORMANCE INCENTIVE PROGRAM

We monitor recognized clinical effectiveness and efficiency measures as part of our national Hospital Performance Incentive Program, which provides the framework for our market-based programs to give hospitals the opportunity to earn reward payments based upon achieving performance targets.

For each market-based program, we typically incorporate measures for areas where the hospital has opportunities to improve and where improvement will reduce costs and increase patient safety and outcomes. By setting goals and utilizing a diverse set of recognized, externally approved quality metrics and our own efficiency measures, our program encourages hospitals to improve care not only for our members, but also for all their patients.

Our national program includes nationally recognized, evidenced-based measures from the following organizations:

- Aetna (Aetna-developed efficiency and total quality and cost measures)
- Centers of Medicare & Medicaid Services (CMS)
- The Leapfrog Group's hospital survey (patient safety standards)
- Surgical Care Improvement Project (SCIP)

Each hospital performance incentive agreement follows our national program's guidelines and has the flexibility to meet local market needs while also driving hospital-specific improvements. Our guidelines call for each market-based hospital performance incentive program to use specific targets for each metric and provisions for retiring measures.

We customize each hospital performance incentive arrangement to achieve maximum payer and member value. Our intent is to be a value-based purchaser by increasingly linking reimbursement to performance. We base financial incentives on the shared savings that result from hospital efficiency improvements and/or reductions in avoidable costs and complications. Our program adds value, rather than cost, by placing revenue at risk for performance.

INFORMING MEMBERS

We make hospital performance information available to all members to assist them with their health care decisions. Our members can access evidence-based hospital outcomes data on more than 6,000

hospitals nationwide by using the Aetna Navigator® Hospital Comparison Tool on Aetna Navigator, our secure member website. This web-based, decision-support tool provides members with information to help them select a hospital for their inpatient medical care for certain procedures, conditions and diagnoses. Members can compare hospitals based on treatment outcomes and other hospital quality information, including patient satisfaction. We license the Aetna Navigator Hospital Comparison Tool from WebMD Health Services.

The Aetna Navigator Hospital Comparison Tool also contains Leapfrog Hospital Survey results, Centers for Medicare & Medicaid Services (CMS) hospital quality data, The Joint Commission accreditation information and Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient experience survey information.

In addition, DocFind®, our online provider directory, features a list of participating hospitals that have reported to the Leapfrog survey, which includes the patient safety standards that each hospital has met.

Attachments:

2.2.5.2.5 Describe the procedures you follow when a scheduled continued stay review falls on a weekend or holiday, including whether authorization is provided prospectively or retrospectively.

Answer: Our utilization management nurse consultants (UMNCs) conduct, when applicable, utilization reviews before weekends and holidays. When they anticipate a discharge over a weekend or on a holiday, our UMNCs will proactively advise the physician or the hospital clinical review staff. They will then retrospectively verify discharge with the hospital on the next business day. A medical director is available 24 hours per day, 7 days per week for consultation on coverage decisions.

Discharge planning is discussed from the first date that UM began following the member's case. The staff works regularly with the hospital discharge planner or case manager, and do not wait until the discharge occurs. Our discharge planning nurse would have already provided par provider names and discussed any services which the member would need upon discharge.

Attachments:

2.2.5.2.6 Describe how and where you will locate on-site nurses to serve the State of Alaska.

Answer: We currently have one nurse located in Homer, Alaska. We are willing to explore hiring an additional nurse that meets our employment criteria in Alaska.

Attachments:

2.2.5.2.7 Explain whether your organization performs 100% clinical reviews for inpatient care. If not, describe the policy for inpatient clinical reviews.

Answer: Not all inpatient admissions require a clinical review for medical necessity. Our non-clinical staff can perform registration of activities in our medical management system for services we do not designate for medical review in accordance with the member's benefit plan. Some examples are hysterectomy and laparoscopic cholecystectomy. Our rationale is these are elective admissions where length of stay is less than three days.

The FIT is an Aetna tool used in the concurrent review process for acute care facilities. This tool is used as a guide to direct and balance efforts for efficient use of resources and is not intended to replace clinical criteria/guidelines or clinical judgment during the coverage determination process. We did not develop the FIT for use with SNFs, rehabilitation facilities, LTAC facilities or behavioral health admissions.

- The FIT categorizes diagnosis/procedure codes and facilities into groups with varying levels of review activity identified as “interventions.”
- The FIT assigns an intervention based upon member plan type, provider specific utilization history, ICD-9/CPT code, and contractual conditions.

Local initiatives and goals can result in the need to manually override the FIT results and adjust the FIT intervention for a specific provider or diagnosis/procedure code.

Attachments:

2.2.5.2.8 If your organization does not perform 100% clinical reviews for inpatient care, which of the following are used to determine if a clinical review is required?

**Answer: 1: Diagnosis,
2: Length of inpatient stay,
4: Procedure,
7: Targeted facilities**

Detail: Not all inpatient admissions require a clinical review for medical necessity. Our non-clinical staff can perform registration of activities in our medical management system for services we do not designate for medical review in accordance with the member's benefit plan. Some examples are hysterectomy and laparoscopic cholecystectomy. Our rationale is these are elective admissions where length of stay is less than three days.

The FIT is an Aetna tool used in the concurrent review process for acute care facilities. This tool is used as a guide to direct and balance efforts for efficient use of resources and is not intended to replace clinical criteria/guidelines or clinical judgment during the coverage determination process. We did not develop the FIT for use with SNFs, rehabilitation facilities, LTAC facilities or behavioral health admissions.

- The FIT categorizes diagnosis/procedure codes and facilities into groups with varying levels of review activity identified as “interventions.”
- The FIT assigns an intervention based upon member plan type, provider specific utilization history, ICD-9/CPT code, and contractual conditions.

Local initiatives and goals can result in the need to manually override the FIT results and adjust the FIT intervention for a specific provider or diagnosis/procedure code.

We will also work with the State to review our clinical findings to refine utilization management and pre-certification requirements to provide higher quality care and lower costs.

Options:

1. Diagnosis
2. Length of inpatient stay
3. Multiple admissions over a designated time period
4. Procedure
5. Projected cost of care
6. Readmission for the same/similar diagnosis
7. Targeted facilities
8. Performs 100%
9. Other: [Text]

Attachments:

2.2.5.2.9 Provide the percentage of reviews performed onsite at the facilities vs. telephonically.

Answer: We currently perform 100 percent of our reviews telephonically in Alaska. Our process is based on telephonic because of the technology interface and information sharing that is in place with our network providers. Prior to the development of these systems and technology onsite reviews were leveraged more frequently as part of our process.

Attachments:

2.2.5.2.10 What percentage of Alaska-based reviews are performed by onsite review staff?

Juneau	0.0%
Fairbanks	0.0%
Anchorage	0.0%

Detail: We perform 100 percent of our reviews telephonically in Alaska. We currently have a UM nurse based in Homer, Alaska and we would be happy to further discuss the value of providing an onsite nurse at local facilities for the State.

Attachments:

2.2.5.2.11 Describe whether concurrent reviews are performed by clinical staff. Provide the credentials of the staff who perform this function.

Answer: Clinical licensed professionals, including RNs and MDs conduct our concurrent review functions. RNs track our members' daily care. Our medical directors review and work with attending physicians to promote access to quality care.

All of our concurrent review nurses and supervisors are RNs with a minimum of two years of acute care experience in rehabilitation, home health care, case management, or utilization review. Our supervisors must have previous supervisory experience, or proven leadership ability. NICU nurses are all RNs, with additional critical care, pediatric or neonatology certifications.

We encourage our nurses and supervisors to maintain any nursing certifications they may have. We also encourage them to attend clinical and company-sponsored educational programs. We require our nurses to complete 10 continuing education hours yearly.

Our board-certified medical directors must have a solid command of care management concepts and procedures. They must have practiced medicine in the community for more than 5 years and have experience in the disciplines of emergency medicine, family practice, general surgery, or internal medicine.

We support our local medical directors with a panel of physicians certified in various specialties. These specialists are available to discuss cases with the local medical director.

Attachments:

2.2.5.2.12 Describe when concurrent reviews are performed. Are they performed on or before the last certified day?

Answer: The first request for concurrent review clinical information occurs within the first 24 hours of receipt of the case. For those admissions that require ongoing review, we base the frequency on the severity or complexity of the member's condition or on necessary treatment and discharge planning activity.

We comply with applicable federal regulatory and accreditation requirements for national timeliness standards for making and notifying members and providers of coverage decisions. National timeliness standards are the maximum time frames and we strive to perform reviews more quickly whenever possible.

Our utilization management staff determines the frequency of review on a case-by-case basis based on the member's clinical progression and the internally developed Focused Interaction Tool (FIT).

The FIT is an Aetna tool used in the concurrent review process for acute care facilities. This tool is used as a guide to direct and balance efforts for efficient use of resources and is not intended to replace clinical criteria/guidelines or clinical judgment during the coverage determination process. We did not develop the FIT for use with SNFs, rehabilitation facilities, LTAC facilities or behavioral health admissions.

The FIT categorizes diagnosis/procedure codes and facilities into groups with varying levels of review activity identified as "interventions."

The FIT assigns an intervention based upon member plan type, provider specific utilization history, ICD-9/CPT code, and contractual conditions.

Local initiatives and goals can result in the need to manually override the FIT results and adjust the FIT intervention for a specific provider or diagnosis/procedure code.

Concurrent review is performed on the last covered day. If that date is a Saturday or holiday, the UM staff will request a clinical review on the prior day.

Attachments:

2.2.5.2.13 Describe your process for concurrent review when the next review date falls on a weekend or holiday, including whether days are authorized prospectively or retrospectively.

Answer: Our utilization management nurse consultants (UMNCs) conduct, when applicable, utilization reviews before weekends and holidays. When they anticipate a discharge over a weekend or on a holiday, our UMNCs will proactively advise the physician or the hospital clinical review staff. They will then retrospectively verify discharge with the hospital on the next business day. A medical director is available 24 hours per day, 7 days per week for consultation on coverage decisions.

Discharge planning is discussed from the first date that UM began following the member's case. The staff works regularly with the hospital discharge planner or case manager, and do not wait until the discharge occurs. Our discharge planning nurse would have already provided par provider names and discussed any services which the member would need upon discharge.

Attachments:

2.2.5.2.14 In the event an inpatient review of services was not subject to pre-certification or concurrent review, explain whether you routinely perform retrospective reviews to confirm the medical necessity of services. Describe your process for accomplishing this function.

Answer: We perform retrospective review of the hospital stay if we did not previously review and make a medical necessity determination at the time of the admission. Our Quality Management program would handle any quality of care issues involved.

Retrospective review looks at certification requests after the member received the service. Retrospective review, while not the preferred method of review, may be necessary due to various

reasons such as the clinical condition of a member at the time of admission. We prefer concurrent review and prospective review to retrospective review. This way, our nurses can review an alternate level of care on or before the service takes place. When retrospective review is necessary, the process includes making coverage determinations for the appropriate level of the past service. The determination must be consistent with the member's needs at the time of service. The retrospective review nurse must also confirm eligibility and the availability of benefits within the member's benefit plan at the time of service. Retrospective review for non-urgent care also includes an analysis of the administrative issues surrounding prospective precertification requirements.

Retrospective review:

- Is conducted only for services included on a precertification list or that require precertification under the terms of a member's plan
- May be necessary to review coverage requests when precertification is not obtained (examples are: clinical condition of a member prevents notification during an inpatient stay, primary coverage misidentified)
- Is performed for inpatient stays before claim payment when an initial clinical review for the level of services has not occurred (examples are: intensive care, surgical)
- Is used to identify and refer members when appropriate to covered specialty programs including case management, disease management, behavioral health, maternity management and transplant management
- Is used to identify and refer potential quality and/or utilization issues and to begin follow-up actions
- Does not include a preferred/in-network level of benefits determination for non-emergent services performed by a non-participating provider

We do not conduct retrospective review after the rendered service in the following situations:

- Services not included on our National Precertification List (examples are: office visits, behavioral health outpatient counseling)
- Ambulatory services included on the National Precertification List for participating providers (exception Medicare and TC Plans)
- Network deficiency requests for review of non-emergent services rendered by a non-participating provider

Attachments:

2.2.5.3 Outpatient Review

2.2.5.3.1 Describe your process for performing outpatient pre-certification and review.

Answer: We have developed a list of precertification requirements based on evidence-based medicine that is integrated into our clinical policies that our providers contractually follow. We manage and monitor outpatient services that are included on our precertification list through the precertification process.

We welcome the opportunity to review all procedures and conditions requiring precertification. We can share both clinical data and incidents to support the State in the assessment of all precertification requirements.

Some examples of outpatient services and equipment that may require coverage approval for benefits by our precertification staff are:

- Diagnostic high-tech radiology services
- Limb and torso prosthetics
- Certain surgical procedures
- Select medical injectables
- Outpatient dialysis treatments
- Surgery at an out-of-network ambulatory surgical facility performed by PCP or participating specialist

Our utilization management staff uses evidence-based clinical guidelines from nationally recognized authorities along with regional criteria and the terms of the member's benefit plan to guide decisions for precertification. Our staff consults the on-line guidelines from the following sources:

- Milliman Care Guidelines® (Seattle, WA: Milliman USA)
- Our internally developed Clinical Policy Bulletins (CPBs)
- National and local Medicare coverage policies
- Other Aetna recognized criteria
- Applicable state and federal guidelines

Licensed and experienced clinicians and professionals make decisions based on the above sources as well as the individual needs of the member. Our regional Quality Advisory Committee annually reviews the utilization management criteria.

We use the same review process for outpatient as we do for our inpatient services. It begins with the attending physician (for in-network) or the member (for out-of-network) contacting our precertification unit. We then apply national criteria and other Aetna recognized guidelines for decision making. Because most services are of an on-going nature, a period-of-care coordination and utilization monitoring follows the initial certification.

If members have questions about an outpatient service that is not on the precertification list, they may contact our Member Services department using the toll-free number located on their ID card.

Attachments:

2.2.5.3.2 Who reviews outpatient services when directed by the plan?

Answer: A mix of clinical and administrative professionals performs our outpatient precertification function. Our medical directors review and work with attending physicians to promote access to quality care.

Our inbound queue associates check basic eligibility, benefit information, and COB, and create a

record of the request for certification along with demographic information in eTUMS, our electronic Total Utilization Management System. The system then tasks the record to our nurse reviewers.

All of our nurse reviewers and supervisors are LPNs or RNs with a minimum of two years of acute care experience in rehabilitation, home health care, case management, or utilization review. Our supervisors must have previous supervisory experience, or proven leadership ability.

Our board-certified medical directors must have a solid command of care management concepts and procedures. They must have practiced medicine in the community for more than 5 years and have experience in the disciplines of emergency medicine, family practice, general surgery, or internal medicine.

Attachments:

2.2.5.3.3 Please confirm you perform outpatient services review, for home health care, skilled nursing care, and the services listed as requiring precertification in the plan documents.

Answer: Confirmed. We provide precertification for home health care, skilled nursing care, and the services listed as requiring precertification in the State's plan documents and amendments.

Attachments:

2.2.5.3.4 Describe how the pre-certification of outpatient services is documented in your system. Explain the system's accessibility to utilization staff, care managers, and the appropriate claims and customer service personnel when responding to questions about a member's pre-certification status.

Answer: eTUMS, our electronic Total Utilization Management System, is a comprehensive information system developed and managed by our Information Technology department. It supports all products and care management activities on one platform.

Our inbound queue associates check basic eligibility, benefit information, and COB, and create a record of the request for certification along with demographic information in eTUMS. The system then tasks the record to our nurse reviewers.

Our nurse reviewers check the eligibility benefit information and collect/document information regarding the member's physical condition, plan of treatment and clinical findings. They scan the member's recent history in the system to identify earlier hospital admissions and significant diagnostic-related information. If necessary, they can also review claim history screens. If the nurse reviewers cannot get all the necessary medical information from the caller, they may telephone the attending physician's office.

If certification meets our criteria, the nurse reviewers verbally inform the caller and document the information in eTUMS. If the information obtained by the nurse reviewers does not meet the established criteria, they refer the case to the medical director. The nurse reviewers cannot deny services based on medical necessity. If upon review, the medical director determines the care meets the criteria outlined within established guidelines, we certify the services and inform the requestor. If the medical director determines the care does not meet the established guidelines, we deny certification and record it in our system.

While separate units handle care management, member services and claims functions, the data associated with each of these is integrated online. This allows each function to review the others when needed. Through our electronic utilization management system, claims processors and member services can view all medical utilization decisions and documentations, such as non-compliant issues.

These are immediately available in real time after entered by our nurse reviewers. This information is provided in a read-only format and can only be edited by authorized staff members.

Attachments:

2.2.5.4 Discharge Planning

2.2.5.4.1 Describe any policy in place that requires UM staff to document the member's discharge planning process, including the discharge disposition, current health status, health care needs, and after care plans.

Answer: Our policy and program procedure manual requires our staff to document 100 percent of their calls in our medical management system. This includes member's discharge planning process, consisting of the discharge disposition, current health status, health care needs, and after care plans.

Discharge documentation includes the date of discharge, the date the discharge date was received, the discharge disposition, the discharge needs, any services that were set up, any follow-up plans, and any referrals to other internal or external programs.

If we identify and accept a member for case management while in the hospital, the case manager will collaborate with the UMNC to perform the discharge planning. The case manager follows the member throughout the continuum of care and is responsible for the assessment and coordination of the member's discharge planning needs.

The discharge plan may include having the member use a variety of services and benefits upon discharge from an inpatient stay. Based upon the physician's discharge plan, the UMNC or the case manager may contact alternative care facilities to arrange for the member's admission. In addition, they may approve and coordinate the delivery of home care services and arrange for outpatient services as well. Goals include:

- Timely provision of requested services and supplies
- Facilitate timely discharge to the appropriate setting
- Promotion of optimal recovery
- Prevention of hospital readmission
- Delivery of care in a safe, appropriate setting
- Continuity of care
- Cost-effective utilization of resources
- Identification of members for referral to case management or other Aetna specialty programs

Case managers and UMNCs work on teams together and monitor all services authorized through the discharge planning process to their conclusion to promote continuity of care and proper utilization of resources. This promotes collaboration and a smooth transition for members in the case management program.

Attachments:

2.2.5.4.2 Describe how your organization works with the member and provider community to promote discharge planning and provide alternatives to inpatient care.

Answer: Whenever possible, we include the hospital reviewer/case manager or other alternate care provider, other health care providers, the treating practitioner, the member and the member's family, in the discharge planning process.

Our discharge planning program encourages providers to develop a plan that provides an appropriate

transition from one level of care to the next appropriate level of care. It also facilitates the delivery of cost-effective, quality care.

The utilization management nurse consultant (UMNC) is responsible for managing the discharge planning needs through that member's continuum of care, including:

- Inpatient assessment, evaluation and monitoring
- Consultation with the medical director on an as-needed basis in determining coverage decisions

The discharge plan may include having the member use a variety of services and benefits upon discharge from an inpatient stay. Based upon the physician's discharge plan, the UMNC may contact alternative care facilities to arrange for the member's admission. In addition, they may approve and coordinate the delivery of home care services and arrange for outpatient services as well. Goals include:

- Timely provision of requested services and supplies
- Facilitate timely discharge to the appropriate setting
- Promotion of optimal recovery
- Prevention of hospital readmission
- Delivery of care in a safe, appropriate setting
- Continuity of care
- Cost-effective utilization of resources
- Identification of members for referral to case management or other Aetna specialty programs

COMPASSIONATE CARE

We worked with a team of experts in the field to develop the Aetna Compassionate Care program. This program helps members and their families better handle the difficult and emotional issues involved in taking care of a person at the end of life. We provide various programs and services to both the person who is sick and the caregiver. The enhanced program covers hospice with curative care. In addition, it provides respite care and bereavement care services. The program also provides tools and information to encourage advance planning for the kind of issues often associated with end-of-life care.

The enhanced hospice benefit package includes:

- The option for a member to continue to seek curative care while in hospice
- The ability to enroll in a hospice program with a 12-month terminal prognosis
- The elimination of the current hospice day and dollar maximum plan limits

The Compassionate Care website is www.aetnacompassionatecareprogram.com. This website information is available on both our secure member website and our public website. The site includes:

- Resources and lists to help guide end-of-life decisions

- A list of key documents to compile
- Discussions tips to make it easier to talk about end of life
- Links to advance planning tools and living will forms

Our nurse case managers coordinate end-of-life care as part of their job. We worked with the National Hospice and Palliative Care Organization (NHPCO) to further develop their training. NHPCO is America's oldest and largest nonprofit membership organization. We train our nurses to:

- Assess and manage a member's care in a sensitive manner
- Improve pain and other symptom management
- Improve continuity of care
- Improve advance care planning
- Expand personal support
- Encourage better use of community-based resources
- Assist in helping to find a hospice provider, if needed

Attachments:

2.2.5.4.3 Provide your process if a discharge plan is potentially unsafe or not in the member's best interest.

Answer: When a discharge plan is potentially unsafe or not in the member's best interest, our nurses or behavioral health clinicians refer it to a medical director. Our medical directors are physicians, psychiatrists and psychologists who apply clinical judgment and the member's individual health needs when reviewing coverage requests against criteria/guidelines.

The medical director will advise the nurse as to next steps, and at times may contact the attending physician for a peer to peer discussion if that is needed. Each case is different and is handled based on individual concerns.

Attachments:

2.2.5.4.4 Identify and explain who is available to assist with complex discharge planning needs and can participate in a peer-to-peer discussion, if needed.

Answer: We developed a Utilization Management Nurse Associate (UMNA) consultation process to support the care teams including discharge planning. This process ensures compliance with both the Department of Labor (DOL) and State Nursing Practice Guidelines. The UMNA uses this consultation process to identify and refer high acuity and/or complex cases for supervisory review and consult.

We will refer any case identified by a UMNA that requires assistance to a supervisor, supervisory RN designee, or medical director as appropriate, including when a member's discharge plan has stalled. For peer-to-peer discussions, we support our medical directors with a panel of physicians certified in various specialties. These specialists are available to discuss complex cases with the medical director.

Attachments:

2.2.5.4.5 Does your utilization management program routinely perform telephonic outreach to post-hospital discharged members?

Answer: Confirmed. All members triggered for case management because of an inpatient hospital stay receive a call from a case manager within 3 business days following the member's documented discharge date to home. We complete the initial outreach attempt within 3 business days of the notification of the discharge. We complete the second outreach attempt within 12 business days of the notification of discharge. The program also applies to members discharged from skilled nursing

facility with home care services, and to parents of neonatal intensive care unit babies.

These calls are a follow-up to discharge planning that has already occurred while the member was in the facility. These calls are done to verify that any home care services, DME equipment, or other services are in place. The case manager also reviews medications, signs and symptoms of complications, upcoming doctor appointments, transportation concerns, support in the home, and any other needs that the member may have since discharge occurred.

Attachments:

2.2.5.5 Approvals/Denials

2.2.5.5.1 During the most recent calendar year, what percentage of all acute inpatient days were denied due to lack of medical necessity?

Answer: In 2011, 2.4 percent of all inpatient acute days were denied due to lack of medical necessity.

Attachments:

2.2.5.5.2 During the most recent calendar year, what percentages of your outpatient services/procedures are typically subject to denial.

Answer: In 2011, of the precertification requests that involve non-clinical review, our staff denied 4.3 percent at the time of precertification. Of the precertification requests that involve clinical review our medical directors denied 3 percent of those nurse referred cases.

These percentages for non-clinical and clinical review include both inpatient/outpatient and elective/non-elective denials. We do not break these out by category.

All of our clinical policies are on-line and communicated to providers, which we believe reduces the number of denials. Also, any alternative settings are not tracked as a denial.

Attachments:

2.2.5.5.3 Provide details regarding reasons for denied inpatient days due to lack of medical necessity.

Answer: Reasons for denied inpatient days due to lack of medical necessity are as follows:

- Non-coverage of a service or supply based upon the submitted clinical information not meeting our criteria for coverage. An example is a procedure or service determined to be cosmetic in nature.
- "Downgrade" or reduction in coverage from the requested level of care to a lower level of care when clinical review guidelines/criteria indicate a lower level can adequately manage the member's clinical needs. An example is a member admitted to the Intensive Care Unit for monitoring and upon clinical review, the medical director determines a Step Down Unit can provide the monitoring.
- "Downgrade" or reduction in coverage and/or non-coverage of inpatient days due to medically unjustified delays in services or supplies that extends the length of stay. An example is a procedure, consultation or diagnostic test.
- Non-coverage of the requested in-network level of benefits for treatment or consultation by a nonparticipating provider (whether or not a specific procedure/service was requested) when the coverage request is not specifically excluded under the member's benefits plan. An example is a coverage request for bariatric surgery performed by a nonparticipating provider when bariatric surgery is a covered benefit and treatment for the member's condition (obesity) is available from a participating provider.

Attachments:

2.2.5.5.4 Of the inpatient days denied, what percentage was overturned on appeal?

Answer: We are unable to provide an appeal rate specific to utilization management. We receive appeals for many reasons including claim payments, precertification denials, etc. We base available appeal statistics on all appeals without distinction to the source of the initial determination.

In 2011, approximately 28 percent of decisions were overturned and 65 percent of decisions were upheld as a result of an appeal. The remaining 7 percent were either partially overturned or were redirected to the customer/employer for handling.

Attachments:

2.2.5.5.5 Is a formal appeal process in place that complies with all Utilization Review Accreditation Commission and Department of Labor requirements?

Answer: Confirmed. Aetna has a National Member Complaint and Appeal policy that is compliant with URAC and DOL requirements. We provide a nationally standardized process for resolving member complaints and appeals to enhance our ability to handle complaints and appeals in a consistent and timely fashion. To the extent that the complaints and appeals process varies from the applicable laws and/or regulations of an individual state, the requirements of the state are adopted and supersede the nationally standardized process.

Attachments:

2.2.5.5.6 For denials, does your organization inform both members and providers of appeal rights and the appeal process?

Answer: Confirmed. If our medical director determines that care does not meet the established guidelines, we deny certification. We will send a denial letter to the member and provider at that time. The letter will include the reason for the denial, the availability of clinical rationale used to support the decision and the process for filing an appeal.

Additionally, if the member contacts our My AlaskaCare Single Point of Contact (health concierge), the health concierge would inform them of the appeal decision or provide a call back if they needed to make internal outreaches.

Attachments:

2.2.5.5.7 Does your organization offer peer-to-peer discussion prior to an initial denial of services?

Answer: Confirmed. Our medical directors are always available for requested peer-to-peer discussions with providers. This peer-to-peer review may take place before or after the coverage denial determination. When appropriate, if information is missing or if we have questions about a request, we will conduct a peer-to-peer discussion for clarification before decisions.

All of our decision notifications include information for the provider or member to appeal a decision or to contact a medical director to request a peer-to-peer review.

Attachments:

2.2.5.5.8 Confirm there is an expedited appeal process of 72 hours or less for situations where the normal appeal timeline could jeopardize a patient's health.

Answer: Confirmed. Expedited first level appeals will be resolved within 36 hours as will any subsequent second level appeals.

Attachments:

2.2.5.5.9 Are appeals specialty matched to a member's condition and/or prescribing physician?

Answer: Confirmed. A medical director who practices the same specialty as the attending physician handles the appeal. Any second level appeal review is performed by a practitioner who typically treats the condition, performs the procedure, or provides the treatment under review and was neither involved in the original denial of coverage determination or Level I appeal.

Attachments:

2.2.5.5.10 Describe how you will meet the client's appeal process requirements including two levels of review by the Contractor and providing copies of all claim and appeal documents for appeals that reach the State's level.

Answer: We process claims and administer benefits in accordance with applicable ERISA requirements. We are proposing the claim fiduciary arrangements.

We will provide mandatory Level I and Level II appeals and write the letter to the member to communicate the upheld or overturned decision. We will act as claim fiduciary on Level I and Level II appeals, as well as the External Review option, if applicable. We will defend any lawsuit originating during or after completion of the first two levels of appeal. After all levels of appeal and the External Review option, if applicable, are exhausted, there is a Voluntary Appeal process available through the State that members can avail themselves to. We will provide the State with a copy of the claim/initial determination file. When applicable, this file includes the copies of any medical reviews, whether by our own medical directors or outside consultants related to the decision. The State becomes responsible for defense of any lawsuit originating from the Voluntary Process.

EXTERNAL REVIEW

In compliance with health care reform, Aetna will be able to support and administer an external review process for self-funded group health plans that will follow the federal process outlined in the DOL technical release 2010-01. Aetna will administer this process for the State upon request as an extension of their ASC agreement and in compliance with the internal appeal process requirements as outlined in the Affordable Care Act.

Under the Federal guidelines, the member will have four months from the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination to request an external review. Upon receipt of a request for external review, Aetna will perform a preliminary review to determine whether i) the member was covered by the plan on the date the services were requested or provided, ii) the adverse determination does not relate to the member's failure to meet the requirements for eligibility under the terms of the group health plan, iii) the member has exhausted the plan's internal appeal process (unless not required under the interim final regulations); and iv) the member has provided all the information and forms required to process the external review. The plan must issue notification in writing to the member if complete but ineligible with notification to include the reason for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-3272). If not complete, the notification must describe the information needed to make the request complete and must allow the member to perfect the request within the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

The IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review and must deliver the notice of final external review decision to the member and the plan. If the IRO overturns the decision the health plan is required to

immediately provide coverage or payment or authorize services as applicable. The decision of the independent reviewer is binding on Aetna and the State. Members are not charged a professional fee for the review.

An expedited process is available when the determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the member or would jeopardize the member's ability to regain maximum function and the member or provider on behalf of the member has filed a request for an expedited internal appeal.

We have contracted with the following URAC accredited independent review organizations: IMEDECS and MCMC, LLC and AMR.

Attachments:

2.2.5.6 Travel Management

2.2.5.6.1 Describe how you will meet the requirements for pre-authorizing travel as set forth in the Plans.

Answer: Our customer service concierge team assigned to the State of Alaska will be trained on the details of the travel program included with the State of Alaska's medical plan. The training will include a detailed review of the conditions for which travel may be reimbursed, as well as what specific expenses are eligible for reimbursement. The concierge team will serve as the initial contact for a member who is requesting pre-authorization of travel by phone.

We will use our representatives located in Alaska to complete the review, make a determination and send a written communication to the member as to the approval or denial of the travel request. If requested, we will also call the member to advise of the decision.

In addition, we will set up a dedicated fax number for travel requests for State of Alaska employees, retirees and their family members. Travel requests received via fax will be handled by the representatives located in Alaska just as if the request was initiated through the concierge team.

Attachments:

2.2.5.6.2 Does your travel authorization review process include a review of the treatment for which travel is being requested to determine coverage under the plan?

Answer: Yes. During the review for travel requests, we do confirm that the treatment for which the member is traveling for treatment is eligible for travel coverage under the plan. For example, we confirm that they are traveling for actual medical treatment and that the visit is not just diagnostic in nature.

Attachments:

2.2.5.6.3 Explain the process you propose to use to inform members of the status of their travel pre-authorization requests.

Answer: As mentioned above, a letter is sent to the member advising them of the travel approval or denial. If requested, we will also call the member to advise them of the decision.

We have attached samples of our Travel Management Authorization Letter and our Travel Management Denial Letter.

Attachments: [Travel Mgmt Sample Authorization Letter.doc](#)
[Travel Mgmt Sample Denial Letter.doc](#)

2.2.5.6.4 Provide the number of clients for whom you currently provide travel pre-authorization.

Answer: We currently provide travel pre-authorization for Alaska members of 17 clients.

Attachments:

2.2.5.6.5 Describe how you will determine both the “nearest facility capable of providing treatment” and if there are “services not available locally” prior to approving a travel authorization.

Answer: As mentioned previously, the reviews will be completed by our Alaska representatives. In addition to their knowledge of Alaska's geography and health care availability, they may use mapping tools, as well as discuss location options for care with clinical or network team members to confirm that the member's location request is the nearest place to provide the care and that the service is not available to the member locally.

Our experience is that the majority of the requests are for either Seattle or Anchorage, depending on where in Alaska the member resides. In addition, since the plan requires the member to pay upfront for the travel, it tends to deter the request to travel for a medical need, unless it is truly necessary.

Attachments:

2.2.5.6.6 Describe the process for paying a claim for travel when pre-authorization has been approved.

Answer: When a travel claim is received, we review our records to confirm that pre-authorization of the travel was obtained. We then review the member's medical claims files to confirm that the medical treatment was performed at the location to which the member traveled. Once the medical treatment is confirmed, we will then proceed with processing the reimbursement for the travel of the member.

Attachments:

2.2.5.6.7 Describe the process for denying a claim for travel when pre-authorization has not been approved.

Answer: All travel reimbursement requests are reviewed to confirm if pre-authorization of travel was obtained or not. If pre-authorization was not obtained, we will proceed with denial of the travel reimbursement.

Attachments:

2.2.5.6.8 Explain your training program for the person(s) responsible for pre-authorizing travel benefits.

Answer: The plan sponsor liaison and the account team for State of Alaska will train the members of the customer service concierge team and claims processors assigned to the State of Alaska on the travel program. The training will include a detailed review of the conditions for which travel may be reimbursed, as well as what specific expenses are eligible for reimbursement. While the concierge team members located outside of Alaska will not be responsible for the actual pre-authorization process, they will have responsibility for answering member questions related to the travel program and will be the initial contact for a member who is requesting pre-authorization of travel via phone.

Due to the travel program being unique, there will be periodic refresher training sessions held for the team, in addition to special training sessions for any new team members.

Attachments:

2.2.5.6.9 Do you have a program for medical travel which assists members in finding and authorizes travel to other locations where care is less expensive?

Answer: Yes. Our concierge team members can work with a member to assure they understand how to access these tools and utilize them for their comparison needs. A member can also use our Cost of

Care tools to determine estimated costs for a specific procedure in various areas they may be willing to travel to determine if the “Surgery In Other Locations” travel option may apply to them.

Attachments:

2.2.5.6.10 If you answered yes, what services are provided in your medical travel benefit and how do you propose to communicate the benefit to the State's membership? (Please include details on communications you've used for other clients.)

Answer: We would suggest wording for the benefit descriptions in the State's plan summaries and booklets that would advise the State's members of the Cost of Care tools on Aetna Navigator and our Mobile Apps. Members will also have the ability to contact the Concierge with any questions or for assistance.

Attachments:

2.2.5.6.11 How does your product coordinate with other vendor partners the client may have?

Answer: Aetna will be managing the Travel Management program internally. We can work with the State to assess any need to coordinate with other vendors.

Attachments:

2.2.6 Case Management

2.2.6.1 How many total covered lives do your case management programs support?

Answer: Our case management program covers 17,818,931 members, as of September 2012.

Attachments:

2.2.6.2 Provide the total number of full time employees in your case management unit.

Answer: We have 778 full time employees supporting our National Care Management Program. This includes:

- 194 case management nurses
- 31 care management associates
- 63 Flex Model case managers
- 8 Flex Model care management associates
- 53 medical directors
- 59 managers/supervisors

Attachments:

2.2.6.3 What is the average caseload for each case manager?

Answer: The average active caseload for 2012 is approximately 38 cases per nurse in our Flexible Medical Model case management program.

Attachments:

2.2.6.4 What percentage of members are managed in your case management program in a typical population?

Answer: As of 3rd quarter 2012, for the model we will use with the State, we enrolled 8.26% of our Aetna Flexible Medical Model members for outreach in case management. Of those enrolled, we engaged 94%.

Attachments:

2.2.6.5 Provide the percentage of clinical case management staff certified in case management.

Answer: Approximately 52% of the National Care Management staff are Case Management certified.

Attachments:

2.2.6.6 Describe the unique credentials of your specialty case managers.

Answer: Our nurses are experts in many specialty areas. Some examples include:

- Gerontology
- ER
- NICU
- OR
- Trauma
- Rehabilitation
- Obstetrics
- Midwifery
- Perinatal
- Critical care
- Oncology

Each case manager also receives comprehensive training on end-of-life care coordination.

Attachments:

2.2.6.7 What percentage of your case management staff has a clinical degree?

Answer: 100% of our nurse case managers have an RN degree. Some also have baccalaureate and masters degrees. Additionally, approximately 52% of the National Care Management staff are Case Management certified.

Attachments:

2.2.6.8 Which days of the week is your case management program available?

Answer: Our teams are available Monday through Friday.

Attachments:

2.2.6.9 Will the case management program be available to members for at least 8 hours during Alaska time?

Answer: Yes. Hours of operation for our Flexible Medical Model teams are Monday through Friday 8 a.m. to 5 p.m. local time.

Attachments:

2.2.6.10 What percentage of calls are monitored?

Answer: 1: 90 to 100 percent

Detail: We record and monitor all calls for our case management staff. In addition, we use our system for silent and side-by-side monitoring. Our staff also documents 100% of their calls in our medical management system. Because of HIPAA privacy regulations we do not record nor monitor calls without agreement from all parties.

Options:

1. 90 to 100 percent
2. 80 to 90 percent
3. 60 to 80 percent

4. 40 to 60 percent
5. 20 to 40 percent
6. 10 to 20 percent
7. 5 to 10 percent
8. 0 to 5 percent

Attachments:

2.2.6.11 Which of the following most accurately describes your approach to case management?

Answer: 2: Participants work with one nurse care manager

Detail:

Options:

1. Participants work with a team of nurse care managers
2. Participants work with one nurse care manager
3. Participants work with a team of professionals and non-professionals

Attachments:

2.2.6.12 How are your case management services delivered to participants (check all that apply)?

Answer: 6: Telephonic

Detail:

Options:

1. Face to face – onsite
2. Live chat online
3. Mail
4. Online
5. Social networking
6. Telephonic
7. Other, please specify: [Text]

Attachments:

2.2.6.13 Are specialty case management programs available for:

Answer: 1: NICU,

2: Oncology,

3: Renal disease,

4: Transplant,

5: Other, please specify: [We also offer a Compassionate Care program, which provides end-of-life care and hospice management services.]

Detail: If members with renal disease are on the kidney transplant list, they may be active in our National Medical Excellence Program®. If their doctors authorized medications such as Epogen® or Procrit® for an ambulatory event, the member may or may not require case management. It depends on the individual case. Case managers may manage a member with renal disease based on identification triggers we have related to readmissions within a rolling 90-day period, a high dollar trigger, or a referral from another Aetna program.

Options:

1. NICU
2. Oncology
3. Renal disease
4. Transplant
5. Other, please specify: [Text]

Attachments:

2.2.6.14 Indicate any accreditations you currently hold SPECIFIC to your case management program.

Answer: Our health plans are accredited by NCQA under the accreditation for health plan standards. This includes review of our utilization and case management programs. We do not have separate accreditation for our Aetna Health Connections utilization/case management programs.

The NCQA health plan accreditation standards include extensive requirements related to case management, including the following:

- Annual assessment of the characteristics and needs of its member population and subpopulations, and how the organization updates processes to address member needs.
- Identifying members eligible for complex case management using seven required data sources, such as claims data, pharmacy data, providers and purchasers.
- Processes for staff to receive referrals from six required sources such as informed health line, caregivers and providers.
- Use of case management systems that support evidence-based clinical guidelines, automatic documentation of the case management interactions and automated prompts for follow-up.
- Processes to assess the needs of each member requiring case management that include 15 required components.
- An annual evaluation of the case management program that includes a member satisfaction survey and complaint analysis.
- Measuring the effectiveness of the case management program using three measures.

Attachments:

2.2.6.15 Provide written protocols in place that address:

- Timeliness of case management referrals
- Timeliness of case management assessment and outreach
- Development and documentation of short and long term goals
- Minimum intervals for member follow-up and reassessment
- Documentation standards
- Case management discharge criteria
- Referrals to the Medical Director and/or Quality Management Program.

Answer: Our policy and program procedures manual addresses all of the protocols mentioned above.

Timeliness of case management referrals

Referrals are made in real time. While we designed our Aetna Total Clinical ViewSM System (ATV) to deliver most case management opportunities automatically and in real time through the system,

there are times when we need to identify some opportunities manually, such as private duty nursing and home hospice. These manual referrals are forwarded to the case management team as soon as we determine the need based on the discharge plan.

Timeliness of case management assessment and outreach

We require case managers to activate their complex cases within two business days of the case creation date. We require case managers to activate their proactive cases within 10 business days of the case creation date.

Case managers make their initial outreach attempt for all cases within three business days of the open date or discharge date, and initiate their second outreach attempt within 12 business days.

When we are unable to contact a member despite outreach attempts, the case manager may alternatively investigate opportunities to engage the treating doctors as a means to impact the member's health status.

Development and documentation of short and long term goals

A case plan is developed within 12 business days of the case open date.

The case plan is then personalized to meet the member's specific needs, as evidenced by the population of deficits, goals, activities related to the member's recommended personalized action plan. Case managers utilize Motivational Interviewing techniques along with questionnaires to assist members with developing a case plan.

Member goals are also prioritized by the member and case manager: as evidenced by documentation in an ATV Note.

Development of an individualized case plan includes development of scheduled follow-up calls and communications with members.

Minimum intervals for member follow-up and reassessment

The case manager is required to evaluate and validate member case plans no less frequently than once a month (every 30 calendar days) or as clinically appropriate.

The frequency of engagement monitoring and evaluation is based on all of the following:

- The Case Manager's clinical judgment;
- The member's need for support services;
- The member's/caregiver's compliance with the case management plan;
- The Medical Director or Care Team supervisor/manager/COC manager suggestions

Documentation standards

Case managers track their cases through a task list in ATV. The list shows the follow-up days and next-call dates, which are broken out over a period of time. Managers track the volume and timeliness of case managers' work.

Case management discharge criteria

Once all identified care needs have been resolved and monitoring/evaluation is no longer necessary, we disengage the member from case management.

Disengagement examples include:

- Complex care coordination needs are no longer necessary and the member is in the appropriate care setting
- A baseline or custodial level of care is met and no additional needs are identified
- No further progress is expected from case management
- An unwillingness to change behavior is demonstrated and the identified case management activities require member participation
- Enrollment is terminated (e.g., change in health benefits coverage or member dies)
- A member declines the program
- A member or provider requests the discontinuance of case management
- Other insurance is verified to be primary and our plan is not at financial risk and there is no obligation to the State to perform case management for the member
- A member and/or provider do not respond to initial case management outreach attempts
- A member becomes unable to reach after engaging in the program
- The remaining open identified issues are related only to claims
- Admitted to a non-acute facility such as, skilled nursing facility or rehabilitation facility, and there are no actionable case management activities during the member's non-acute inpatient stay

Our case managers discuss with members the potential for case closure once they reach their goals.

Referrals to the Medical Director and/or Quality Management Program

Case managers consult with a medical director when physician assistance is needed to develop or address a complex case management issue. The result of the consultation may be:

- Medical director or case manager outreach to the treating doctor or member
- Identification of an alternative to the initially developed case management plan
- Additional internal program referrals

Referrals are made to the Quality Management department by any of our clinical programs when a member safety issue is identified. Per our policy, these referrals are not documented in the system due to the strict confidential aspect.

Our medical directors meet with case managers either in person or by telephone any time they encounter a difficult or complex situation. Medical directors also perform Grand Rounds monthly. During this session, a medical director provides a clinical presentation about a medical condition or procedure. We also have Schwartz Center Rounds on a monthly basis. These are multiple multidisciplinary forums where caregivers/case managers discuss difficult emotional and social issues that arise in caring for patients. A case manager presents a specific case and then colleagues give feedback, provide support and share ideas for handling similar situations.

Attachments:

2.2.6.16 Describe standardized case management assessments used to promote quality and consistency in assessments and interventions.

Answer: Our case management staff uses several sets of national guidelines including:

- Healthwise® Knowledgebase database
- Milliman Care Guidelines
- Internal policies
- Internally developed Clinical Policy Bulletins (available on our Aetna.com public website)

Case managers also use condition-specific case management assessments. Clinical protocols and guidelines form the basis of these assessments. Specialty associations and nationally recognized organizations develop the assessments. Our medical directors then approve these assessments for our case management program. We update the guidelines on a continuing basis. Guidelines are available on line.

A medical director reviews all treatment plans that would not meet our clinical criteria.

Attachments:

2.2.6.17 Describe how case managers have access to network provider information either internally or by data feed from the claims payer/network manager to view member activity and costs.

Answer: Case managers have access to member activity and costs through our integrated systems. Care management, eligibility, member services and claims data is integrated online. Our system enables care management nurses to toggle from care management screens to claims screens as needed. This information is provided in a read-only format and can only be edited by authorized staff members. The use of claims screens, in addition to formal, daily communication between care management nurses and claim representatives is an integral part of our care management process.

Attachments:

2.2.6.18 Describe whether case managers have access to the claims payment and utilization systems to view member activity and costs.

Answer: Yes. Our systems are integrated online so that our nurses can view eligibility and claims data as necessary.

Attachments:

2.2.6.19 When is a case considered to be high dollar or catastrophic?

Answer: We flag cases over \$75,000 as high dollar. Because we are providing the State our enhanced case management program, called Flexible Medical Model, the State has the option to lower the \$75,000 threshold. We will be happy to assist the State in determining the value in changing this threshold. Additionally, we also do specific targeted management for the catastrophic cases approaching or above \$300,000.

Attachments:

2.2.6.20 What % of these cases do you outreach to?

Answer: We outreach to all targeted members identified for our Flexible Medical Model. This was 5.91% of our total membership who have the Flex Model as part of their plan in 2011.

Attachments:

2.2.6.21 What % of these cases enroll?

Answer: 94% of members we identify for the Flexible Medical Model are engaged in the program. On a book of business basis, our Flexible Medical Model Enrollment Rate was 8.26% of our total membership who have the Flex Model as of third quarter 2012.

Attachments:

2.2.6.22 Does your system flag a member if they are enrolled in another vendor partner program so that members are not outreached to when already participating?

Answer: If our case managers are aware that the member is enrolled in a vendor program, they document in member notes in the system. However, we continue to work with the member even if they are engaged in the external vendor's program unless they request no calls.

Attachments:

2.2.6.23 Indicate which of the following are used to identify candidates for your case management program:

**Answer: 1: Claims dollar threshold,
2: Diagnosis,
3: Medical claims data mining,
4: Member self-referrals,
5: Multiple ER visits,
6: Length of stay,
7: Pharmacy claims data mining,
8: Procedure codes,
9: Referrals from external sources – Client, Employer, physicians, on site clinics, etc.,
10: Referrals from internal programs,
11: Repeat inpatient admissions – readmissions,
12: Selected outpatient services,
13: Specialty pharmacy utilization**

Detail:

Options:

1. Claims dollar threshold
2. Diagnosis
3. Medical claims data mining
4. Member self-referrals
5. Multiple ER visits
6. Length of stay
7. Pharmacy claims data mining
8. Procedure codes
9. Referrals from external sources – Client, Employer, physicians, on site clinics, etc.
10. Referrals from internal programs
11. Repeat inpatient admissions – readmissions
12. Selected outpatient services
13. Specialty pharmacy utilization
14. Other, please specify: [Text]

Attachments:

2.2.6.24 Provide the percentage of your total membership referred to the case management program in the most recent calendar year.

Answer: As of 3rd quarter 2012, for the model we will use with the State, we enrolled 8.26% of our members for outreach in case management. Of those enrolled, we engaged 94%.

Attachments:

2.2.6.25 In the most recent calendar year, what percent of members referred to the case management program were actively engaged to participate (defined as working with an RN)?

Answer: 9: 90 to 100 percent

Detail: We outreach to all targeted members in the Flexible Medical Model. In 2011, our case managers actively engaged 96.7% of our targeted Flexible Medical Model population. We base this percent on the number of members we were able to reach.

Options:

1. 5 percent or less
2. 5 to 10 percent
3. 10 to 15 percent
4. 15 to 20 percent
5. 20 to 30 percent
6. 30 to 50 percent
7. 50 to 70 percent
8. 70 to 90 percent
9. 90 to 100 percent

Attachments:

2.2.6.26 What is the typical drop-out rate for enrollees in your programs?

Answer: 1: 5 percent or less

Detail:

Options:

1. 5 percent or less
2. 5 to 10 percent
3. 10 to 15 percent
4. 15 to 20 percent
5. 20 to 30 percent
6. 30 to 50 percent
7. 50 to 70 percent
8. 70 to 90 percent
9. 90 to 100 percent

Attachments:

2.2.6.27 Do case managers refer eligible members to the following programs? (Please check all that apply)

Answer: 1: Disease management programs,

2: EAP,

3: Behavioral health,

4: Health coaching programs,

5: Maternity management programs,

6: Wellness programs

Detail:

Options:

1. Disease management programs
2. EAP
3. Behavioral health
4. Health coaching programs
5. Maternity management programs
6. Wellness programs
7. Other, please specify: [Text]

Attachments:

2.2.6.28 Please describe how you can partner with disease management programs to coordinate data and care protocols.

Answer: We believe that a single-nurse point of contact is very important to assure minimal confusion and optimal participation and positive outcomes for members who touch various programs. To that end, we have established a hierarchy within our programs and how we work with other vendors to identify who the member's primary contact will be when the member qualifies for more than one program. Because of our integrated clinical management system, all nurses of our care team have a comprehensive view of member information.

When the member qualifies for both case management and disease management, the case manager will be the primary contact initially. The case manager will coordinate more acute health needs, such as care needed after a hospitalization, through our case management program. Once the member is stable, we will follow established protocols we agree to with the DM vendor during implementation, including sharing key data points and updated care protocols accomplished with the member. We will introduce the role of the DM nurse and transition the single-point of contact formally with the member at that time. A warm transfer and brief three way discussion is sometimes implemented depending on the bi-directional referral processes established. The disease management nurse will not contact the member until the case management nurse completes working with the member. At that time, the case manager will close the case management file and the disease management nurse will become the primary contact.

While a smooth transition and referral process is possible with any disease management vendor, we have established a seamless process when Aetna provides the Utilization and Case Management services and our sister company, ActiveHealth, provides the Healthcare Management services, such as we are proposing for the AlaskaCare membership. Aetna and ActiveHealth already share claims data and our nurses and coaches can view and document care status and protocols in the system to assure efficient and thorough communication during any transitions. The member is introduced to our team not by "program" but rather by expertise to assist them at various points in their care continuum.

Our teams work closely together and members have reported that they appreciate the expertise of our nurses and coaches working closely together on their behalf.

Attachments:

2.2.6.29 Describe how staff are prompted for timely follow-up as indicated by the plan of care.

Answer: We identify members for outreach and follow up by our internal clinical rules engine. Nurses use a smart desktop called Aetna Total Clinical View that keeps nurses informed about the members they are helping and tracks their progress. Case managers track their cases for review and outreach through a personalized task list within the system. The list shows the follow-up days and next-call dates that are broken out over a period of time.

The case management process includes development of an individualized case plan with planned follow-up calls and communications with members. The nurse and member may agree to schedule a specific time and day, or they may agree on call back in a specific time frame. In addition, case managers share their confidential e-mail and phone number with members/caregivers so they can contact their case manager directly whenever they wish.

Aetna Total Clinical View gives the nurse a 360-degree view of each member. With this tool, the nurse can better understand the member's current (and past) health situation. Our team can see many details, including the member's medications, measurements, diagnoses, procedures, and doctors. This helps us spot gaps and potential errors in care, patterns of misuse and opportunities for improvement. The system also has a Call Tracking tab that displays support documentation of incoming and outgoing program contacts and call attempts, including success, failure, and failure reasons.

Attachments:

2.2.6.30 Describe the available reporting specifically relating to the case management program.

Answer: We provide our Medical Management Activity Report (MMAR) report and the Flexible Medical Model Report.

The MMAR report provides a view of members identified, targeted for outreach and currently participating in the Aetna Health Connections case management program. It also provides additional details to highlight identified deficits and goals, referrals to and from the program, identification sources and referral reasons, and areas of case management focus while participating in the program.

The Flexible Medical Model Report details the additional clinical outreach provided, such as applicable clinical outreach related to:

- Pre-admission calls
- Post-discharge calls
- Predictive modeling (PULSE) scores
- High-dollar claim utilization
- Frequent emergency room visits
- Multiple providers and/or services
- Post Informed Health Line calls
- Outpatient chemotherapy and radiation treatments

Both reports are available quarterly via our online reporting tool 45 days after the close of the quarter.

Attachments:

2.2.6.31 What type of metrics do you report on for high cost cases?

Answer: We provide quarterly utilization reports that include metrics on paid claims for medical catastrophic claimants with user specified dollar threshold, prior and current reporting periods and current trend with and without these catastrophic claimants. There is an additional detail report showing medical catastrophic claimants with a user specified dollar threshold that includes inpatient

and ambulatory paid amounts and diagnosis code. We mask these reports to protect against individual identification.

Attachments:

2.2.6.32 How often can you export case management files to vendor partners?

Answer: If ActiveHealth were awarded the contract, there would be no need to export case management files, as we have integrated systems and work flows to share access to real time data.

Should the disease management or wellness vendors not be ActiveHealth, we can export case management files to external vendors weekly or monthly, for an additional charge. This file feed contains basic clinical program participation for our case management program.

The file includes data such as:

- Identification dates
- Engagement dates
- Engagement levels
- Closure reason codes

Attachments:

2.2.6.33 Is the case manager responsible for discharge planning of hospitalized patients?

Answer: Yes.

Attachments:

2.2.6.34 If a member is actively engaged in case management and is admitted to the hospital, does the case manager continue to monitor the care and provide authorizations for inpatient care?

Answer: Yes.

Attachments:

2.2.6.35 If no, then describe the coordination between the case manager and utilization management when a patient receives services from Utilization Management.

Answer: Not applicable. When a member engaged in case management is hospitalized, their assigned case manager continues to act as the member's single point of contact, and is responsible for monitoring and authorizing their inpatient care, and coordinating discharge planning needs.

Attachments:

2.2.6.36 Is a formal process in place to communicate with the plan sponsor regarding potential large claimants or adverse determinations?

Answer: Yes. When case management is aware of a potentially large claim, our case manager notates the member's file with a "Forecasted High Dollar" heading in the care management system. The system then sends the notification electronically to the High Dollar Forecast Database which your account team monitors. Once the account team is aware of a potentially large claim, they notify you if it impacts stop loss and reserve funding; however, they do not identify individual names to you. The account team can also notify Buck if we have an agreement from the State.

We may provide case management notes consistent with applicable law.

We would not contact the State when we deny a service. We handle member personal health

information (PHI) confidentially. We release it only after staff validates that the member authorized this person to receive the information.

Attachments:

2.2.6.37 Confirm you will manage an alternate benefit program (individual case management) for large/complex cases where, with approval from the State, members can receive non-covered services in lieu of covered services to contain costs.

Answer: Confirmed.

Attachments:

2.2.6.38 How do you evaluate the effectiveness of your case management program?

Answer: 1: Clinical outcomes,

2: Costs avoided,

3: Member satisfaction,

5: Return on investment

Detail:

Options:

1. Clinical outcomes
2. Costs avoided
3. Member satisfaction
4. Redirection to lower level care
5. Return on investment
6. Other, please specify: [Text]

Attachments:

2.2.7 Claims Processing

2.2.7.1 Claims Processing - General

2.2.7.1.1 Will you prepare, print and furnish to the State, at no cost, a Medical Expense Benefit Manual, or something similar, containing information of a substantive nature relative to how you will administer the State's plans, including UCR determination, sampling techniques and procedures? Will you provide to the State timely updates of any change in practice or procedure affecting plan administration?

Answer: Yes. In order to provide you with the most up-to-date administrative information, we offer our Group Benefits Administrative Handbooks located on our website at http://www.aetna.com/employer-plans/national-accounts/national_admin_manuals.html. We will provide the State with a welcome letter that includes the URL to access the handbook online.

Our Group Benefits Administrative Handbooks contains information including:

- Customer Service
- Enrollment
- Billing
- Continuation of Coverage

Attachments:

2.2.7.1.2 Describe how you will provide a dedicated system of claims administration.

Answer: We build the State's plan designs and specifications into our claims system plan file. The system interfaces with our claim intake systems, member, provider, quality management and patient management databases. The claims system automatically determines and applies deductibles, various coinsurance levels, plan limits and maximums. Our existing claims system is a sophisticated system that has the flexibility to support a wide range of custom and specific plans for customers. Modification of the claims system for an individual customer is typically not necessary.

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

In addition, our claims system has the capacity to include a VIP indicator to alert the claim processor with an edit indicating special handling procedures for a member file. Claim and customer service staff has access to online documentation screens for member files.

In order to flag member files with appropriate instructions, we require the State to provide a list of members requiring special handling.

When we cannot accommodate customer-specific features through plan set up, we make system changes (customer specific or general) on a pre-defined release schedule.

Attachments:

2.2.7.1.3 Does your claim system have a common database for edits, pricing, production of EOBs and reporting?

Answer: Yes. We use a customized version of McKesson's ClaimsXten™ software to detect unbundled, upcoded and fragmented provider bills. We fully integrated ClaimsXten into our claims processing systems. We use this product to address claims in a broad range of services:

- Surgical
- Surgical assistance
- Medical (e.g., office care)
- Diagnostic services (e.g., X-ray, lab)

ClaimsXten is a robust tool as it contains in excess of one million edits.

Editing applies to both participating and non-participating providers. The software includes the following types of edits on non-facility providers:

- Incidental
- Mutually exclusive
- Rebundling
- Frequency
- Correct coding guidelines

The software includes the following types of edits on facility providers:

- Frequency

- Correct coding guidelines

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

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

Attachments:

2.2.7.1.4 Explain your capability to accept electronic claims directly from providers and claim clearinghouses on behalf of members.

Answer: Network providers must submit a claim on the member's behalf. The member is never responsible for submitting claims for in-network and referred services.

Providers can submit all claims, including Coordination of Benefits claims and corrected claims electronically. The following providers may use electronic submission:

- Hospitals
- Pharmacies
- Laboratories
- Other institutional providers
- Physicians
- Dentists

They can transmit claims directly to us through:

- An Aetna-approved vendor
- Our secure provider website
- Our direct-connect website, www.aetnaedi.com
- Any number of clearinghouses

Through our electronic data interchange (EDI) vendors, providers can send:

- Referrals
- Precertifications
- Payment estimates
- Claims

Providers can also:

- Check claim status
- Receive electronic remittance advice (ERAs)
- Review electronic explanation of benefits (eEOB's) via online portal
- Verify member eligibility
- Have instant access to extensive member benefit and eligibility information electronically

Except for adding a referral or requesting a payment estimate, we offer all of these services to both non-participating and participating physicians on our secure physician website, free of charge.

Attachments:

2.2.7.1.5 Do you review claims for billing irregularities by a provider (such as regular overcharging, unbundling of procedures, upcoding or billing for inappropriate care for stated diagnosis, etc.)? If so, please describe your review process and what action you take in the event you find billing irregularities?

Answer: Our Special Investigations Unit (SIU) uses the Fraud and Abuse Management System (FAMS) tool, which examines provider treatment and billing behavior to identify potential fraud. FAMS profiles providers by peer group, specialty, product, geography, etc. Profiles are typically based on 3 to 12 months of detail claims. FAMS identifies approximately 300 cases per year. FAMS is the primary proactive detection tool used by our SIU and we are recognized as the industry leader in the use of FAMS by IBM (the creator and owner of FAMS).

The claims system employs automated claim review software to identify and adjust for unbundling of services and duplicate claim billings. We also use additional software, known as the Aetna Standard Table to identify diagnoses and procedures designated as inappropriate according to our clinical policy.

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

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

When we suspect fraud, we create a case and assign an SIU investigator. When the investigator substantiates an allegation of fraud, we place a flag on the provider's file which triggers an edit informing claim processors that the provider is under investigation or review for a specific billing impropriety. Approximately 20,000 providers are currently flagged for fraud. In 2011, fraud flags resulted in pre-payment claim denials totaling \$163.6 million (red flag savings). The SIU has sole authority to place and remove fraud flags in the system.

Attachments:

2.2.7.1.6 Where will claims processing dedicated offices be located?

Answer: Claims will be handled by our Fresno Service Center located at 1385 E. Shaw Avenue, Fresno, CA.

Attachments:

2.2.7.1.7 What are the hours/days of operation for the claims processing unit?

Answer: The hours of operation for the Fresno Service Center are Monday through Friday, 8 a.m. to 6 p.m., local time.

Members who are located in a different time zone, will have access to our standard 10 hours of phone

coverage through call routing to another office. Standard customer service hours consist of 8 a.m. to 6 p.m. local time to the Alaska based member.

Attachments:

2.2.7.1.8 How many claims processors will be dedicated to the State's plans?

Answer: There will be 20 claim processors assigned to the State. There will be 10 primary claim processors and 10 as back-up processing resources.

Claim teams are headed by claim team managers. Claim teams are run by claim supervisors who report to the claim managers. Claim supervisors have total responsibility and accountability for the prompt and proper payment of the State's claims.

A claim team consists of approximately 20 claim processors. The teams are comprised of both office-based and home-based staff.

Attachments:

2.2.7.1.9 What are the average years of experience for your claim processing staff?

Answer: The average years of experience of our claim processing staff is 11.5 years.

Attachments:

2.2.7.1.10 What is the average length of employment for claim processing staff?

Answer: The average years of experience for all claim staff in our Fresno Service Center is 11.5 years.

Attachments:

2.2.7.1.11 Describe your training program for claims processing staff.

Answer: Our training programs help our staff provide prompt, efficient, and accurate service. In fact, both the health benefits and training industries recognize the strength of our programs. In February 2011, Training magazine ranked us 22 out of the top 125 companies with the best employee training. This is the 5th year in a row we have placed in the top 125.

Our trainees spend the first 10 to 15 weeks learning the claims system and as well as how to interpret benefits. They also study anatomy, terminology and the health care delivery system.

We deliver our training through mixed media such as:

- Classroom lectures
- Satellite broadcasts
- Videos
- Sound-slide presentations
- Audio-workbook programs
- Computer-assisted instruction

We use the "learning by discovery" method. This includes claim examples and hands on instruction. We evaluate participants' skills and productivity with written tests, online assessments and oral quizzes.

As trainees pass the tests and quizzes, we gradually move them into claim processing while still in a

training environment. We audit 100 percent of all claims handled by trainees.

When processors are ready, we assign them to production units where we continue to monitor them. We use the buddy system and pair new processors with seasoned professionals for day-to-day guidance and support.

CUSTOMER SPECIFIC TRAINING

As part of the implementation process, our service center staff will be trained on the State's specific plan. This includes a thorough review of your benefit program, special administrative issues and other unique requirements.

During this training, we use copies of the State's employee benefit booklets, announcements, other communications and any materials that you recommend, to provide our staff with a clear understanding of your program. This provides a smooth transition for responding to employee inquiries, as well as claim settlement. We welcome the State's participation in this process.

ONGOING TRAINING AND AUDITING

Training extends beyond our initial programs. We hold bi-weekly or monthly meetings to discuss recent updates to our policies. In addition, we conduct refresher training on trends we have noted through our audit and quality programs.

We have sessions for:

- New health care trends and delivery systems
- New benefit options
- Claim system enhancements and revised administrative procedures
- Communications and other interpersonal skills, such as cultural diversity, peak performance and time management
- Our code of conduct and state and federal legislation, including HIPAA
- Our fraud awareness programs

On a monthly basis, we continue to review processors for accuracy, production and overall results. We conduct classroom or one-on-one training to address concerns as needed.

We also provide tuition assistance programs. These include the Certified Employee Benefits Specialist program and college degree programs.

Attachments:

2.2.7.1.12 Explain any incentive programs you employ to retain competent claim processing staff.

Answer: We begin the retention process from the date of hire.

CLAIM PROCESSORS

We provide all claim processors with extensive training which allows them to perform their jobs well. Our environment is one of on-going learning. We also provide our staff with partners and quality

analysts to help them stay current on all updates. We provide excellent bonus and incentive programs along with the opportunity for personal development and advancement.

We manage our turnover through:

- Continued education and training
- Incentive plans
- Connecting personally with the staff
- Providing excellent benefits
- Career development
- Hiring the right people

CLAIM STAFF

In addition to the incentive programs for claims staff, we have an internal program supported by staff to further the following goals:

- To actively promote career paths (e.g., customer service, auditors and trainers), skills progression and knowledge development
- To identify and develop leadership skills and talent
- To recognize demonstrated service excellence
- To enable all employees to quantify the value of their work on an individual level at any point in time.

Attachments:

2.2.7.1.13 What is the average productivity of the claims approvers on a per approver per day basis?

Answer: Claim processors are subject to varying production standards based on their responsibilities, experience and the complexity of the plans for which they are responsible. Typically, we require processors to handle a weighted 10 claims per hour.

Attachments:

2.2.7.1.14 How does the claim office handle periods of significantly increased workload?

Answer: We assign work based on volume. In order to provide our members with optimal service, our workforce management team projects the volume of work by:

- Evaluating membership
- Projecting auto-adjudication rate
- Type of plan

Using these projections, our workforce management team forecasts the needed staff and we assign work to processors accordingly. Service center managers continually monitor staffing to maintain quality standards and service targets.

Attachments:

2.2.7.1.15 How does the claim office's performance for the past two years compare with the claim turnaround time goal?

Answer: 7: Other. Indicate: [Our goal is to process 90% of all claims in 14 calendar days. In 2011, the Fresno Service Center processed 90% in 4.4 days and YTD 2012 we processed 90% in 4.7 days.]

Detail:

Options:

1. Up by 5--10%
2. Up by 11--15%
3. Up by 16--20%
4. Down by 5--10%
5. Down by 11--15%
6. Down by 16--20%
7. Other. Indicate: [Text]

Attachments:

2.2.7.1.16 What percentage of claims are processed in 5, 10, 20 and 20+ days?

	Indicate % of claims paid in # of days
% paid in under 5 days	69%
% paid in 5--10 days	24%
% paid in 10 -- 20 days	5.1%
% paid in over 20 days	2%

Detail: Our turnaround time goal is to process 90 percent of all claims within 14 calendar days of our receipt of complete claim and eligibility information.

DEFINITION OF TURNAROUND TIME

We define turnaround time as the number of calendar days necessary to process the claim beginning on the date we receive complete claim and eligibility information in the service center and ending on the date we process it, including weekends and holidays.

We include all claims in our turnaround time definition: clean claims, COB claims, internal referrals, external investigations, out-of-network claims and pended claims (except those pended claims for which you have provided incomplete eligibility information).

A clean claim is one that we can process without referring to any source for additional information.

Our standard claim processing turnaround time to process a claim is 90% in 14 calendar days and 95% in 30 calendar days.

As of 9/30/2012, our claim processing turnaround time to process a claim for the Fresno Service Center was 90% in 4.7 days, and 95% in 8.75 days.

Attachments:

2.2.7.1.17 In the claim processing office that will have payment responsibility for this account, what are your standard targets and average statistics for the following?

	Standard Target	Average Statistics
Claims processing turnaround time	90% in 14 calendar days.	90% in 4.7 calendar days.

	Standard Target	Average Statistics
Answer speed	30 seconds	26 seconds
Wait time	75% of all calls answered within 30 seconds	78.30% of all calls answered within 30 seconds.
Abandonment rate	Less than 2.5%	1.10%.
Payment accuracy	96%	99.45%
Financial accuracy	99.85%	99.69%
Member Satisfaction	92%	94.86%
First Call Resolution	90%	94.40%

Detail:

Attachments:

2.2.7.1.18 What clinical staff is available as a resource to the claims processors?

Answer: When necessary, our Clinical Claim Review department will assist with the review of claims. The Clinical Claim Review staff currently includes 78 registered nurses and 3 therapists that work within a defined scope of responsibility based on clinical and technical qualifications. We have 14 medical directors who support our Clinical Claim Review units. Medical directors provide consultation to registered nurses when they indicate a claim should be denied due to medical necessity.

Clinical Claim Review is a department within National Care Management that provides a consistent and standardized medical review program focused on claim administration.

Attachments:

2.2.7.1.19 Did you develop the claims system internally? If you did not develop your system internally, which firm developed it and when?

Answer: We began processing claims on the Automatic Claim Adjudication System (ACAS) in 1997. We customized ACAS, based on the Dun and Bradstreet system ClaimFacts to support our book of business.

Attachments:

2.2.7.1.20 Are all claims processed on a single claims system?

Answer: Yes. They are processed on our Automatic Claim Adjudication System (ACAS) We are a full-service carrier and provide all aspects of claim adjudication.

Attachments:

2.2.7.1.21 How are changes to the claims system implemented?

Answer: We make major enhancements to our system on a quarterly basis via our enterprise release calendar (February, May, August and November). We schedule system releases over the weekends to avoid meaningful downtime for our processing centers, members and providers.

We complete routine maintenance based on business needs. Maintenance is an ongoing process included in activities related to certain user table updates, to address jobs thatabend or fail to run or other jobs that are monitored on a daily basis, as well as requests from our business areas that can be handled under a day-to-day service request.

Attachments:

2.2.7.1.22 When was the last update to your claim processing system, and what changes were implemented?

Answer: The last major ACAS release was on November 9, 2012. We make major enhancements on a quarterly basis through our enterprise release calendar. The latest and upcoming ACAS enhancements focus primarily on Healthcare Reform ICD-10 compliance.

We are constantly updating our system as technology improves or changes. Some of the updates have been implemented when a new product is being offered, new pricing methodologies or pricing by external vendors. We also update our system for additional medical rules and policies for claim reviewing with added support for facility claims, automatic adjudication and Payment Estimator capability.

Attachments:

2.2.7.1.23 Are system changes planned in the next two years? If there are system changes planned, please indicate the nature of the changes.

Answer: Over the next year we will continue to make enhancements for new product offerings, new pricing methodologies, pricing by external vendors, additional medical rules and policies for claim reviewing with added support for facility claims, automatic adjudication and Payment Estimator capability. In addition, we will be enhancing our systems to be compliant with the new ICD-10 coding methodology required in 2013, and all other required enhancements for Health Care Reform.

Attachments:

2.2.7.1.24 Does your claims system have the capability to process network and non-network claims on the same system?

Answer: Yes. Our claims system automatically links the member, the plan, the provider, the network, any applicable referral and the fee arrangements.

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

Attachments:

2.2.7.1.25 Please provide a claims workflow diagram from date of receipt of a claim through release of payment and reporting to plan sponsor.

Answer: Confirmed. We have attached a claim workflow diagram. A key feature is our system contains all components resulting in no repricing by a 3rd party and all payments made directly by Aetna.

Attachments: [Aetna Claim Workflow Diagram.ppt](#)

2.2.7.1.26 Confirm that you are able to pay claims in accordance with provider contracts held by the State and not your network.

Answer: Confirmed. We are able to administer custom contracts including those held by the State. Based on requirements for network contracts, we can work with the State for any agreements that must be on Aetna paper including any in force agreements.

Attachments:

2.2.7.1.27 For what period of time are claims records maintained after records are purged from the system?

Answer: We move claims greater than five years old that meet specific criteria into an archive database. These claims are available for recall (in most cases, immediately) and will display all claim details.

We also keep three years of financial data on the claims system that are used during adjudication. Financial data beyond the three years are available for historical view only. This includes the family/member's accumulator information such as plan limits, deductibles and amounts accumulated towards those limits.

ONLINE HISTORY

Our claims system maintains claims history online indefinitely including detailed claim history for each family member on submitted expenses and processed claims (paid, pended and denied). Aetna Navigator, our secure member website, only displays claim history information online for two years (current and previous year).

We maintain financial data for three years.

Attachments:

2.2.7.1.28 Does your claims system automatically match claims with predetermination information, both for in- and out-of-network?

Answer: Yes, our claims system and medical management systems are integrated, and automatically match claims with predetermination information, for both in- and out-of-network claims.

Separate units handle care management, eligibility, member services and claims functions. The data associated with our claims, customer service, utilization review, case management and disease management departments is fully integrated online. This allows each function to review the others when needed. However, the data associated with each of these is integrated online. This allows each function to review the others when needed.

Through our electronic utilization management system, claims processors, member services and eligibility consultants can view all medical utilization decisions and documentations, such as non-compliant issues. These are immediately available in real time after being entered by our nurse reviewers. This information is provided in a read-only format and can only be edited by authorized staff members.

When the associated claim is submitted and processed, the claims adjudication system automatically flags the claim and alerts the claim processor to review the member's care management file for payment instruction. Our system enables care management nurses and claims representatives to toggle from care management screens to claims screens as needed. The use of claims screens, in addition to formal, daily communication between care management nurses and claim representatives is an integral part of our care management process.

Attachments:

2.2.7.1.29 Confirm that you are able to pay claims in accordance with provider contracts held by the State and not your network.

Answer: Confirmed. We can pay claims in accordance with custom agreements. These agreements can be for providers both in and out of our network. Our claim system enables linkage to custom contracts and all standard claim processes apply.

Attachments:

2.2.7.1.30 For what period of time are claims records maintained after records are purged from the system?

Answer: We move claims greater than five years old that meet specific criteria into an archive database. These claims are available for recall (in most cases, immediately) and will display all claim details.

We also keep three years of financial data on the claims system that are used during adjudication. Financial data beyond the three years are available for historical view only. This includes the family/member's accumulator information such as plan limits, deductibles and amounts accumulated towards those limits.

ONLINE HISTORY

Our claims system maintains claims history online indefinitely including detailed claim history for each family member on submitted expenses and processed claims (paid, pended and denied). Aetna Navigator, our secure member website, only displays claim history information online for two years (current and previous year).

We maintain financial data for three years.

Attachments:

2.2.7.1.31 What percentage of claims are auto-adjudicated for contracted Alaska providers? For non-contracted?

Answer: The Fresno Service Center adjudication rate is 79.23%, as of November 2012. We do not track the auto adjudication rate by contracted or non-contracted Alaska providers. We track the overall office auto-adjudication rate.

Auto adjudication is a component of the plan design and we will work with the State to identify plan design changes that can increase auto adjudication rates.

Attachments:

2.2.7.1.32 Describe your organization's success in increasing auto adjudication rates for Alaska providers.

Answer: The auto adjudication rate for Alaska providers increased 2.68% from November 2011 to November 2012. We define automatic claim adjudication as benefit determination through the claims system without processor intervention.

We are focused on identifying opportunities to increase auto adjudication through contracting, plan design and system capability enhancements. One of the more notable opportunities resulted in a three percentage point increase in the overall auto adjudication rate for Providers in 2012 as compared to 2011. In collaboration with the State of Alaska, we were successful in making several changes including adding a per admission deductible for non-par facilities, which eliminated a portion of manual processing.

Attachments:

2.2.7.1.33 Is customer/member services housed with the claims paying unit?

Answer: 1: Yes

Detail: Most claim processing and member service teams are co-located where we have office-based staff.

Options:

1. Yes
2. No

Attachments:

2.2.7.1.34 What was your percentage of turnover for claims examiners in 2011 and 2010 at the claim office(s) that would be assigned to this account.

Answer: The average turnover for all Fresno Service Center claim staff in 2011 was 4.10% and in 2010 was 13.30%.

Many processors with successful performance track records move into alternate roles within our organization as part of their career development plans.

Attachments:

2.2.7.1.35 Does the proposed claims processing facility have a Medical Director?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

2.2.7.1.36 Which of the following descriptions would best characterize your claim adjudication process?

Answer: 1: System-based adjudication with claims specialist oversight

Detail:

Options:

1. System-based adjudication with claims specialist oversight
2. Claim specialist adjudication with system-based claim tracking
3. Primarily claim specialist adjudication and tracking
4. Other: [Text]

Attachments:

2.2.7.1.37 What security measures are in place to ensure that reimbursements are issued to the proper party?

Answer: 3: Other: [Our claims system automatically links the member, the plan, the provider, the network, any applicable referral and the fee arrangements. The system automatically calculates benefits on the basis of the negotiated arrangement or, for non-network providers,

according to Nonparticipating Provider Reimbursement policy such as percent of Medicare, state-mandated rate and percent of Fair Health, etc. and other guidelines.

The claims system employs automated claim review software to identify and adjust for unbundling of services and duplicate claim billings. We also use additional software, known as the Aetna Standard Table to identify diagnoses and procedures designated as inappropriate according to our clinical policy.

]

Detail:

Options:

1. Assignment signature required
2. Network provider automatically assigned
3. Other: [Text]

Attachments:

2.2.7.1.38 Will you accept liability for claim processor negligence? Fraud?

Answer: 1: Yes

Detail: All of our employees are bonded through fidelity (employee dishonesty) bonds from a bonding company licensed to operate in all states.

Options:

1. Yes
2. No

Attachments:

2.2.7.1.39 Can you use an identifier other than the SSN?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

2.2.7.1.40 If an identifier other than SSN is used, is there an additional charge? If so, please indicate on the rate sheet.

Answer: 2: No

Detail: There is no additional charge. Our standard non-SSN identifier will be used.

Options:

1. Yes
2. No

Attachments:

2.2.7.1.41 Explain whether you offer direct deposit of participant benefit reimbursement.

Answer: Direct deposit is not available for member reimbursement under the medical plan. We provide this service for our FSA Administration.

Attachments:

2.2.7.2 UCR Management

2.2.7.2.1 Confirm that your negotiated provider reimbursements are the lower of a discount amount or UCR and members or the plan will not be billed for amounts above UCR?

Answer: Confirmed.

Attachments:

2.2.7.2.2 Describe how you would implement the plan documents UCR requirements, including how you collect claim charge data to assess UCR. Identify any parties with whom you share this data to verify statistical appropriateness or to ensure adequate claim data for Alaska is available for analysis.

Answer: For Reasonable and Customary (R&C) based benefit determinations, we consult an external database. We use the FAIR Health Benchmarks database produced by the non-profit entity FAIR Health.

COLLECT DATA

We obtain information from FAIR Health, Inc. Health plans send FAIR Health copies of claims for services they received from providers. The claims include the date and place of the service, the procedure code and the provider's charge. They combine this information into databases that show how much providers charge for most services in any zip code.

CALCULATION OF PORTION WE PAY

We use the 80th percentile to calculate how much we pay for out-of-network services. Payments at the 80th percentile means 80 percent of the charges in the database are the same or less for that service in the particular zip code. If charges are not enough (less than 9) for service in a particular zip code, we may use derived charges data. This charge is based on the charges of comparable procedures, multiplied by a factor that takes into account the relative complexity of the procedure that was performed.

OUTPATIENT FACILITIES

For outpatient facility services, we determine the reasonable charge level for the service using the MarketScan data licensed from the MedStat division of Thomson Reuters, which is updated annually. This data consists of charges submitted by outpatient facilities to commercial payers and sorted into geographic areas. We typically use the 80th percentile for the applicable geographic area of this database.

INPATIENT FACILITIES

For inpatient facility services, we determine the reasonable charge using the cost report information submitted by hospitals to government agencies. Financial cost to charge ratios specific to each hospital are developed using this information and applied to hospital charges to determine costs for the confinement. If the specific hospital cost information is not available, the state average inpatient hospital costing information is utilized. A state markup, representing the average profit margin for hospitals in the state, is then added to this amount.

Attachments:

2.2.7.2.3 Describe any difficulties you would have in implementing the plan's UCR requirements, including any additional charges that would be required.

Answer: We base payment for services or supplies received from network providers on the contract between us and that provider. Our recognized amount is applied to services or supplies that a member chooses to receive out of network. Payment for other out-of-network services, typically received in emergency rooms or from out-of-network doctors practicing in hospitals that are part of our network, will be based on our payment policies.

Attachments:

2.2.7.2.4 How often do you update your UCR profiles?

Answer: We use the FAIR Health database for our reasonable and customary (R&C) reimbursement amounts. FAIR Health database updates are released twice per year. Aetna's systems are updated following those releases.

Attachments:

2.2.7.2.5 Are UCR allowances applied to all services?

Answer: For out-of-network services, we apply our recognized charge (which, depending on the plan, is based on reasonable and customary charges, Medicare (RBRVS) or Aetna Out-of-Network rates) to a wide range of categories, including:

- Ambulance services
- Certain drugs
- Chiropractic services
- Dental services and oral surgery
- Durable medical equipment
- General anesthesia
- Home health care
- Injections
- Laboratory
- Medical materials and supplies
- Physician office services
- Podiatric services
- Psychiatric and psychological care
- Radiology (diagnostic and therapeutic)
- Surgery
- Surgical assistance
- Therapies

Attachments:

2.2.7.2.6 Can the UCR percentage be changed at the State's request?

Answer: Yes. We can support the State's current 90th UCR percentile rate. The State may opt for the following recognized amount level alternatives: 50th, 60th, 70th, 75th, 80th, 85th, or 95th percentile. These alternate recognized amount level percentiles will not affect automatic system calculation.

Attachments:

2.2.7.2.7 Describe whether you are willing to disclose UCR to plan members upon request.

Answer: Yes. We provide relevant data about specific recognized charges available by CPT code for a particular geographic area upon request from you, a provider or a member.

Attachments:

2.2.7.2.8 Are UCR profiles calculated based on the most recent 6 months of claims charge data? If not, explain what period of time you use to calculate UCR data.

Answer: Our recognized charge is applied based on the date of service. FAIR Health is updated 2 times per year and thus applies to 6-months of claims.

We will work closely with the State to ensure your plans' actual reimbursements for out-of-network services are consistent with your intent. We remain committed to controlling health care costs for our members and customers. We believe we are able to continue to do so using FAIR Health database.

Attachments:

2.2.7.2.9 Do you maintain separate UCR profiles for the State of Alaska?

Answer: Provider fees reflect differing costs of business in various parts of the country. The FAIR Health Benchmark recognizes these regional differences and uses the first 3 digits of the U.S. Postal Service zip code to divide the charges into population areas based on cost-similar and geographically-adjacent areas. There are 491 zip code areas. The locations supported in Alaska are the following 3-digit zips: 995, 996, 997 & 998.

Attachments:

2.2.7.2.10 Do Alaska UCR profiles reflect the differences between the rural and urban areas of the State?

Answer: No. The FAIR Health Benchmark recognizes regional differences and uses the first 3 digits of the U.S. Postal Service zip code to divide the charges into population areas based on cost-similar and geographically-adjacent areas. The locations specific to FAIR Health are the following 3-digit zips: 995, 996, 997 & 998.

Attachments:

2.2.7.2.11 Please describe the geographic areas for which you maintain UCR profiles by zip code, including the geographic factors used in determining groups that determine UCR.

Answer: Our payment is based on the zip code where the service is provided. Provider fees reflect differing costs of business in various parts of the country. The FAIR Health Benchmark recognizes these regional differences and uses the first 3 digits of the U.S. Postal Service zip code to divide the charges into population areas based on cost-similar and geographically-adjacent areas. The locations specific to FAIR Health are the following 3-digit zip codes in AK: 995, 996, 997 & 998.

The FAIR Health database consists of provider charge data collected from more than 150 major contributors, including commercial insurance companies and third-party administrators.

Attachments:

2.2.7.2.12 Is the claims charge data collected to assess UCR for Alaska limited to providers in Alaska?

Answer: Yes. The UCR for Alaska is limited to providers practicing in Alaska in the 3-digit zip codes.

Attachments:

2.2.7.2.13 Describe any recommendation you would have to change the plan's UCR methodology.

Answer: We suggest that UCR be discussed within the overall network fortification discussions we will have with the State. Our goal is to support the State in the handling of the overall Alaska network and modify UCR accordingly to steer utilization to in-network providers.

Attachments:

2.2.7.2.14 Describe how you calculate reimbursement when UCR data is not sufficient in a geographic area.

Answer: Our payment is based on the zip code where the service provided. UCR charges are determined by collecting the claims submitted for each procedure, defined by the procedure code, in a specific geographic area. The highest and lowest charges are ignored and the charge that allows 90% of all claims to be paid in full is set as the UCR charge for that procedure. The geographic area is determined by where the procedure is performed. For example, most procedures in Juneau are based on charges submitted from all of Southeast Alaska.

INSUFFICIENT DATA

Some type of procedures, such as surgery, are based on statewide claims data to ensure sufficient information to establish UCR. If data is insufficient to determine a UCR charge, the claims administrator may consider such items as the following:

- The prevailing charges in a greater geographic area
- The complexity of the service or supply
- The degree of skill needed
- The type or specialty of the provider
- The range of service or supplies provided by a facility

FACILITY SERVICES

Please refer to the following attachment: Inpatient and Outpatient FCR Reasonable Charge Detailed Summary.doc.

Attachments: [Question 2.2.7.2.14 Attachment Inpatient and Outpatient FCR Reasonable Charge Detailed Summary Alaska .doc](#)

2.2.7.2.15 For purposes of appeal, UCR data and underlying calculations may have to be made available to members and the Division upon request. Describe how you would implement this requirement and any difficulties you anticipate in complying with this requirement.

Answer: Upon request, and with appropriate releases, the methodology around how we determine UCR is sent to members and could be sent to the Division.

Attachments:

2.2.7.2.16 List your current UCR for the following CPT-4 codes (at the 90th percentile using the format shown below.

Detail: CONFIDENTIAL - Aetna's negotiated average network discounts are confidential and a competitive differentiator in the industry. Our provider contracts and negotiations include that Aetna will not make this information available in a public format.

Attachments:

2.2.7.3 Explanation of Benefits (EOB)

2.2.7.3.1 Provide a copy of your company's electronic EOB.

Answer: 1: Attached

Detail:

Options:

1. Attached
2. Not Attached

Attachments: [Aetna Medical EOB.pdf](#)

2.2.7.3.2 Describe your process and timing for printing and mailing or otherwise distributing explanations of benefits to members and providers.

Answer: Members who register for Aetna Navigator®, our secure member website, can view the status of a medical, dental or pharmacy or flexible spending account (FSA) claim for themselves or a covered dependent, 24 hours a day, 7 days a week. They can check to see if a claim is completed, in process, or if more information is needed.

In addition, members may download personal claims safely and securely to a computer or disk for use in planning for health care expenses, tax reporting and record keeping.

MEMBERS

We mail member EOBs for the same family, in the same envelope, whenever possible. Any personal health information that is protected under privacy laws is masked or not included on the EOB. In addition, a member can request a privacy restriction if desired by contacting member services.

We mail the EOBs on a consistent day of the week based on the state of residence of the member. We use an every 21-day mailing schedule; however, we may send EOBs out at 7 days or 14 days to comply with any state regulations. EOBs will go out daily, and not age, when there is a member payment or request for additional information from the member. We produce EOBs in Erlanger, KY by an off-site print vendor.

Our claims system will suppress in-network EOB production if benefits are assigned and the member's liability is zero, or if the member's liability consists of a copayment only.

Members can also view EOBs on Aetna Navigator®, our secure member website at www.aetnavigators.com.

PROVIDERS

We age and bulk in a schedule provider EOBs and checks, whether for network or non-network providers. This allows delivery within 24 days of the claim received date. We send the majority on either a weekly or biweekly schedule, and on a consistent day of the week determined by state location of the provider. A provider EOB accompanies each provider draft. The EOB breaks down the payment by patient and gives pertinent information about the payment and non-covered expenses.

Attachments:

2.2.7.3.3 Describe your method to provide the electronic communication of the adjudicated claim to the member.

Answer: Members can elect to suppress paper medical EOBs and receive electronic EOBs only. Members that elect paper suppression will receive an e-mail notification to their e-mail address regarding the EOB transaction.

Members who register for Aetna Navigator can view the status of a medical, dental or pharmacy or flexible spending account (FSA) claim for themselves or a covered dependent, 24 hours a day, 7 days a week. They can check to see if a claim is completed, in process, or if more information is needed.

In addition, members may download personal claims safely and securely to a computer or disk for use in planning for health care expenses, tax reporting and record keeping.

Attachments:

2.2.7.3.4 Identify how your EOB's provide sufficient information to explain claim processing, including display of annual individual and family maximums met, payee – including date paid and check number, and any applicable benefit maximums met by an individual, per claim.

Answer: Our member EOB provides a payment summary of paid benefits by Aetna as well as what the member may owe. There is also a section that gives a breakdown of how a claim was paid. Details include:

- Amount billed
- The member rate
- Any amount that is pending or not payable and any remarks that may explain why
- Amount applied to the deductible
- What the member's plan paid
- Any amount the member may owe

Attachments:

2.2.7.3.5 Does your claims system have the capability to show, on the EOB, the negotiated and actual charge?

Answer: 3: Both

Detail:

Options:

1. Negotiated
2. Actual
3. Both

Attachments:

2.2.7.3.6 Explain your process for ensuring member and provider EOBs correctly reflect the processing and payment of benefits prior to sending them to members and providers. Provide a sample copy of both a provider and a member EOB.

Answer: We audit EOBs internally on a monthly basis for accuracy. There are also routine quality reviews performed by the business team. We handle any findings promptly with an action plan.

We process and communicate the status of claims and payment of benefits as follows:

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

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

- Benefits are assigned and member's liability is zero
- Benefits are assigned and member's liability consists of a copayment only (applicable for pharmacy)
- Incomplete claims - For claims that are missing information (e.g., accident details, diagnosis and other coverage information), claim processors will attempt to contact the provider or employee for the additional information. If we are unable to obtain the missing information, we send the employee an EOB acknowledging receipt of the claim, explaining the reason for the delay and/or requesting the necessary information. We will only pend the expense in question.
- Denied claims - We send employees and providers an EOB explaining the reason for the denial. The EOB describes the appeals process in the event the employee/provider does not agree with our determination.

Attachments: [Aetna Medical EOB.pdf](#)
[Aetna Provider EOB.pdf](#)

2.2.7.3.7 Describe how you ensure the line-by-line EOB remarks correctly reflect the reason for denial or reduction of any line item charge.

Answer: We have a committee, dedicated to overseeing the process of creating or revising EOB remark codes. The committee meets weekly. It has representation from a cross functional population of the various business areas, including legal counsel. Their goal is to ensure they create and approve a remark that is clear, easy to understand and explains the reason for denial or reduction. There are also separate efforts underway to review existing codes to ensure they adhere to the same standards. A monthly EOB audit performed also chooses random selections of EOBs to examine remarks for the same set of standards.

In addition, our claim system supports this process with built-in edits. We have four mechanisms in place to promote coding and EOB accuracy:

- We update all of our systems with all new, termed and revised codes as documented by industry code set owners for set effective dates.
- We provide extensive processor training.
- Our quality audit program identifies coding problem areas and then provides retraining as needed.
- We use Flash Code software to improve the accuracy of our coding for surgical, medical and dental procedures and diagnoses.

Flash Code automatically translates descriptive terminology into the appropriate diagnostic or procedural coding and vice versa. Our processors can access this feature as they process claims. For example, a processor can determine the appropriate code if:

- A code is not on the claim form
- A code is invalid (e.g., mammogram for male patient) or incomplete
- A code conflicts with the written description

This helps to ensure the proper coding of claims, and in turn, the correct EOB remarks are assigned.

Attachments:

2.2.7.3.8 Explain what accumulator fields and service limits are currently available to be printed on your EOBs, for example: year to date out-of-pocket maximum met; spinal disorder maximum met to date, and biennial vision frame benefit, as applicable.

Answer: We standardly display applicable plan deductible and out of pocket limits on member EOBs. We allow specialty benefit displays if requested by the State.

We also offer several methods that CDHP members can use to receive and view EOBs and account balances:

- eNotify is our e-mail notification service. Members can go to a screen within the web portal, and choose which notifications they want to receive as well as when and how they want to receive them. For example, members can select eNotify to:

- Notify them when we receive a claim (Claim Received)
- Notify them when we process a claim (Explanation of Benefits)
- Provide them with updates on their account balance (Balance Reminder)

- Aetna Navigator is our secure member website, available 24 hours a day, seven days a week. Registered subscribers can check the status of a claim, view EOB statements for their HDHP claim activity online at www.aetn navigator.com.

- Paper statements. Members can also choose to receive paper EOB statements through the mail.

- PayFlex® secure website. Enrolled HSA members can also view their HSA account balances and account activity through the PayFlex website. We also provide paper account statements upon request.

Attachments:

2.2.7.3.9 Provide your EOBs Flesch-Kincaid readability score.

Answer: We redesigned the member EOB in October, 2011. The components of the EOB are at a 5th and 8th grade readability level.

Dalbar rated our member EOB against other member EOBs in the industry. It received their communications seal as well as ranked in the top 5. Our EOB rated best in class for clarity.

Attachments:

2.2.7.3.10 Describe how you respond to EOB improvement recommendations made by providers and members.

Answer: We take EOB improvement requests into consideration and measure them for feasibility. If we determine a change is necessary, we use a standard process for implementing code changes.

Attachments:

2.2.7.3.11 Does your claims system have the capability to customize EOB messages? If there is an additional cost, please indicate the cost on the rate sheet.

Answer: Yes. The State has the option to customize EOB messages at no additional charge. Our business and legal departments must approve custom EOB messages and/or message campaigns. We recommend that messages be as short as possible (maximum of 3 lines) and have a recommended stop date (i.e., 3 or 6 months in the future). The 3 lines have a maximum of 140 characters per line including spaces and punctuation. There is no additional charge for customization of the notes section of the EOB.

Attachments:

2.2.7.3.12 Do you have the ability to customize financial and service limit information that appears on your EOBs? If there is an additional cost, please indicate this cost on the rate sheet.

Answer: Yes. The State can customize the label headings on EOBs at no additional charge.

Attachments:

2.2.7.3.13 What percentage of claims are auto-adjudicated for contracted Alaska providers? For non-contracted?

Answer: The auto-adjudication rate for Alaska claims is 79.23%, as of November 2012.

We do not currently track the auto-adjudication rate by contracted versus non-contracted Alaska providers.

Attachments:

2.2.7.3.14 Describe your organization's success in increasing auto adjudication rates for Alaska providers.

Answer: The auto adjudication rate for Alaska providers increased 2.68% from November 2011 to November 2012. We define automatic claim adjudication as benefit determination through the claims system without processor intervention.

We continue to focus on increasing our automatic adjudication rates. To accomplish this, we continually review the types of claims and benefit designs that could increase our automatic adjudication rates. We also work with the State on your plan designs and identify benefits that would impede automatic adjudication.

We also encourage providers to take advantage of our electronic transaction capabilities, which are integral to saving time and increasing auto-adjudication. We educate providers about our services through our website, newsletters and administrative procedure manuals, as well as through our network representatives and EDI support teams, who work directly with providers and their staff.

Attachments:

2.2.7.3.15 Indicate whether monetary adjustments (whether they are provider write-off or member responsibility) are shown on your EOBs so members are not required to manually calculate the adjustment amount themselves.

Answer: Yes. Monetary adjustments are shown on the EOB. A member does not have to make any manual calculations to determine their share of the costs.

Attachments:

2.2.7.3.16 Do you charge clients for issuance of duplicate EOBs/claims?

Answer: No, there is no charge for duplicate EOBs. Members can request additional copies of EOBs anytime by contacting member services. The State's health concierge will be available to assist members with this request. Additionally, members can view and print detailed claim information anytime by using the secure member website.

Attachments:

2.2.7.3.17 Does your claims system have a common database for edits, pricing, production of EOBs and reporting?

Answer: Yes. The data in our claim system is integrated online. This allows our eligibility areas to view claims information as needed. This information is in a read-only format and can only be updated by authorized viewers. Our claim system automatically feeds to reporting so that the State and your account team has the most accurate information possible in support of your plan.

Attachments:

2.2.7.4 Coordination of Benefits (COB)

2.2.7.4.1 Describe your current COB administrative procedures to ensure all claims are paid consistently in the correct order of benefit determination.

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

- During enrollment, many of our customers collect information about other coverage and share it with us.
- During the precertification process, our nurses ask about other coverage.
- Due to the cooperative nature of our relationship with network providers, hospitals and physicians routinely obtain other coverage information and submit it with the claim.
- In addition to the normal “other coverage” questions on our claim form, we ask if any other family members are employed and specific details.
- We send mailers to members with more than one dependent and members who turn 65.
- Registered plan members can provide us with updated COB information at any time using the Requests and Changes feature of Aetna Navigator, our secure member website.
- We exchange data with CMS (Medicare) regarding member eligibility and enrollment information. We exchange data on a quarterly basis. We update our verification files based on this information.

All claims submitted are screened for COB, even those where the member's current eligibility file does not indicate other coverage.

Identifying COB claims is a combination of system-automated processes and claim processor judgment. When other coverage is possible, the claim is pended online, and we send an EOB to the member requesting specific details. If the member does not respond within 45 days of sending the original mailer, we send a follow-up mailer to the member requesting the additional information. If we still do not obtain a response we would pay, pend, or deny the claim based on state regulation.

When other coverage information is obtained, we update the online family eligibility record to indicate primary/secondary/tertiary status. The system automatically presents a COB edit during claim processing when the eligibility file indicates that other coverage is primary. The notice includes details about the other coverage, which family members the other plan covers, the carrier, type of coverage and date of the last update.

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

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

Attachments:

2.2.7.4.2 Define the process, including who in your organization is responsible, for follow-up on possible COB opportunities.

Answer: Our COB approach is to determine the order of benefits for coordination prior to payment. We investigate any other primary benefits before issuing benefits.

Our claim processors handle claims with COB. We train them in both COB identification and investigation. We also identifying COB claims through our system-automated processes.

COB PROCESS

When other coverage is possible, we pend the claim online. We send an EOB to the member requesting specific details. If the member does not respond within 45 days of sending the original mailer, we send a follow-up mailer requesting the additional information. If we still do not obtain a response we pay, pend or deny the claim based on state regulation. If the information we receive does not seem plausible, we contact the provider or member to inquire about other coverage.

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

- Details about the other coverage
- Family members the other plan covers
- Carrier
- Type of coverage (e.g., medical only, medical-dental, etc.)
- Date of the last update

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

Attachments:

2.2.7.4.3 Explain the edits used in your system to identify potential COB cases on a continual basis.

Answer: All claims submitted are screened for COB, even those where the member's current eligibility file does not indicate other coverage. The system supports COB administration in several ways:

- The system has an online edit to warn the processor when accessing any family member's record for claims processing.
- The system notice or COB database includes details about the other coverage, such as:
 - Family members covered
 - Carrier
 - Date last updated
 - Pertinent facts about the other coverage such as effective date
- Depending on your plan or state legislation, the system automatically picks the type of COB administered.

- The system calculates the COB benefits and updates the member's claim records with some processor intervention. (Exception: Manual processing is required if you choose to offer the COB carve-out method.)

- Electronic and paper claims have a field to indicate with a yes or no whether the claim is a result of a work-related condition or injury. Our claims system will present an edit if the answer to this question is yes. In addition, there are diagnosis codes that the claims system will edit to determine if work related. For claims with these diagnosis codes, the system logic will present the processor with an edit indicating “claim may be accident/workmen's comp related”. On a prepayment basis, processors will review these claims which have an indication of potential occupational injuries or conditions. We deny claims identified as work-related. In addition, we add an online notice in the claims system to flag future related claims. If we suspect a work-related injury due to the diagnosis and time of occurrence, we pend the claim and request additional information from the employee, you and/or the provider.

Attachments:

2.2.7.4.4 Describe how you would fulfill the annual validation to identify other health insurance coverage requirement.

Answer: We have an annual validation process (AVP) in addition to a variety of ongoing ways to identify when members have other coverage. Our COB administration starts with the collection and maintenance of accurate information about other coverage. We exchange data with CMS (Medicare) regarding member eligibility and enrollment information. We exchange data on a quarterly basis. We update our verification files based on this information.

In addition, we have a variety of methods for gathering COB information on an annual and ongoing basis, including:

- During enrollment, the State may wish to collect information about other coverage and share it with us.
- During the precertification process, our nurses ask about other coverage.
- Due to the cooperative nature of our relationship with network providers, hospitals and physicians routinely obtain other coverage information and submit it with the claim.
- In addition to the normal “other coverage” questions on our claim form, we ask if any other family members are employed and specific details.
- We send mailers to members with more than one dependent and members who turn 65.
- Registered plan members can provide us with updated COB information at any time using the Requests and Changes feature of Aetna Navigator, our secure member website, at www.aetnanavigator.com.
- COB screening: We screen all claims for COB, even those where the member's current eligibility file does not indicate other coverage.

Attachments:

2.2.7.4.5 Confirm that you will coordinate COB information electronically with other vendors such as the pharmacy benefit manager, dental network, and health management provider, for their use in coordinating benefits.

Answer: Confirmed. We are a one stop shop for medical, pharmacy, dental and health management services.

Attachments:

2.2.7.4.6 Confirm whether you are able to handle internal coordination when a claimant is covered under more than one State benefit plan such as being covered as the member and also as a dependent.

Answer: Confirmed. We add a special handling indicator and notice on the member's file to indicate internal COB applies. We have detailed workflows for the processors on handling of these claims.

Attachments:

2.2.7.4.7 Describe how you will obtain coordination of benefits information to determine when case management might not be appropriate, such as when the plan is secondary to Medicare or other plans.

Answer: From a claim perspective, we follow the primary plan determination of medical necessity for length of stay. The information is obtained from the primary plan's explanation of benefits.

Our case managers obtain coordination of benefits information through the screening process. Screening identifies members who are appropriate for the program through a review of the member's current eligibility status and benefit plan, including a review of COB information. We close the case when the case manager verifies other insurance is primary and our plan is not at financial risk, and there is no obligation with the State to perform case management for the member.

Attachments:

2.2.7.4.8 Describe your use of computer edit checks or triggers to initiate COB.

Answer: Our claims system includes edits that identify when a member is eligible for other coverage, such as age limit edits for Medicare, to trigger COB. In addition, our claim system edits consider the following as potential indicators of other coverage to initiate COB:

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

Attachments:

2.2.7.4.9 Is COB history stored online?

Answer: Yes. Our eligibility file provides a field that allows documentation of a member's other coverage including:

- Name of the other carrier
- Policy number
- Effective date of the other coverage
- Order of benefit determination.

Attachments:

2.2.7.4.10 Medicare COB:

- Explain whether or not you have an electronic system currently in place to allow Medicare Part B claims filed with the Medicare carrier to automatically coordinate (crossover) with the retiree plans so that retirees are not required to submit secondary Part B claims to this plan.
- Describe your Medicare COB program; note whether you accept information from all Medicare Part B carriers or list those carriers with whom you have contracts.

Answer: Yes. We have a Medicare Direct option. Effective February 2012, we accept both Parts A and B Medicare Direct claims. Under Medicare Direct, the Medicare intermediary submits claims directly to Aetna electronically. The claims show the original submitted expense as well as the Medicare write-off, Medicare payment and member responsibility. The electronic claim submission populates the claim to the member's file. Many of the Medicare Direct claims auto-adjudicate.

Attachments:

2.2.7.5 Health Flexible Spending Account (FSA)

2.2.7.5.1 How many clients utilize your Health FSA services?

	Year or Period	Number of Clients	Number of Participants
Health Flexible Spending Accounts	2012	3,235	1,078,401

Detail:

Attachments:

2.2.7.5.2 Explain your claim adjudication procedures regarding Health FSA claims, including any specific requirements that must be met before claims are paid.

Answer: Aetna/PayFlex:

As a recognized leader in account administration, PayFlex Systems USA, Inc. was recently acquired by Aetna to offer the PayFlex Spending Account and COBRA administration solutions to their clients as well as continuing to provide on a stand-alone basis as well. The transaction was completed on October 3, 2011, making PayFlex a wholly owned subsidiary of Aetna and operating as an independent subsidiary.

Claim Submission:

Participants may initiate claims, e.g., healthcare, dependent care, etc., using any of the following options: participant web portal, mobile application, fax, or paper/mail. The claim must be accompanied by a receipt. Receipts must include enough information to reliably verify that the expense is eligible, such as a medical EOB or a detailed cash register receipt, depending on the type of transaction.

Adjudication Procedures:

Claims are adjudicated by trained Claims Examiners. Incoming claims are electronically queued to Claims Examiners for processing. Load balancing ensures that claims are distributed appropriately throughout the Unit.

Claims Examiners review the incoming claim and documentation and determine whether it meets IRS and our requirements for payment. For faxed and scanned paper claims, the Claims Examiner must accurately enter the necessary information into the system. This includes the date of service, amount and expense type. For electronically submitted claims, this information is verified.

The State's plan design and accompanying account template in CBAS determine the specific expense

types that are applicable for each account.

The Claims Examiner must be proficient in claims processing rules to know which expenses do not qualify and to assign the appropriate denial code, e.g., teeth whitening (not a covered expense); vitamins (letter of medical necessity is required), receipt missing, need itemized receipt or EOB.

From here, our Complete Benefits Administration System (CBAS) does the rest. CBAS looks at the Date of Service to determine if the expense qualifies, it determines which account the claims should be applied, checks for duplicates, determines if adequate funding is available, etc. CBAS then systemically applies any remaining client-specific adjudication and account stacking rules. If a claim is denied, an EOB is generated and delivered to the participant via Email, Web, or Text Message, based on the participant's preferences as established within the participant portal via "Manage Notifications". If the claim is approved, it is released for payment and an EOB is generated.

Autopay/Streamlining:

We also have the ability to support autopay/streamlining options. We are equipped to internally feed claim information to our FSA platform for automatic payment of claims. We also have established interfaces with a number of medical and dental plans through which claims are provided for Healthcare FSA participants. We work with each client to identify specific carrier requirements and to establish additional relationships as required. Once the required relationships are in place, we send the carrier(s) an eligibility file (if required) to identify the client's FSA participants. Once the carrier processes the eligibility file we are ready to receive claims.

Debit Card solution:

The PayFlex Debit card can help automate the process of paying for eligible expenses. It allows flex plan participants to directly pay for eligible expenses at the point of service; thereby eliminating the need to file claims for manual reimbursement. The participant simply presents the card at the point of sale, just like any other debit or credit card. The transaction is submitted for authorization and the result is returned in real time to the point of care. Through the authorization process, funds are "reserved" from the appropriate fund balance or balances and the participant receives and signs a receipt. Participants can use the card at qualifying merchant locations wherever MasterCard is accepted.

Attachments:

2.2.7.5.3 Describe the steps that will be taken to ensure claims are valid.

Answer: Claims are adjudicated by trained Claims Examiners. Claims Examiners review the incoming claim and documentation and determine whether it meets IRS and our requirements for payment.

Participant eligibility is automatically verified by our Complete Benefit Administration System (CBAS) as part of the claims adjudication process. CBAS looks at the Date of Service to determine if the expense qualifies, it determines which account the claims should be applied, checks for duplicates, determines if adequate funding is available, etc. CBAS then systemically applies any remaining client-specific adjudication and account stacking rules. Participant status, effective date, and claim date of service are verified as part of this process. By automating checks such as these we are able to ensure validity, efficiency and accuracy of its claim processing.

Attachments:

2.2.7.5.4 Describe your procedure for notifying participants of denied claims.

Answer: We generate an Explanation of Benefits (EOB) with every adjudicated claim. In the event a claim cannot be approved, the EOB details the reason for denial. For partially denied claims, we reimburse the eligible amounts and report both the eligible and denied portions on the EOB. EOBs are either mailed to the participant's address on file or e-mailed. Participants may elect Email, Web or Text Message delivery of correspondence through our "Manage Notifications" on the participant web portal. All EOBs are archived in PDF format on the participant web portal so that they are easily accessible.

Attachments:

2.2.7.5.5 Explain how you coordinate Health FSA claims with regular medical/dental/Rx/vision claims automatically. If not automated, describe the process you follow to streamline claims and process under the Health FSA.

Answer: Through the "crossover" or "autopay" process, we are equipped to internally feed medical/dental/Rx/vision claim information to our FSA platform for automatic payment of claims. This information is processed by identifying amounts to be reimbursed and providing reimbursement to the participant via paper check, direct deposit or file to The State for application to the participant's pay check. This approach to claims processing reduces the need for participants to complete and submit claims for carrier-related expenses. (Please note that this feature is not available when the debit card is in place.) All claim information is processed within 24 hours of receipt. Once the claim feed information is processed, the reimbursements (checks and direct deposits) will be issued according to The State's reimbursement funding schedule.

Attachments:

2.2.7.5.6 Explain how you can receive claim data from other vendors in order to process through the Health FSA.

Answer: We have established interfaces with a number of medical and dental plans through which claim data is provided for Healthcare FSA participants. We will work with The State to identify specific carrier requirements and to establish additional relationships as required. Once the required relationships are in place, we send the carrier(s) an eligibility file (if required) to identify the client's FSA participants. Once the carrier processes the eligibility file we are ready to receive claim data.

Attachments:

2.2.7.5.7 Indicate how often and in what formats you will provide participant account activity statements.

Answer: All account information regarding account status, claim history, payment information, direct deposit account information, viewing participant statements / EOBs and ability to submit a claim is available 24 X 7 in real time through the employee facing web portal. In addition to the web portal, current account information is available to participants via the Call Center, IVR and Mobile Application. Please see a complete listing of all on-line capabilities following this response in Question # 2.2.7.5.8.

As an optional service, we support the production of participant statements. Statements depict debit card and manual claims activity during the current reporting period. Statements are typically generated on a quarterly basis and may be branded by the client. Participant statements are produced the next business day after the end of each quarter. Statements are available for delivery by mail and electronically (e-mail directs participant to the web portal to access the statement) and are also archived in PDF format on the employee Web portal. An additional fee of \$0.20 pppm is assessed for the generation of quarterly employee statements.

Note that a letter is mailed to participants who have signed up for eNotify™ and currently have an

invalid email address within our Participant Portal. All future correspondence will be mailed to the participant until a valid email address is provided. Statements can also be supported at other intervals defined by The State. The specific fee assessed is dependent upon statement frequency.

Attachments:

2.2.7.5.8 Describe electronic Health FSA activity services available to members.

Answer: Participants can access their account information through an employee-facing web portal at www.aetna.com, where they can access Aetna Navigator. Current access includes:

- My Account - Participants can view account status, claim history, view payment information, manage direct deposit accounts, and even request additional debit cards.
- Claims Submission - Express Claims enables participants to initiate manual claims online, including the ability to upload scanned receipts in PDF format. This eliminates the need to mail or fax claims for adjudication.
- View Documents - View and print correspondence, statements and EOBs generated by the platform.
- My Settings - Maintain web portal login information and sign up for eNotify, which enables participants to select e-mail notification. Note that a letter is mailed to participants who have signed up for eNotify™ and currently have an invalid email address within our Participant Portal. All future correspondence will be mailed to the participant until a valid email address is provided.
- View Eligible/Non-eligible Expenses - A comprehensive list of eligible and non-eligible expenses including over-the-counter items.
- Frequently Asked Questions - Detailed Q & A regarding spending accounts to answer common participant questions.
- Forms and Publications - Access to commonly used forms and links to relevant IRS publications.
- Savings Calculator - Allows participants to calculate their potential savings.
- Tax Credit Wizard - Helps participants determine if they qualify for a Dependent Care Reimbursement Account and how much to contribute.
- Spending Account Buying Center - Provides participants with a convenient way to make qualified purchases through partner vendors: drugstore.com, DrugSourceInc.com, TruVision.com and TruHearing.com.
- Upcoming Payments - any claim payments projected to occur within seven days is displayed on the Participant Portal via the Accounts page. Participants should still verify receipt of payment with their bank before withdrawing funds.
- Unsubstantiated Debit Card Transactions - unsubstantiated debit card transactions are displayed on the Participant Portal. Participants can view transactions and proactively submit documentation online.

Additionally, our mobile application enables participants to submit claims and substantiate debit card transactions using their smart phones - including the ability to upload pictures of receipts taken with their cell phone camera.

Attachments:

2.2.7.5.9 Describe in detail your capability to offer debit cards or a similar product for participants to withdraw funds from their Health FSA account. Indicate any additional costs on the rate sheet.

Answer: Aetna's FSA Administrator, PayFlex, was an early adopter of debit card technology, first offering a debit card in 1999. PayFlex was instrumental in developing many of the functionalities now featured by many card providers, as we often piloted new capabilities. As a result, we now have more debit card experience than any other administrator. Our debit card provider is First Data Corporation, the world's largest card processor. By integrating directly with a card processor we are able to more effectively manage the debit card process, provide more flexible debit card solutions through our own proprietary and branded card platform, and ensure accuracy and efficiency through real-time

connectivity. Thus, we are able to maintain control of all facets of debit card administration.

The Debit card is a MasterCard. Initially we issue one card per participant; however additional cards can be requested at any time via the participant web portal or by phoning the Customer Service call center.

The Debit card can help automate the process of paying for eligible expenses. It allows flex plan participants to directly pay for eligible expenses at the point of service; thereby eliminating the need to file claims for manual reimbursement. The participant simply presents the card at the point of sale, just like any other debit or credit card. The transaction is submitted for authorization and the result is returned in real time to the point of care. Through the authorization process, funds are “reserved” from the appropriate fund balance or balances and the participant receives and signs a receipt.

Participants can use the card at qualifying merchant locations wherever MasterCard is accepted. Debit card restrictions are in place to ensure that the card is not used for ineligible items. Participants can use the card at merchant locations such as physician and dental offices, pharmacies and vision service locations (identified by specific Merchant Category Codes). The card may also be used at pharmacy, grocery and discount merchants who have installed an Inventory Information Approval System (IIAS). The role of an IIAS is to separate the participant's shopping cart, identifying IRS-eligible items, and enabling the card to be used for only those items. The participant is asked to provide an alternative form of payment for non-qualifying items. These transactions are considered auto substantiated, and no further participant action is required. The IRS mandated IIAS for grocery and discount stores as of January 1, 2008 and for pharmacies as of June 30, 2009. Transactions initiated at non-qualifying merchants are automatically declined at the point of sale.

The Debit card's auto-substantiation feature reduces the need for participants to submit receipts to verify purchases. This makes the debit card solution both efficient and attractive to employers and to participants. We use several methods of substantiation for debit card transactions. Transactions are first substantiated electronically if possible using one of the following methods.

- PBM/Carrier File Matching
- Copay Matching
- Recurring Transaction Matching
- IIAS

Through these processes we have been able to achieve a debit card auto-substantiation rate of 90%. Please see accompanying FSA Proposal for any additional fees associated with the use of the Debit card.

Attachments:

2.2.7.5.10 Do you have a standard minimum dollar threshold that must be reached before claims are reimbursed?

	Health Care
No (Check)	No.
Yes - Indicate Threshold	N/A.
Can Client Change Threshold? (Enter Yes or No)	N/A.

Detail: We do not have a standard minimum dollar threshold that must be reached before claims are reimbursed.

Attachments:

2.2.7.5.11 Provide copies of the following:

1. Reimbursement request form;
2. Explanation of Payment form;
3. Health care balance summary report; and
4. Participant activity statements.

Answer: 1: Attached

Detail: Please see attached Aetna/PayFlex requested documents.

Options:

1. Attached
2. Not Attached

Attachments: [2.2.7.5.11 \(1\)FSA Claim Form - final.pdf](#)
[2.2.7.5.11 \(2\) PayFlex EOB .pdf](#)
[2.2.7.5.11 \(3\)PayFlex Employer Reporting Guide .pdf](#)
[2.2.7.5.11 \(4\) Account Statement.docx](#)

2.2.7.6 Dependent Care Assistance Program (DCAP)

2.2.7.6.1 How many clients utilize your Dependent Care Assistance Plan (DCAP) services?

	Year or Period	Number of Clients	Number of Participants
Dependent Care Spending Accounts	2012	2,902	152,348

Detail:

Attachments:

2.2.7.6.2 Explain your claim adjudication procedures regarding DCAP claims, including any specific requirements that must be met before claims are paid.

Answer: Dependent Care Requirements:

Dependent Care expenses must be for a qualifying individual, defined as a dependent of the participant or his/her spouse who is either younger than age 13 or who physically or mentally incapable of self-care and for whom you can claim an exemption. The expenses must be incurred to enable the participant to be gainfully employed and must be for services incurred, not for services yet to be provided.

Dependent care services must be provided by an eligible provider of child care. This includes:

- A licensed child-care facility that complies with applicable state and local laws
- Any individual who is not a tax dependent of the participant
- A child of the participant who is 19 or older

The provider must have a Social Security Number or a Tax ID and the participant must include this information on the Form 2441 that is submitted with his/her annual individual tax return. However, when the participant files a claim the Social Security Number/Tax ID will not be required.

The provider must also identify dependent care payments as income on his/her tax return. The IRS can then match the participant's Form 2441 to the provider's tax filing to verify that all amounts have been properly reported.

Required Documentation:

Acceptable documentation consists of one of the following:

*A completed dependent day care claim form with dates of service, name of dependent, amount requested and day care provider's name and signature. The claim form can be used as an itemized statement if the day care provider provides this information and signs the form where indicated.

*A completed dependent day care claim form and an itemized statement from the day care provider. The itemized statement must include the provider's name, the dependents' names, as well as the specific dates day care services were provided and the cost of care.

Participants may initiate dependent care claims following the same procedures and form as required for Health Care claims.

Claims are adjudicated by trained Claims Examiners. Incoming claims are electronically queued to Claims Examiners for processing. Load balancing ensures that claims are distributed appropriately throughout the Unit.

Claims Examiners review the incoming claim and documentation and determine whether it meets IRS and our requirements for payment. For faxed and scanned paper claims, the Claims Examiner must accurately enter the necessary information into the system. This includes the date of service, amount and expense type. For electronically submitted claims, this information is verified.

The State's plan design and accompanying account template in CBAS determine the specific expense types that are applicable for each account.

The Claims Examiner must be proficient in claims processing rules to know which expenses do not qualify and to assign the appropriate denial code, e.g., teeth whitening (not a covered expense); vitamins (letter of medical necessity is required), receipt missing, need itemized receipt or EOB.

From here, our Complete Benefits Administration System (CBAS) does the rest. CBAS looks at the Date of Service to determine if the expense qualifies, it determines which account the claims should be applied, checks for duplicates, determines if adequate funding is available, etc. CBAS then systemically applies any remaining client-specific adjudication and account stacking rules. If a claim is denied, an EOB is generated and delivered to the participant via Email, Web, or Text Message, based on the participant's preferences as established within the participant portal via "Manage Notifications". If the claim is approved, it is released for payment and an EOB is generated.

Attachments:

2.2.7.6.3 Describe the steps that will be taken to ensure claims are valid.

Answer: Claims are adjudicated by trained Claims Examiners. Claims Examiners review the incoming claim and documentation and determine whether it meets IRS and our requirements for payment.

Participant eligibility is automatically verified by our Complete Benefit Administration System (CBAS) as part of the claims adjudication process. CBAS looks at the Date of Service to determine if the expense qualifies, it determines which account the claims should be applied, checks for duplicates, determines if adequate funding is available, etc. CBAS then systemically applies any remaining client-specific adjudication and account stacking rules. Participant status, effective date, and claim date of service are verified as part of this process. By automating checks such as these PayFlex is able to ensure validity, efficiency and accuracy of its claim processing.

Attachments:

2.2.7.6.4 Describe your procedure for notifying participants of denied claims.

Answer: We generate an Explanation of Benefits (EOB) with every adjudicated claim. In the event a claim cannot be approved, the EOB details the reason for denial. For partially denied claims, we reimburse the eligible amounts and report both the eligible and denied portions on the EOB. EOBs are either mailed to the participant's address on file or e-mailed. Participants may elect Email, Web or Text Message delivery of correspondence through our "Manage Notifications" on the participant web portal. All EOBs are archived in PDF format on the participant web portal so that they are easily accessible.

Attachments:

2.2.7.6.5 Indicate how often and in what formats you will provide participant account activity statements.

Answer: All account information regarding account status, claim history, payment information, direct deposit account information, viewing participant statements / EOBs and ability to submit a claim is available 24 X 7 in real time through the employee facing web portal. In addition to the web portal, current account information is available to participants via the Call Center, IVR and Mobile Application.

As an optional service, we support the production of participant statements. Statements depict debit card and manual claims activity during the current reporting period. Statements are typically generated on a quarterly basis and may be branded by the State. Participant statements are produced the next business day after the end of each quarter. Statements are available for delivery by mail and electronically (e-mail directs participant to the web portal to access the statement) and are also archived in PDF format on the employee Web portal. An additional fee of \$0.20 ppm is assessed for the generation of quarterly employee statements.

Note that a letter is mailed to participants who have signed up for eNotify™ and currently have an invalid email address within our Participant Portal. All future correspondence will be mailed to the participant until a valid email address is provided. Statements can also be supported at other intervals defined by the State. The specific fee assessed is dependent upon statement frequency.

Attachments:

2.2.7.6.6 Provide copies of the following:

1. Reimbursement request form;
2. Explanation of Payment form;
3. DCAP balance summary report; and
4. Participant activity statements.

Answer: 1: Attached

Detail: FSA Healthcare and Dependent Care products utilize the same documents with the exception of it being in either reference to Healthcare or Dependent Care activity.

Options:

1. Attached
2. Not Attached

Attachments: [2.2.7.5.11 \(1\)FSA Claim Form - final.pdf](#)
[2.2.7.5.11 \(3\)PayFlex Employer Reporting Guide .pdf](#)

[2.2.7.5.11 \(2\) PayFlex EOB .pdf](#)
[2.2.7.5.11 \(4\) Account Statement.docx](#)

2.2.7.6.7 What is your schedule for DCAP reimbursements?

Answer: Reimbursement to the participant is based on the reimbursement schedule defined by The State and can be as often as daily. We pride ourselves on our claim turnaround times. All claims are processed within 48 hours of receipt. Healthcare and Dependent Care Participants may elect to receive reimbursement via paper checks or direct deposit to a designated savings or checking account. Daily claim processing promises a 72-hour turnaround time on claim reimbursements when direct deposit is used.

Attachments:

2.2.7.6.8 Can you administer a reimbursement schedule designed to coincide with the client's payroll schedule to ensure that DCAP contributions are taken from participants pay prior to reimbursements to providers?

Answer: 1: Yes

Detail: The Dependent Care Reimbursement Schedule cannot be different than the Health Care Reimbursement Schedule. So, if the State elects the reimbursement schedule referenced above for Dependent Care claims, it will have to be set up that way for Health Care reimbursement schedule as well.

Options:

1. Yes
2. No

Attachments:

2.2.7.6.9 What is your standard mode of claim reimbursement?

Answer: We support both paper reimbursement checks, (mailed directly to the participant's address on file) and direct deposit to participants' designated bank accounts.

Attachments:

2.2.7.6.10 Can you reimburse via direct-deposit?

Answer: Yes.

Attachments:

2.2.7.6.11 Do you have a standard minimum dollar threshold that must be reached before claims are reimbursed?

	Dependent Care
No (Check)	No.
Yes - Indicate Threshold	N/A.
Can Client Change Threshold? (Enter Yes or No)	N/A.
Cost Impact to Change Threshold	N/A.

Detail:

Attachments:

2.2.8 Quality Control (use tables provided in Attachment G1)

2.2.8.1 Please explain in detail how you will evaluate and report to the State your performance under the Contract. Specifically, identify and describe, by function, how each aspect of the work set forth in Section 1.04 of the RFP instructions relative to the Medical Claims Administration and Managed Network component will be evaluated for effectiveness and efficiency. For each function, please provide the following evaluative information:

- A detailed description of each performance standard you will utilize to evaluate each functional component for effectiveness and efficiency.
- The benchmark measurement for each identified performance standard for each functional component.
- The frequency of reporting to the State your evaluation of each identified performance standard for each functional component based on the standards and benchmarks you utilized to determine effectiveness and efficiency.
- Which standards you are willing to subject to penalty for failure to meet.
- Whether the evaluation of each standard will be conducted by your organization or will be conducted by an independent external organization.

Answer: Aetna will measure success by client and member satisfaction, return on investment and other aspects such as timeliness and responsiveness. Below is a complete list of the Medical Implementation and Performance Guarantees that Aetna is offering State of AK. We have also attached the Performance Guarantees as a word document.

General Performance Guarantee Provisions

Aetna Life Insurance Company (ALIC) provides health benefits administration and other services for the self-funded Aetna Preferred Provider Organization (PPO) Medical and Behavioral Health plans. The services set forth in this document will be provided by ALIC (hereinafter "Aetna").

Performance Objectives

Aetna believes that measuring the activities described below are important indicators of how well it services State of Alaska. Aetna is confident that the Plan Administration, Claim Administration and Member Services provided to State of Alaska will meet their high standards of performance. To reinforce State of Alaska's confidence in Aetna's ability to administer their program, Aetna is offering guarantees in the following areas:

Performance Category

Minimum Standard Proposed Penalty

Implementation

- Group Structure, Benefit Plan Design Entered and Tested in System 30 days prior to implementation date 0.5%
- Eligibility Load 30 days prior to start date 0.5%
- Customer Service During open Enrollment Established prior to open enrollment 0.5%
- Client-specific Customer Service during Open Enrollment Able to answer client specific question from 1st day of Open Enrollment 0.5%
- Customer Service on Effective/"Go-Live" Date Fully functioning toll-free line by date to be determined 0.5%
- Member Call Tracking Summary of call by category type available within 1 week of established timeframes 0.5%
- Member Information Package 100% of member packages sent by date to be determined 0.5%
- Member Information Package for New Hires 100% of member packages for new hires sent within 10

days 0.5%

- Communications Implementation Manager to provide weekly updates 0.5%
- Turnaround Time on Resolution of Implementation Issues 5 business days for resolution of implementation issues 0.5%
- Contract Draft Timeliness Respond to client requests within 10 business days from when sent 0.5%
- Implementation Average evaluation score of 3.0 or higher 1.0%

Account Management

- Management Reports Paid claim reports within 45 days, Incurred claim reports within 90 days 0.5%
- Data Distribution Timeliness Data submission sent according to timeframes to be determined 0.5%
- Reporting/Data Distribution Accuracy All reports and data submission will be accurate 0.5%
- Payment from Reconciliation of Claims Pricing Guarantees Within 5 business days 0.5%
- Client/Consultant Responsiveness 90% within 1 business day, 100% within 3 business days 0.5%
- Issue Log 98% 0.5%
- Quarterly Meetings Meetings occur at least quarterly 0.5%
- Overall Account Management Average evaluation score of 3.0 or higher 1.0%

Plan Sponsor Services

- Eligibility Updates 99% within 2 business days 100% within 4 business days 0.5%
- Eligibility Updates - New Group Additions 99% within 2 business days 0.5%

Claim Administration

- Turnaround Time 90.0% of claims processed within 14 calendar days 1.0%
- Financial Accuracy 99.0% 1.0%
- Claim Processing Accuracy 97.0% 0.5%
- Claim system Availability 99.0% 0.5%

Member Satisfaction Positive response rate of 87% or higher 1.0%

Member Services

- ID Card Production & Distribution - Ongoing ID cards mailed within 7 business days of receiving eligibility file 0.5%
- Average Speed of Answer 30 Seconds 1.0%
- Abandonment Rate 2.5% 0.5%
- First Call Resolution 93.0% 0.5%
- E-mail Response Turnaround Time 85% within 24 hours and 95% within 4 calendar days 0.5%
- Telephone Inquiry Response Turnaround Time 85% within 10 business days and 90% within 28 business days 0.5%
- Member Call Tracking Summary of calls by category analyzed weekly 0.5%

Total 20.0%

Guarantee Period

The guarantees described herein will be effective for a period of 12 months and will run from July 1, 2013 through June 30, 2014 (hereinafter “guarantee period”).

The performance guarantees shown below will apply to the self-funded Aetna Preferred Provider Organization (PPO) Medical and Behavioral Health plans administered under the Administrative Services Only Agreement (“Services Agreement”). These guarantees do not apply to non-Aetna benefits. In addition, our network guarantees do not apply to non-Aetna networks.

If Aetna processes runoff claims upon termination of the Services Agreement, performance guarantees of Turnaround Time, Financial Accuracy, and/or Claim Processing Accuracy will not apply to such claims. Furthermore, performance guarantees described herein will not apply to the guarantee period claims if termination is prior to the end of the guarantee period. In addition, performance guarantees

will not be reconciled and payouts will not occur until the full guarantee period administrative service fees have been paid. Failure to remit applicable service fees within the grace period may invalidate certain guarantees listed below

Aggregate Maximum

The maximum penalty adjustment will be equal to 20.0% of actual base service fees, excluding program fees at risk in the Medical Management Guarantees. In no event will fees be adjusted by more than 25.0% due to results of this guarantee and all other guarantees combined (not including the Performance Based Incentive amounts used to offset the fees.)

Administrative Service Fees at risk exclude commissions and charges collected outside of the monthly billed administrative services fees.

Termination Provisions

Termination of the guarantee obligations shall become effective upon written notice by Aetna in the event of the occurrence of (i), (ii) or (iii) below:

- i. a material change in the plan initiated by State of Alaska or by legislative action that impacts the claim adjudication process, member service functions or network management;
- ii. failure of State of Alaska to meet its obligations to remit administrative service fees or fund the State of Alaska bank account as stipulated in the General Conditions Addendum of the Services Agreement;
- iii. failure of State of Alaska to meet their administrative responsibilities (e.g., a submission of incorrect or incomplete eligibility information).

No guarantees shall apply for a guarantee period during which the Services Agreement is terminated by State of Alaska or by Aetna.

Refund Process

At the end of each guarantee period, Aetna will compile its Performance Guarantees results. If necessary, Aetna will provide a "lump sum" refund for any penalties incurred by Aetna.

Measurement Criteria

Aetna's internal quality results for the unit(s) processing State of Alaska's claims will be used to determine guarantee compliance for any Financial Accuracy or Claim Processing Accuracy Guarantees. The results for these guarantees will be calculated using industry accepted stratified audit methodologies.

Implementation

Group Structure/Benefit Plan Design

Guarantee: The initial group structure and benefit plan design will be entered and tested in Aetna's system 35 days prior to the implementation date. This guarantee is dependent on receiving final sign-

off from State of Alaska on the Benefit Plan Design Summary documents by 77 days prior to the implementation date. Aetna will look to revisit these timelines should the state retain a 7/1/2103 implementation date.

Penalty and Measurement Criteria: Aetna will reduce its compensation by 0.5% of the guarantee period administrative service fees if Aetna fails to enter and test the group structure and benefit plan design 30 days prior to the implementation date. Aetna's implementation team records will be used to determine whether the initial group structure and plan design were entered and tested within the specified time frame.

Eligibility Load

Guarantee: Participant eligibility will be loaded 30 days prior to the start date. This guarantee is dependent upon receiving a test file 45 days prior to the start date with all corrections, if necessary, completed and re-tested by 40 days prior to the start date with the final eligibility file to be received from Client 35 days prior to the start date. In addition, State of Alaska sign-off on the Single Source Document must be completed 90 days prior to the effective date.

Penalty and Measurement Criteria: Aetna will reduce its compensation by 0.5% of the guarantee period administrative service fees if Aetna fails to have eligibility loaded 30 days prior to the implementation date. Aetna's implementation team records will be used to determine whether participant eligibility was loaded within the specified time frame.

Customer Service during Open Enrollment

Guarantee: A dedicated toll-free telephone number for member assistance will be established before open enrollment begins and maintained throughout open enrollment.

Penalty and Measurement Criteria: Aetna will reduce its compensation by 0.5% of the guarantee period administrative service fees if Aetna fails to have a toll free number established prior to open enrollment and maintained throughout the open enrollment period.

Client-Specific Customer Service during Open Enrollment

Guarantee: Customer Service will be available to answer client specific benefit questions during open enrollment.

Penalty and Measurement Criteria: Aetna will reduce its compensation by 0.5% of the guarantee period administrative service fees if Aetna's customer service team for State of Alaska is unable to answer group specific benefit questions during open enrollment. State of Alaska will communicate any dissatisfaction with the customer service team to the Account Executive in the Seattle, Washington field office.

Customer Service on Effective/"Go Live" Date

Guarantee: A toll free line will be set-up and fully functioning by the date established in the implementation timeline.

Penalty and Measurement Criteria: Aetna will reduce its compensation by 0.5% of the guarantee

period administrative service fees if Aetna's toll free line for State of Alaska is not fully functioning by the date established in the implementation timeline.

Member Call Tracking

Guarantee: Using standard reports available using Aetna Strategic Desktop, Aetna will provide a summary of the number of member service calls by call category. This report will be provided for both the first week after the effective date, and the first month after the effective date. The reports will be available no later than 1 week after the specified timeframes.

Penalty and Measurement Criteria: Aetna will reduce its compensation by 0.5% of the guarantee period administrative service fees if Aetna fails to provide the member call tracking reports within the specified timeframes.

Member Information Package - Initial

Guarantee: 100% of the member information packages will be sent by the date established in the implementation timeline.

Penalty and Measurement Criteria: Aetna will reduce its compensation by 0.5% of the guarantee period administrative service fees if Aetna fails to provide 100% of the information packages by the date established in the implementation timeline. State of Alaska will communicate with the Account Executive in the Seattle, Washington field office if all member information packages are not received in the specified timeframe.

Member Information Package - New Hires

Guarantee: 100% of the member information packages for new hires will be sent within ten days of receipt of eligibility, unless a different date is agreed upon by State of Alaska and Aetna.

Penalty and Measurement Criteria: Aetna will reduce its compensation by 0.5% of the guarantee period administrative service fees if Aetna fails to provide 100% of the information packages within ten days of receipt of eligibility. State of Alaska will communicate with the Account Executive in the Seattle, Washington field office if member information packages for new hires are not received in the specified timeframe.

Communications

Guarantee: Aetna's Implementation Manager will provide regular weekly updates to State of Alaska tracking the status of implementation.

Penalty and Measurement Criteria: Aetna will reduce its compensation by 0.5% of the guarantee period administrative service fees if Aetna's Implementation Manager fails to provide weekly updates to State of Alaska. Aetna's implementation team records will be used to determine whether weekly updates were provided.

Turnaround Time - Resolution of Implementation Issues

Guarantee: Aetna will resolve any implementation issues within 5 business days of notification of an issue by the State of Alaska.

Penalty and Measurement Criteria: Aetna will reduce its compensation by 0.5% of the guarantee period administrative service fees if Aetna's implementation team fails to resolve implementation issues within five business days of being notified of an issue. State of Alaska will communicate with the Account Executive in the Seattle, Washington field office if implementation issues are not resolved within the specified timeframe.

Contract Draft Timeliness

Guarantee: Aetna will respond to requests from State of Alaska or its designee regarding the contract draft with an acknowledgement within 10 business days from when requests are sent. State of Alaska recognizes that more than 10 business days may be needed to resolve a request.

Penalty and Measurement Criteria: Aetna will reduce its compensation by 0.5% of the guarantee period administrative service fees if Aetna's implementation team fails to respond to a request regarding the contract draft with an acknowledgement within 10 business days of receipt. State of Alaska will communicate any dissatisfaction with the customer service team to the Account Executive in the Seattle, Washington field office.

Implementation Satisfaction Guarantee

Guarantee: Aetna developed and utilizes the implementation team concept to carefully coordinate all aspects of the implementation. An Implementation Manager will be assigned to assemble State of Alaska's implementation team and develop an Implementation Management Plan for the conversion to the new plan of benefits. This plan will outline the tasks to be accomplished, including the distribution of communication and open enrollment materials and the successful transfer of eligibility. The Management Plan will also indicate target dates for their completion.

Working with State of Alaska's team, the Implementation Manager will help determine the implementation priorities. As new information becomes available and priorities change, the Implementation Management Plan will be updated. However, for the implementation to progress in a timely manner, State of Alaska will be responsible for providing key information to the Implementation Manager as close to the target dates as possible (e.g., finalized account structure, finalized plan of benefits, accurate eligibility files, signed legal agreements).

Aetna is confident that State of Alaska will be pleased with our implementation team approach and therefore we are offering an implementation performance guarantee. This guarantee is effective for the implementation period in the first guarantee period. The implementation period commences at the initial implementation meeting and runs through the implementation sign-off.

Penalty and Measurement Criteria: Via timely responses to the attached Implementation Evaluation Tool (provided at the end of this guarantee section), State of Alaska agrees to make Aetna aware of possible sources of dissatisfaction throughout the implementation period. Each question will be given a rating of 1 - 5 with 1 = lowest, 5 = highest. Aetna will tally the results from the evaluation tool when received. State of Alaska's responses to the attached evaluation tool will be used to facilitate a discussion between State of Alaska, the Implementation Manager and the Account Executive in our Seattle, Washington field office regarding the results achieved. If, at the end of the implementation process, the average score of the evaluations falls below a 3.0, Aetna will make a mutually agreed upon reduction in compensation, subject to a maximum reduction of 1.0% of the guarantee period administrative service fees.

Account Management

Management Reports

Guarantee: Aetna will provide State of Alaska with quarterly Aetna Informatics (e.PSM) reports within 45 days after the end of the reporting period and incurred claims reports within 90 days after the end of the reporting period.

Penalty and Measurement Criteria: If State of Alaska does not receive their management reports, Aetna will reduce its compensation to a maximum of 0.5% of the guarantee period administrative service fees. Aetna's records will be used to determine if the terms of this guarantee have been met.

Data Distribution Timeliness

Guarantee: All data submission will be sent according to the timeframes specified or agreed upon during implementation.

Penalty and Measurement Criteria: Aetna will reduce its compensation by 0.5% of the guarantee period administrative service fees if data submissions are not sent according timeframes specified or established during implementation. State of Alaska will communicate with the Account Executive in the Seattle, Washington field office if data submissions are not sent according to the specified timeframes.

Reporting/Data Distribution Accuracy

Guarantee: All reports and data submissions will be accurate.

Penalty and Measurement Criteria: Aetna will reduce its compensation by 0.5% of the guarantee period administrative service fees if data submissions and reports are not accurate.

Payments from Reconciliation of Pricing Guarantees

Guarantee: Any amounts owed based on completed reconciliation reports (actual claims costs versus guarantees) will be posted within five (5) business days after the reconciliation report has been accepted, which begins on the date each party agrees to the results presented.

Penalty and Measurement Criteria: Aetna will reduce its compensation by 0.1% of the guarantee period administrative service fees for each full day beyond five days that Aetna fails to post a check or wire payment for reconciliation of pricing guarantees. The maximum reduction will be 0.5% of the guarantee period administrative service fees. The check posting date will be verified by shipping carrier receipt or wire transfer date provided by banking documentation.

Client/Consultant Responsiveness

Guarantee: A minimum of 90% of all voice and/or e-mail messages sent by State of Alaska or their consultant will receive an acknowledgement within one (1) business day and 100% will receive an acknowledgement within three (3) business days. An acknowledgement may not resolve the inquiry. The acknowledgement or referral to another member of Aetna's team will provide a target completion/resolution date if Aetna is unable to resolve with the initial response.

Penalty and Measurement Criteria: Aetna will reduce its compensation by 0.5% of the guarantee

period administrative service fees if acknowledgements of inquiries are not received within the specified timeframes. The tracking and measurement of this guarantee will be determined during implementation.

Issue Log

Guarantee: At least 98% of open issues will be captured and tracked accurately.

Penalty and Measurement Criteria: Aetna will reduce its compensation by 0.5% of the guarantee period administrative service fees if open issues are not captured and tracked accurately by the account team. The tracking and measurement of this guarantee will be determined during implementation.

Quarterly Meetings

Guarantee: The Aetna Account team will meet with the State of Alaska no less than quarterly (unless State of Alaska rejects offer of meeting) to discuss the performance of the plan, opportunities, industry trends, and to present Performance Standard/Guarantee statistics as appropriate.

Penalty and Measurement Criteria: Aetna will reduce its compensation by 0.5% of the guarantee period administrative service fees if Aetna's account team is unable to meet with State of Alaska quarterly.

Overall Account Management Guarantee

Guarantee: Aetna will guarantee that the services (i.e., on-going financial, eligibility, drafting, and benefit administration and continued customer support) provided by the Field Office Account Management Staff and/or the Employer Service Team during the guarantee period will be satisfactory to State of Alaska.

Penalty and Measurement Criteria: Via semi-annual responses to the attached Account Management Evaluation Tool (provided at the end of this guarantee section) and this link <http://www.aetnasurveys.com/se.ashx?s=103ED34467D2D0E0>, State of Alaska agrees to make Aetna aware of possible sources of dissatisfaction throughout the guarantee period. State of Alaska's responses to the attached evaluation tool will evaluate account management services in the following categories: technical knowledge, accessibility of personnel, responsiveness of personnel, interpersonal skills, communication skills (written and oral) and overall assessment of the services provided to State of Alaska. Each category will be given a rating of 1 - 5 with 1 = lowest, 5 = highest. Aetna will tally the results from the report cards when received. The results of the surveys will be used to facilitate a discussion between State of Alaska and the Account Executive in our Walnut Creek, CA field office regarding the results achieved and opportunities for improvement.

If all report cards based on the frequency of the guarantee are not completed and returned within 15 days after the six month period it will be assumed that the service provided to State of Alaska is satisfactory and the guarantee is met. If the score on the first report card and the report card for the subsequent survey average a 3.0 or higher, no credit is due. Satisfactory service would equal a score of 3.0 and would be based on the total average of 24 questions with a rating scale of 1 to 5. Should the score from the first report card and the average of the remaining report card fall below a 3.0 (meaning that service levels have not improved), Aetna will make a mutually agreed upon reduction in compensation, subject to a maximum reduction of 1.0% of the guarantee period administrative service fees.

Plan Sponsor Services

Eligibility Updates

Guarantee: Aetna will guarantee that 99.0% of non-Open Enrollment eligibility updates will be processed within 2 business days of receipt of complete and accurate data and 100% of non-Open Enrollment eligibility updates will be processed within 4 business days of receipt of complete, accurate and viable data (if a tape requires adjustments the customer will be notified by email as soon as the need is identified). Updates will be processed with 99.5% accuracy.

Definition: Complete enrollment/eligibility data is defined as employee name, address, provider selection, DOB, SSN, and covered dependent information if applicable as well as mutually agreed upon eligibility specifications. This information will be submitted electronically, by magnetic tape, or by cartridge. The guarantee is contingent upon the file being transmitted successfully to Aetna (files received after 12:00 Noon will be considered as having been received on the next business day). Any eligibility data received which must be adjusted by Aetna using a tape fix will negate the guarantee and normally adds 72 hours to the entire process. Depending on the eligibility submission method, the following reports will be used to determine the completeness of the data provided by State of Alaska: Audit Certificate List, ELR Report, and Transaction Audit Report. Errors caused by the lack of complete data will be excluded from the terms of this guarantee.

Penalty and Measurement Criteria: Aetna will reduce its service fee by 0.1% for each day that the non-Open Enrollment eligibility submissions are not processed. The maximum reduction in service fees will be 0.5% of the guarantee period administrative service fees. Aetna's results will be used to determine whether the terms of the guarantee have been met.

Eligibility Updates - New Group Additions

Guarantee: Aetna will guarantee that 99.0% of new group addition eligibility updates will be processed within 2 business days of receipt of complete and accurate data (if a tape requires adjustments the customer will be notified by email as soon as the need is identified). Updates will be processed with 99.5% accuracy.

Definition: Complete enrollment/eligibility data is defined as employee name, address, provider selection, DOB, SSN, and covered dependent information if applicable as well as mutually agreed upon eligibility specifications. This information will be submitted electronically, by magnetic tape, or by cartridge. The guarantee is contingent upon the file being transmitted successfully to Aetna (files received after 12:00 Noon will be considered as having been received on the next business day). Any eligibility data received which must be adjusted by Aetna using a tape fix will negate the guarantee and normally adds 72 hours to the entire process. Depending on the eligibility submission method, the following reports will be used to determine the completeness of the data provided by State of Alaska: Audit Certificate List, ELR Report, and Transaction Audit Report. Errors caused by the lack of complete data will be excluded from the terms of this guarantee.

Penalty and Measurement Criteria: Aetna will reduce its service fee by 0.1% for each day that the new group addition eligibility submissions are not processed. The maximum reduction in service fees will be 0.5% of the guarantee period administrative service fees. Aetna's results will be used to determine whether the terms of the guarantee have been met.

Claim Administration

Turnaround Time

Guarantee: Aetna will guarantee that the claim turnaround time during the guarantee period will not exceed 14 calendar days for 90.0% of the processed claims on a cumulative basis each year.

Definition: Aetna measures turnaround time from the claimant's viewpoint; that is, from the date the claim is received in the service center to the date that it is processed (paid, denied or pended).

Weekends and holidays are included in turnaround time.

Penalty and Measurement Criteria: If the cumulative year turnaround time (TAT) exceeds the day guarantee as stated above, Aetna will reduce its compensation by an amount equal to 0.2% of the guarantee period administrative service fees for each full day that Turnaround Time exceeds 14 calendar days for 90.0% of all processed claims. There will be a maximum reduction of 1.0% of the guarantee period administrative service fees.

A computer generated turnaround time report for State of Alaska's specific claims will be provided on a quarterly basis.

Financial Accuracy

Guarantee: Aetna will guarantee that the guarantee period dollar accuracy of the claim payment dollars will be 99.0% or higher.

Definition: Financial accuracy is measured using industry accepted stratified audit methodology. The results are calculated by calculating the financial accuracy for a subset of claims (a stratum) and then extrapolating the results based on the size of the population and combining with the extrapolated results of the other strata. Each overpayment and underpayment is considered an error; they do not offset each other. Includes both manual and auto adjudicated claims.

Penalty and Measurement Criteria: Aetna will reduce its compensation by an amount equal to 0.2% of the guarantee period administrative service fees for each full 1.0% that financial accuracy drops below 99.0%. There will be a maximum reduction of 1.0% of the guarantee period administrative service fees.

Aetna's audit results for the unit(s) processing State of Alaska's claims will be used. Those results include Aetna's performance in processing ALL customers' claims handled by the unit(s) in question during the Guarantee period, not just your plan's claims. The results for these guarantees will be calculated using industry accepted stratified audit methodologies.

Claims Processing Accuracy

Guarantee: Aetna will guarantee that the guarantee period overall accuracy of the claim processing will not be less than 97.0%.

Definition: Overall accuracy is measured using industry accepted stratified audit methodology. Accuracy in each stratum (a subset of the claim population) is calculated by dividing the number of claims processed correctly by the total number of claims audited, and then extrapolating the results based on the size of the population and combining with the extrapolated results of the other strata.

Penalty and Measurement Criteria: Aetna will reduce its compensation by 0.1% of the guarantee period administrative service fees for each full 1.0% that total claim accuracy drops below 97.0%. There will be a maximum reduction of 0.5% of the guarantee period administrative service fees.

Aetna's audit results for the unit(s) processing State of Alaska's claims will be used. Those results include Aetna's performance in processing ALL customers' claims handled by the unit(s) in question during the Guarantee period, not just your plan's claims. The results for these guarantees will be calculated using industry accepted stratified audit methodologies.

Claims System Availability

Guarantee: Aetna will guarantee that the claims processing system availability rate will be 99.0% or higher. Measurements will be based on our book of business.

Penalty and Measurement Criteria: Aetna will reduce its compensation by 0.1% of the guarantee administrative service fees for each 1.0% that our claims processing system is not available at least 99.0% of the total operational time. There will be a maximum reduction of 0.5% of the guarantee period administrative service fees.

Member Satisfaction

Definition: Aetna will guarantee a positive response rate of 90.0% or better on a customer specific member satisfaction survey. Aetna will work with the State of Alaska to determine the survey questions. The survey is based on a randomly selected sample of active and retired members. Interviews are conducted on a continuous basis throughout the year.

Penalty and Measurement Criteria: Aetna will reduce its compensation by 1.0% of the guarantee period administrative service fees if it fails to meet a positive response rate of 90.0% or better. Results of the Aetna Performance Tracking Process will be used as the measurement criteria. These surveys are performed based on statistically valid samples of members, by product across all customers.

Member Services

ID Card Production and Distribution - Non-Open Enrollment

Guarantee: Aetna guarantees that it will produce and mail ID cards to plan participants within 7 business days of receiving the enrollment eligibility file.

Definition: For all complete, accurate and viable enrollment data provided by State of Alaska and accepted by the system, Aetna agrees to produce and mail ID cards within 7 business days of file receipt.

Penalty and Measurement Criteria: Aetna will reduce its compensation by 0.5% of the guarantee period administrative service fees if Aetna fails to produce and mail ID cards to State of Alaska's members within 7 business days of receiving the enrollment eligibility file. Aetna's account team records will be used to determine whether ID cards were produced and mailed within the specified time frame.

Average Speed of Answer

Guarantee: Aetna will guarantee that the average speed of answer for the phone skill(s) providing

State of Alaska's member services will not exceed 30 seconds.

Definition: On an ongoing basis, Aetna measures telephone response time through monitoring equipment that produces a report on the average speed of answer. Average speed of answer is defined as the amount of time that elapses between the time a call is received into the telephone system and the time a representative responds to the call. The result expresses the sum of all waiting times for all calls answered by the queue divided by the number of incoming calls answered. ASA measures the average speed of answer for all callers answered. Interactive Voice Response (IVR) system calls are not included in the measurement of ASA.

Penalty and Measurement Criteria: Aetna will reduce its compensation by 0.2% of the guarantee period administrative service fees for each full second that the average speed of answer exceeds 30 seconds. There will be a maximum reduction of 1.0% of the guarantee period administrative service fees. Aetna's results for the phone skill(s) providing member services for State of Alaska will be used.

Abandonment Rate

Guarantee: Aetna will guarantee that the average rate of telephone abandonment for the phone skill(s) providing State of Alaska's member services will not exceed 2.5%.

Definition: On an ongoing basis, Aetna measures telephone response time through monitoring equipment that produces a report on the average abandonment rate. The abandonment rate measures the total number of calls abandoned divided by the number of calls accepted into the skill.

Penalty and Measurement Criteria: Aetna will reduce its compensation by 0.1% of the guarantee period administrative service fees for each 1.0% that the average abandonment rate exceeds 2.5%. There will be a maximum reduction of 0.5% of the guarantee period administrative service fees. Aetna's results for the phone skill(s) providing member services for State of Alaska will be used.

First Call Resolution Rate - Outbound Call Survey

Guarantee: Aetna will guarantee that the First Call Resolution rate will be 93.0% or higher.

Definition: On an annual basis, Aetna will share with State of Alaska the First Call Resolution results from the accountable unit that services State of Alaska. We define the first call resolution rate as the percentage of member calls resolved on the first call as reported by the member during the outbound call survey. The rate will be calculated based upon first calls where the issue was within Aetna's control to resolve.

Penalty and Measurement Criteria: Aetna will reduce its compensation by 0.1% of the guarantee period administrative service fees for each 1.0% that the First Call Resolution rate falls below 93.0%. The data will be shared at the accountable unit level. The maximum reduction will be 0.5% of the guarantee period administrative service fees. Results of the Outward Bound Survey will be used as the basis of the measurement criteria. The Account Executive in our servicing field office will compile the results and report them to State of Alaska on an annual basis.

E-Mail Response Turnaround Time

Guarantee: Aetna will guarantee to respond to 85.0% of all Internet inquiry e-mails within 24 hours and 95.0% within 4 calendar days.

Definition: Aetna measures email turnaround time from the time the email is received in the service center to the time that the inquiry is responded to.

Penalty and Measurement Criteria: Aetna will reduce its compensation by 0.1% for each full percentage point that the cumulative e-mail response rate falls below 85.0% of emails responded to within 24 hours and 95.0% within 4 calendar days, to a maximum reduction of 0.5%. Results will be measured at the Internet Team Level.

Telephone Response Turnaround Time

Guarantee: Aetna will guarantee to respond to 85.0% of all telephone inquiries within 10 business days and 90.0% within 28 calendar days.

Definition: On an ongoing basis, Aetna measures telephone response turnaround time through monitoring equipment that produces a report on the number of days taken to resolve and close a telephone inquiry.

Penalty and Measurement Criteria: Aetna will reduce its compensation by 0.1% for each full percentage point that the cumulative telephone inquiry response rate falls below 85.0% of telephone inquiries responded to within 10 business days and 90.0% within 28 calendar days, to a maximum reduction of 0.5%. Aetna's results for the phone skill(s) providing member services for State of Alaska will be used.

Member Call Tracking - Non open Enrollment

Guarantee: Using standard weekly reports available using Aetna Strategic Desktop, Aetna will provide a summary of the number of member service calls by call category. This report will be analyzed for patterns or problems weekly.

Penalty and Measurement Criteria: Aetna will reduce its compensation by 0.5% of the guarantee period administrative service fees if Aetna fails to analyze the member call tracking reports weekly.

Attachments: [Medical Performance Guarantees.doc](#)

2.2.8.2 Are you willing to put fees at risk for network expansion if needed?

Answer: We are including our National Advantage Program (NAP) which offers access to contracted rates for out-of-network services and case-specific rate negotiation with out-of-network providers. NAP also offers review for eligible inpatient and outpatient facility claims. Should any network gaps be identified Aetna is willing to work with State of Alaska to resolve the issue.

Attachments:

2.2.8.3 Are you willing to guarantee savings in this proposal? If so, please explain.

Answer: Yes. Aetna is confident in our ability to provide savings to State of Alaska. We have proposed Performance Based Incentives for both a Claim Target Guarantee and a Discount Guarantee. We have reduced our proposed fees on the Active and Non-Medicare Eligible Retiree population and have designed guarantees in which Aetna will need to deliver significant savings to State of Alaska to

earn back the fee reduction. Please refer to the Discount Performance Based Incentive Guarantee and Claim Based Performance Based Incentive Guarantee for complete details (attached.)

Attachments: [CONFIDENTIAL Claim Based Earn Back Guarantee.docx](#)
[CONFIDENTIAL Medical Discount Guarantee.doc](#)
[CONFIDENTIAL State of Alaska Concierge Incentive.doc](#)
[REDACTED State of Alaska Concierge Incentive.doc](#)
[REDACTED Medical Discount Guarantee.doc](#)
[REDACTED Claim Based Earnback Guarantee.doc](#)

2.2.8.4 Are you willing to place fees at risk for meeting certain performance standards and guarantee outcomes under the Contract?

Answer: Yes, Aetna had placed fees at risk in both our Medical Performance Guarantees and in our Demonstrating Value Scorecard. Please refer to the Performance Guarantee and Demonstrating Value Scorecard below (and clean Word document attached) for more details.

Attachments: [CONFIDENTIAL Demonstrating Value Scorecard.docx](#)
[Medical Performance Guarantees.doc](#)
[REDACTED Demonstrating Value Scorecard Gaurantee.doc](#)

2.2.8.5 Confirm you will not charge the State for claim payments not authorized by the State's plans when such payments were erroneously authorized by Contractor's employees, subcontractors or joint venturers, including pre-authorizations issued by Contractor's employees, subcontractors or joint venturers, causing the State's plans to incur costs for non-covered services.

Answer: Confirmed.

Attachments:

2.2.8.6 When are performance penalties paid out?

Answer: Reconciliation and associated penalty payouts vary based on the type of guarantee. Many financial guarantees (eg. Demonstrating Value Scorecard, Discount savings Guarantee, etc...) require data up to 6 months after the close of the contract period, so our commitment to our customers is in those instances to make every effort to release results and pay out appropriate penalties no later than 90 days following the availability of the data. Service performance guarantees also vary based on when data needed to reconcile becomes available, but typically we can agree to provide results and associated penalties within 180 days of the close of the contract period. In addition, for State of Alaska, we have placed a portion of the administrative fees at risk regarding payment of penalties and have guaranteed that any amounts owed based on completed reconciliation reports (actual claims costs versus guarantees) will be posted within five (5) business days after the reconciliation report has been accepted, which begins on the date each party agrees to the results presented.

Attachments:

2.2.8.7 Can tracking and reporting of the performance standards be based on State-specific data?

Answer: Our financial guarantees are based on State of Alaska specific data and while many of the service performance standards we've offered are based on State of Alaska specific results, we do offer some performance standards which are only available based on Aetna's book of business results. Please refer to our proposed Service Performance Guarantee and Demonstrating Value Scorecard documents for further details.

Attachments: [CONFIDENTIAL Demonstrating Value Scorecard.docx](#)
[Medical Performance Guarantees.doc](#)
[REDACTED Demonstrating Value Scorecard Gaurantee.doc](#)

2.2.8.8 Please confirm that you will permit and cooperate with internal audits on any aspect of the administration of the program, as the State determines to be necessary and appropriate. State personnel or outside auditors that the State selects may perform these audits, including audits that may take place after the end of the contract period.

Answer: Confirmed. We agree with your right to audit and would like to discuss the logistics of any audit if selected as the successful bidder.

Attachments:

2.2.8.9 Please confirm that you will provide claims, payment documentation and other necessary information required for the State to complete its annual health funds audits.

Answer: Confirmed. We agree with your right to audit and would like to discuss the logistics of any audit if selected as the successful bidder.

Attachments:

2.2.8.10 Do you agree to fund an implementation audit, prior to effective date, up to \$50,000 to be performed by a firm of the State's choosing?

Answer: Yes.

Attachments:

2.2.8.11 Please indicate whether or not you agree with the following statements regarding Audits.

	Agree
You will allow auditing of your operations as they relate to the administration and servicing of this account.	1: Agree
Your organization will not charge for services rendered in conjunction with the audit.	1: Agree
If problems are discovered, follow-up audits will be paid by your organization.	1: Agree

Detail: Confirmed. In regard to items 1 and 2, we agree with your right to audit and would like to discuss the logistics of any audit if selected as the successful bidder. In regard to item 3, Aetna can agree to bear the expense of reasonably tailored follow-up audits.

Attachments:

2.2.8.12 Do you use a statistically significant sample for internal audits?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

2.2.8.13 Do you have a dedicated internal audit staff?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

2.2.8.14 With what frequency is the claims processing function audited by an external auditing firm?

Answer: 4: Other: [We engage our external auditor on an annual basis.]

Detail:

Options:

1. Daily
2. Weekly
3. Monthly
4. Other: [Text]

Attachments:

2.2.8.15 With what frequency is the claims processing function audited internally?

Answer: 1: Daily

Detail:

Options:

1. Daily
2. Weekly
3. Monthly
4. Other: [Text]

Attachments:

2.2.8.16 Are audits performed on a pre- or post-disbursement basis?

Answer: 3: Both

Detail:

Options:

1. Pre-Disbursement
2. Post-Disbursement
3. Both

Attachments:

2.2.8.17 How are claims selected for audit?

Answer: 1: Random by system,

2: Set percent per day,

3: Set number per approver per day/week,

4: Diagnosis,

5: Dollar amount

Detail:

Options:

1. Random by system
2. Set percent per day
3. Set number per approver per day/week
4. Diagnosis
5. Dollar amount
6. Other. Please specify: [Text]

Attachments:**2.2.9 Appeals**

2.2.9.1 Describe your method for processing appeals for certification review, claim review and/or billing appropriateness.

Answer: We provide a nationally standardized process for resolving member complaints and appeals to enhance our ability to handle complaints and appeals in a consistent and timely fashion. Some states have requirements that are different from federal requirements. State requirements supersede only when they are more advantageous to the member (e.g., more aggressive turnaround times for response). For example, the State of Alaska requires that post-service utilization review appeals be resolved and written notice sent to the member within 18 working days. We recognize the AlaskaCare plan is not subject to the Alaska Division of Insurance Statutes, but we could accommodate if this were to ever change in the future. Aetna's law department will support the business area in the interpretation of applicable law.

COMPLAINTS

Our Customer Service Representatives (CSRs) respond to most member inquiries at the point of contact. If the issue cannot be resolved during the call, the CSR forwards the complaint to the Customer Resolution Team (CRT) for handling, and, if needed, to the appropriate business area for investigation and response. We will have a concierge for the State's members with local representatives in Juneau and Anchorage who will be familiar with the kinds of issues facing Alaska members and provide a high level of satisfaction. Members who are not satisfied with the response may file an oral or written complaint and/or appeal.

APPEALS

To start the appeals process, the member or provider/representative acting on behalf of the member submits a verbal or written request asking for a change in the initial determination decision. The member or authorized representative has 180 days after receipt of a coverage decision to file an appeal. A written notice stating the result of the review will be forwarded to the member. If the member or authorized representative is not satisfied with the outcome of the Level I appeal decision, they may submit an oral or written request, within 60 days of receipt of a Level I decision, for further appeal review. For clinical appeals, the second level review is performed by a practitioner who typically treats the condition, performs the procedure, or provides the treatment under review and was neither involved in the original denial of coverage determination or Level I appeal.

If a Level II appeal is denied, the written notice includes all specific reasons for the denial, including the clinical rationale, reference to applicable plan provisions, medical and dental information reviews, and any other applicable appeal procedures that may be available.

EXTERNAL REVIEW

Aetna will support and administer an external review. The member will have four months from the

date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination to request an external review. Upon receipt of a request for external review, Aetna will perform a preliminary review to determine whether i) the member was covered by the plan on the date the services were requested or provided, ii) the adverse determination does not relate to the member's failure to meet the requirements for eligibility under the terms of the group health plan, iii) the member has exhausted the plan's internal appeal process (unless not required under the interim final regulations); and iv) the member has provided all the information and forms required to process the external review. The plan must issue notification in writing to the member if complete but ineligible with notification to include the reason for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-3272). If not complete, the notification must describe the information needed to make the request complete and must allow the member to perfect the request within the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

The IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review and must deliver the notice of final external review decision to the member and the plan. If the IRO overturns the decision the health plan is required to immediately provide coverage or payment or authorize services as applicable. The decision of the independent reviewer is binding on Aetna and the State. Members are not charged a professional fee for the review.

An expedited process is available when the determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the member or would jeopardize the member's ability to regain maximum function and the member or provider on behalf of the member has filed a request for an expedited internal appeal.

Attachments:

2.2.9.2 Explain how you use staff medical professionals and/or outside consultants to review disputed claims for medical necessity and billing appropriateness.

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

CRTs are comprised of complaint and appeal analysts who are responsible for all member appeals. Medical directors make appeal decisions with a clinical element. The medical directors review the clinical evidence provided against current medical standard of practice as well as Aetna clinical policies and procedures.

The medical director is board certified in an area of clinical medicine with experience in private practice. We require leadership experience in managed care and demonstrated accomplishments in the areas of:

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

Our medical directors are required to have an M.D. or D.O. degree and be board certified in a recognized specialty including post-graduate direct patient care experience. We also require an active

and current state medical license without encumbrances and a minimum of three to five years experience in the health care delivery system, for example, clinical practice and health care industry.

OUTSIDE CONSULTANTS

Aetna will support and administer an external review. The member will have four months from the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination to request an external review. Upon receipt of a request for external review, Aetna will perform a preliminary review to determine whether i) the member was covered by the plan on the date the services were requested or provided, ii) the adverse determination does not relate to the member's failure to meet the requirements for eligibility under the terms of the group health plan, iii) the member has exhausted the plan's internal appeal process (unless not required under the interim final regulations); and iv) the member has provided all the information and forms required to process the external review. The plan must issue notification in writing to the member if complete but ineligible with notification to include the reason for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-3272). If not complete, the notification must describe the information needed to make the request complete and must allow the member to perfect the request within the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

The IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review and must deliver the notice of final external review decision to the member and the plan. If the IRO overturns the decision the health plan is required to immediately provide coverage or payment or authorize services as applicable. The decision of the independent reviewer is binding on Aetna and the State. Members are not charged a professional fee for the review.

An expedited process is available when the determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the member or would jeopardize the member's ability to regain maximum function and the member or provider on behalf of the member has filed a request for an expedited internal appeal.

Attachments:

2.2.9.3 Describe how you retain medical consultants that represent various specialties for use in pre-authorization and claims resolution.

Answer: For clinical appeals, the second level review is performed by a practitioner who typically treats the condition, performs the procedure, or provides the treatment under review and was neither involved in the original denial of coverage determination or Level I appeal.

In addition, our precertification nurses refer cases to a medical director when:

- The available clinical information does not meet decision-making guidelines
- The length of stay exceeds guidelines

Our medical director may discuss the individual member's situation with the attending physician. If necessary, the medical director may also ask another physician of the same or similar specialty to review. Only our medical directors can make denial decisions based on medical necessity.

We employ over 100 full-time medical directors in varied roles. Major specialties include:

- Ob/gyn
- Cardiology
- Oncology
- Neonatology
- Gastroenterology
- Pediatrics
- Internal medicine
- Orthopedics
- General surgery
- Ophthalmology

Attachments:

2.2.9.4 Describe your multi-level appeals process for administrative and clinical denials.

Answer: A Level I appeal is defined as a verbal or written request by a member, or a member's authorized representative, requesting a change in an initial determination decision. This includes but is not limited to requests related to the following:

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

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

Expedited appeals: 36 hours

Pre-service appeals: 15 days

Post service appeals: 30 days (For Alaska insured business we currently use a 18 day timeframe for post-utilization of review appeals, and could put this in place for Alaska if amenable)

If the member or authorized representative is not satisfied with the outcome of the Level I appeal decision, they may submit an oral or written request, within 60 days of receipt of a Level I decision, for further appeal review. For clinical appeals, the second level review is performed by a practitioner who typically treats the condition, performs the procedure, or provides the treatment under review and was neither involved in the original denial of coverage determination or Level I appeal.

If a Level II appeal is denied, the written notice includes all specific reasons for the denial, including the clinical rationale, reference to applicable plan provisions, medical and dental information reviews, and any other applicable appeal procedures that may be available, including the External Review.

Attachments:

2.2.9.5 Describe how you will meet the State's appeal process requirements and confirm you will be able to provide copies of all claim and appeal documents to the State for appeals that reach the State's level.

Answer: We provide a complete packet that includes all documentation used in making original claim and appeal determinations when fiduciary responsibility shifts to the State.

Attachments:

2.2.9.6 Confirm that you will participate, if needed, in administrative hearings resulting from denial determinations.

Answer: Confirmed. We will defend any lawsuit originating during or after completion of the first two levels of appeal. After all levels of appeal and the External Review option, if applicable, are exhausted, there is a Voluntary Appeal process available through the State. The State becomes responsible for defense of any lawsuit originating from the Voluntary Process.

Attachments:

2.2.9.7 Provide the percentages of total claims processed monthly that are appealed for other clients of similar size to the State.

Answer: Approximately 0.2% of all claims received are appealed.

We do not track appeals by client size.

Attachments:

2.2.9.8 For your book of business, explain what percentages of your outpatient services/procedures are typically subject to denial.

Answer: The percent of admits/precertifications requested that were denied without a medical director review (lack of medical information) is 3.3%. The percent of all admits/precertifications requested that were denied by a medical director is 4%.

These percentages include both inpatient/outpatient and elective/non-elective denials. We do not break these out by category.

Attachments:

2.2.9.9 For your book of business, explain what percentages of your inpatient admissions/hospital bed days are typically subject to denial.

Answer: The percent of admits/precertifications requested that were denied without a medical director review (lack of medical information) is 3.3%. The percent of all admits/precertifications requested that were denied by a medical director is 4%.

These percentages include both inpatient/outpatient and elective/non-elective denials. We do not break these out by category.

Attachments:

2.2.9.10 Of your total denials, provide the percentage of services that are generally overturned on appeal.

Answer: In 2011, approximately 28% of decisions were overturned and 65% of decisions were upheld as a result of an appeal. The remaining 7% were either partially overturned or were redirected to the customer/employer for handling.

Attachments:

2.2.9.11 Do you have a dedicated appeals staff?

Answer: Yes. We have an internal team who is dedicated to appeals resolution.

Attachments:

2.2.9.12 Confirm the State will have a single point of contact for appeals related inquiries.

Answer: Confirmed. The State's Plan Sponsor Liaison (PSL) is the single point of contact for appeals related inquiries. The PSL serves as an extension of the State's account management team. They are located in the customer service center and act as a single point of contact for the State to assist you in resolving escalated issues. Your PSL will work with the appeals team and other Aetna resources to obtain all of the necessary information surrounding inquiries.

Attachments:

2.2.9.13 Please provide copies of all appeal decision notices you use.

Answer: 1: Attached

Detail:

Options:

1. Attached
2. Not Attached

Attachments: [Aetna Appeal Letter Sample.doc](#)

2.2.9.14 Describe other services you offer prior to or during appeal.

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

CRTs are comprised of complaint and appeal analysts who are responsible for all member appeals.

The State will also have a health concierge who can assist members with the appeal process, as well as local service representatives within our Anchorage and Juneau offices.

Attachments:

2.2.10 Data Analysis

2.2.10.1 Data Collection

2.2.10.1.1 Do you utilize a data warehouse for reporting and claim and trend analysis?

Answer: Yes.

Attachments:

2.2.10.1.2 Describe your organization's data warehousing and population health analytical services, including software used.

Answer: One of our most differentiating assets, our vast data warehouse, consists of 18 terabytes of integrated claim, membership, product and provider information.

The data warehouse is larger and more sophisticated than standard database management systems available in the marketplace. It is sourced by numerous operational systems such as:

- Enrollment/eligibility
- Claims administration
- Provider applications
- Patient management applications

The data warehouse encompasses the following product lines:

- Medical
- Pharmacy
- Dental
- Vision
- Disability
- Behavioral Health

From this data warehouse we execute numerous data analytic, reporting, trending, predictive modeling and data mining processes and activities, including our Aetna Health Information Advantage and Actionable Information Reports.

Aetna Health Information Advantage

Aetna Health Information Advantage includes standard reports and analyses that show:

- How well your plan is doing
- What key drivers impact costs
- Use and trend analysis
- Program performance
- Program participation rates

The system offers these features:

- Dashboard - You define the key metrics so you easily see when your information is out of line.
- Dynamic reporting - At-a-glance data —provided in bar graph, table, linear graph, tree map or geography format — lets you see your results and drill down for answers immediately. Find out how your experience compares to others in your industry or against our book of business.
- Information management - Save and reuse reports that you design. Print reports or export data for further analysis.
- Real-time help - Easily find what you want using a keyword search. Get immediate help through built-in training and rollover tool tips.

For no extra charge, you choose from eight preformatted reports. Run them on demand with choices of filters — such as account structure, age band and network. Available reports include:

- Executive Summary
- Provider Profile
- Membership Enrollment
- Utilization Detail
- Monthly Claims and Membership
- Large Claimant
- Health Profile
- Impact of Catastrophic Claimants

Actionable Information Reports

Your Aetna account team uses the Actionable Information Report during the annual plan review meeting. The report provides a clear, easy-to-understand summary of plan performance, key clinical findings and cost drivers.

Unlike many of our competitors, we provide a complete set of adjusted book of business benchmarks. This annual report automatically flags any variance from those benchmarks. Armed with this information, you and your account team can discuss ways to adjust your health and wellness programs and communications to sustain or improve results.

The report runs on an incurred basis with a two-month lag. We recommend at least 12 months of your incurred data to compare to the benchmark. With two full years, we can compare your data year-over-year and to the benchmark.

The report displays clinical metrics into separate content areas, such as ambulatory radiology and medical pharmacy. This helps us rapidly identify areas where different products, programs and services can have an impact on affordability and quality.

Attachments:

2.2.10.1.3 What resources do you provide from a health data analyst perspective to support your clients?

Answer: Your account team is available to assist you with reports at any time. We also provide printed communications to help you understand how to interpret and use our reports. In addition, Aetna Health Information Advantage includes an on-line help facility, which demonstrates how to use the features and content, and Aetna Informatics® contacts are available to assist you.

We have data reporting resources that can support development of detail analytics beyond what is available in ePSM, AHIA and our Actionable Information reports. The State will have 50 hours per year for reporting.

Attachments:

2.2.10.1.4 If yes, please provide the name of the warehouse and indicate if the State will have access to data and reporting. If there is an additional cost, please indicate the cost on the rate sheet.

Answer: Yes, the State will have access to data and reporting at no additional cost. Aetna Health Information Advantage reporting tool produces the information you need when you need it. Our reporting system is fast, flexible and customizable. It can help you make benefits and plan decisions quickly and confidently. Aetna Health Information Advantage will take your benefits and plan performance to the next level.

INDUSTRY LEADING ANALYTICAL TOOLS

Aetna Informatics® combines data, systems and people to give you answers to questions you did not know to ask. Our seasoned experts use our world-class data warehouse and cutting-edge technologies to pull together reports for you. You get information that is easy to understand and recommended actions to help you craft a better benefits package for your unique population.

FLEXIBLE REPORTING OPTIONS

We can provide you with all the data and information needed, in the way you need it, to effectively monitor your programs, address your issues, and help you make benefits strategy decisions. As a start, you receive immediate access to Aetna Health Information Advantage, a rapid and flexible Web-based

decision support tool that houses your health benefits data. It includes standard and ad hoc reports, giving you all the fundamental information you need when you need it. You can also choose other levels of reporting and services for a fee.

INTEGRATED DATA FOR A HOLISTIC VIEW

Our experts take different data types from various sources and organize them on a member-centric basis. This means we can link an individual member's data across many different sources. This total information content is then available for analysis. It is a holistic view of an individual person. This approach to data allows for a clear understanding of problems. It helps us pinpoint actions to recommend for your group. Aggregating data, on the other hand, stops short of this level detail. It limits your ability to have even a basic understanding of any problem or issue.

Our tool can help you see:

- Total cost of your health benefits
- How well your medical and other programs work together
- Impact of your benefit design

It can also help you:

- Draw stronger conclusions about member choices and incentives
- Isolate cause and effect of activities on overall health care costs
- Achieve insights into outcomes of programs across a variety of measures
- Increase your ability to conduct offset analyses

With our tools you can better analyze your current situation and customize the perfect health benefits solution — based on actual experience — for your workforce, taking into account your budget and benefits strategy.

Attachments:

2.2.10.1.5 Explain whether your organization will release detailed claims data to a central data warehouse for non-AlaskaCare health plan related analysis. Indicate if you are paid to provide this data.

Answer: One of our primary responsibilities is the protection and confidentiality of member information. In keeping with this requirement we provide information to a variety of external organizations as follows:

- We provide summarized information in support of national initiatives to monitor and manage quality of care. As an example, we provide HEDIS measures at the Aetna Plan level to NCQA.
- We contribute claims data to a national file used to develop UCR (usual, customary and reasonable) fee schedules for providers. This claims file does not include any member information.
- We at times provide de-identified claims data to universities, research organizations or pharmaceutical or device companies in support of beneficial member studies. All parties who participate in these studies are fully compliant with HIPAA regulations.
- We provide claims data to state and federal regulatory bodies when required.

- We disclose data in accordance with HIPAA under the treatment, payment and health care operations.

Attachments:

2.2.10.1.6 Explain how you will maintain the following claims data and provide the following information as requested by the Project Director or their authorized representatives.

1. Member/Patient Data
 - a. Patient Identification
 - b. Patient Type
 - i. Employee
 - ii. Spouse/same sex partner
 - iii. Child
 - c. Patient Age
 - d. Patient Sex
 - e. Coverage Code
 - f. Patient Residential ZIP Code
 - g. Patient Date of Birth
2. Provider Data
 1. Hospital Name
 2. Provider Identification (All Others)
 3. Provider Type
 - i. Hospital Name
 - ii. M.D. (Specialty Code)*
 - iii. Chiropractor*
 - iv. Laboratory
 - v. Alcoholic Inpatient Treatment Facility
 - vi. Dentist* /Oral Surgeon*
 - vii. Ph.D.*
 - viii. Attending Surgeon*
 - ix. Nursing
 - x. Extended Care Facility
 - xi. Outpatient Surgery Department
 - xii. Radiology
 - xiii. Ambulance
 - xiv. Home Health Care
 - xv. Optometrists
 - xvi. Other

* Indicate Provider's Name and Address

Service Type

- . Hospital
 - i. ICU
 - ii. CCU
 - iii. Room and Board
 - iv. Laboratory
 - v. Diagnostic X-Ray and Lab
 - vi. All Other
- a. Inpatient Room and Board--All Other

- b. Inpatient—Ancillary
- c. Emergency Room
- d. Hospital Outpatient (other than emergency room, X-ray, lab)
- e. Extended Care Facility
- f. Alcoholic Inpatient Treatment Facility
- g. Substance Abuse
- h. Psychiatric Hospital
- i. Outpatient Surgical Center
- j. Professional Fees, Visits and Number of Procedures
 - i. Inpatient Surgery
 - ii. Outpatient Surgery
 - iii. Inpatient Physician Visit
 - iv. Hospital Outpatient Physician Visit
 - v. Physician Office and Home Visits
 - vi. Chiropractor Office Visit
 - vii. Chiropractor X-Ray
 - viii. Psychiatric Office Visit (mental/nervous, alcohol or substance abuse)
 - ix. Psychiatric Inpatient Visit
 - x. Anesthesiologist
 - xi. Home Health Care
 - xii. Physician--Maternity
 - xiii. Radiologist Inpatient
 - xiv. Other
- k. Nursing
- l. Ambulance
- m. Prescription Drugs
- n. Outpatient Lab
- o. Outpatient X-Ray
- p. Non-hospital Equipment and Supplies
- q. Vision Care—Hardware
- r. All Other

For Each Service Type, the Following Data is Required

- a. Eligible Covered Charges
- b. Amount Paid
- c. Diagnostic Code (ICD-9-CM) (Hospital/Professional)
- d. Procedure Code (CPT-4) (Professional Only)
- e. Number of Days, Visits, Units, etc.
- f. Treatment Dates
- g. Discharge Diagnosis (ICD-9-CM)
- h. Discharge Status (i.e., dead or alive)
- i. Submitted Charges

For Inpatient Hospital Service Type

- a. Date Confined
- b. Date Discharged
- c. Date of Surgery
- d. Admitting Physician Identification

- e. Number of Admissions
- f. Payment Data (Combined for all Claims)
- g. Billed Charges
- h. Eligible Coverage Charges
- i. UCR Cutbacks
- j. Admitting Physician Identification
- k. Co-Insurance
- l. COB
- m. Third Party Recovery
- n. Benefits Paid
- o. Error Ratios

Answer: Our data warehouse captures all of the above information. We disclose processed claim transaction data as outlined above in our standard Universal File formats. These electronic claims data extracts are available through CD-ROM or electronically on a fee-for-service basis. If the standard format does not meet the State's needs, customized reporting is available. Charges for customized and standard claims data extracts include an initial set-up fee and annual charge. This charge will vary based on frequency. Our general pricing for our standard claims data extracts is \$1,000 for initial set up/installation and \$500 for ongoing frequencies after first set-up run. Frequencies include monthly, quarterly, semi-annually, annual or irregular.

Attachments:

2.2.10.2 Reporting

2.2.10.2.1 Please confirm the Contractor will provide the State or its authorized representatives with the following reports at the designated frequencies in a format compatible with Microsoft Excel or Access. Please identify what information is contained in each report. Please attach a sample of each report.

Report Plan Frequency

Claims Processing Accuracy All Plans Combined Quarterly

Claim Turnaround Time All Plans Combined Monthly

Catastrophic Claims (including referrals to care management or other program

resources) By Plan Monthly

Statistical Summary By Plan Monthly

-- Covered lives

-- Billed fees/charges

-- Paid claims

-- Transactions

Provider Summary By Plan Annually

-- Diagnosis

-- Service

Top 25 Codes By Plan Quarterly

-- DRG

-- CPT4/ICD-10

Claim Payment Summary By Employee Group & Retirement System Monthly

-- Transactions and claim dollars

-- Type of service

Utilization Summary By Plan Quarterly

-- Type of service

-- Claimants

-- Place of service

-- Days of inpatient service approved/denied

-- In-network versus out-of-network

-- Network cost savings

-- Denials and appeals

-- Referral activity to specialty programs (such as ICM)

Cost Trends By Plan Annually

Cost Containment Trends By Plan Annually

COBRA Activity By Plan Monthly

-- Eligibility and premium payment

-- Additions, Drops, Changes

-- Mailing list

Direct Bill Activity By Plan Monthly

-- Eligibility and premium payment

-- Additions, Drops, Changes

-- Mailing list

Health FSA Activity By Group Monthly

-- Eligibility and contributions

-- Claims paid

Dependent Care FSA Activity By Plan Monthly

-- Eligibility and contributions

-- Claims paid

Case Management Participation By Plan Quarterly

Case Management Outcomes By Plan Quarterly

UM Participation By Plan Quarterly

UM Outcomes By Plan Quarterly

Claims paid/incurred lag reports By Plan Monthly

HIPAA Certificates By Plan Monthly

Patient Auditor Program By Plan Annually

Audit Data – Claim Details for all below

-- Checks Cleared By Plan & Benefit Type Monthly

By Group & Retirement System

-- Incurred but not paid By Plan Annually

-- Outstanding checks By Plan Annually

-- Lag reports By Plan Annually

Travel Claims By Plan Monthly

Managed Vision Care Summary Active Plan Annually

Performance Standard Verifications By Standard Annually

Appeals Statistics By Plan Quarterly

-- Denial reason

Answer: Confirmed. We will provide the reports listed above through our comprehensive standard reporting package and ad hoc reporting capabilities. Included below is a description of our standard reporting package, including the content of each report. In addition, we will provide the State with 50 prepaid hours for ad hoc reporting to address all of your reporting needs.

ACCOUNTING REPORTS

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

- Master Services Agreement (MSA) Reconciliation - This shows recorded claims, pending adjustments and the resulting wire transfers. It also compares paid fees to actual fees to develop the MSA balance.
- Current and Prior Period Reserve Analysis - This shows the recommended reserve levels, for customers who hold the reserves, by comparing existing reserves to actual contract period run-off claims and new reserves to current run-off to date.

BANKING REPORTS

We provide the following monthly banking reports in a Microsoft Word format. We make the reports available to you through our secure e-mail no later than the 25th of the following month for the prior month's activity.

Funds Summary Report - This report provides a current month and a year-to-date control-suffix breakdown of claims and the funding applied.

Funds Request and Receipt Report - This report shows the daily wire transfer requests and receipts for a given month.

CLAIM REPORTS

We provide you with monthly claim reports, in a Microsoft Access format 10 business days following the end of the reporting period. The electronic reports summarize claim activity by line of coverage, along with providing detailed claim information for each employee as well as claim totals for employees and dependents by Medicare status.

UTILIZATION REPORTS

Aetna Health Information Advantage, our information application software tool created by Aetna Informatics®, makes performance experience data available in real time through the Internet.

Aetna Health Information Advantage is the ideal tool for benefits managers, placing valuable information right at their fingertips. Interactive data analysis can be performed on topics such as key measures, components of medical trend, medical, high cost claimants, network savings and membership. These topics, called modules, are produced at the customer level by funding arrangement

and product type on an incurred basis with a two-month claim lag. The modules offer a high-level view of the current data as well as book of business and prior year comparisons.

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

Preformatted reports are also available. The reports offer a view of the current year's and the prior year's data, illustrating utilization and financial trends in a concise, graphical format. The reports are available monthly, within 30 days following the end of the reporting period.

The Standard Report package can also be run with variations on time periods, account structure, product combinations, network service area, large claimant threshold and claim basis (incurred versus processed). We update our data monthly.

In addition to the product-specific standard reports, we offer a Summary by Product package that provides key information for all medical product lines, pharmacy and dental in one package.

PERFORMANCE GUARANTEES (including claim turnaround time and processing accuracy statistics, as applicable)

We provide reporting for results on a quarterly basis at no additional cost. We reconcile performance guarantees annually.

MEDICAL MANAGEMENT

We provide the Aetna Health Connections Medical Management Activity Report on a calendar quarterly basis. The report package provides an aggregate view of members identified, targeted for outreach and currently participating in the Aetna Health Connections case management program. It also provides additional details to highlight identified deficits and goals, referrals to and from the program, identification sources and referral reasons, and areas of case management focus while participating in the program.

HIPAA

Each month, we mail a report that reflects the information included in any HIPAA certification mailed to terminated members during the previous month.

APPEALS

Upon request, and with appropriate confidentiality releases in consort with our corporate confidentiality policies, we provide a quarterly, case-specific complaint and appeal report. The standard complaint and appeal report profiles case resolution statistics and is intended for plan administration purposes only. We release the report two to three weeks after the close of the quarter.

TRAVEL MANAGEMENT

We have the ability to extract a custom report from our claims systems which would include all travel claims paid within a specified reporting period. We would then provide a summary report to the State of Alaska advising how many travel claims were processed under the plan, how many were reimbursed and denied, as well as the dollar amount paid. We would have the ability to also separate the information out by plan or bargaining group, etc. We would recommend that the travel report be prepared on a quarterly basis.

FSA-HEALTH CARE & DEPENDENT CARE / COBRA:

A full suite of comprehensive reports are included and available through the employer web portal.

Standard report frequency is based on the purpose and use of each report. Generally, reports can be produced daily, weekly, monthly or annually. Aetna/PayFlex's On-Demand Reports capability feature will enable the State of Alaska to request specific reports across client-defined intervals. Requested reports will then be delivered to the State of Alaska's Employer portal.

Our standard suite of reports is extensive. As a result, customization is not generally requested. However, custom reports can be provided upon client request based on data availability. The time frame for development and the associated cost is dependent upon the type of data requested. We will work with you to determine the feasibility of any custom reporting request.

The Aetna/PayFlex system -Complete Benefit Administration System (CBAS) supports four structural levels of reporting: Client, Employer, Category and Division. The platform supports multiple Employers within a client and up to 999 Divisions within an Employer. This structure provides clients with reporting flexibility. Detailed reporting is provided at the Employer Level which reflects each participant's Category and/or Division and can be sorted as the client desires. PayFlex also supports consolidated reporting across Employers at the Client Level for those clients whose structure requires multiple Employers.

Attachments: [Appeal SAMPLE Standard quart report 3Q05.xls](#)
[Medical Management Activity Report.pdf](#)
[Aetna Accounting Exhibits Sample.xls](#)
[Aetna Banking Report Sample.pdf](#)
[Aetna Claim Report Sample.xls](#)
[2.2.10.2.1 Aetna-PayFlex COBRA and Direct Billing Reports Guide.pdf](#)
[2.2.10.2.1 Aetna-PayFlex Employer FSA- HealthCare & Dependent Care Reporting Guide 8 2012.pdf](#)
[Performance Guarantee Results Sample.doc](#)
[Aetna Utilization Reports Sample.zip](#)

2.2.10.2.2 Please confirm that when requested to do so by the State, reports can track claims separately by benefit type (e.g., medical, vision, audio, health FSA, retirement system).

Answer: Confirmed.

For travel management reports, we have the ability to extract a custom report from our claims systems which would include all travel claims paid within a specified reporting period. We would then provide a summary report to the State of Alaska advising how many travel claims were processed under the plan, how many were reimbursed and denied, as well as the dollar amount paid. We would have the ability to also separate the information out by plan or bargaining group, etc. We would recommend that the travel report be prepared on a quarterly basis.

Attachments:

2.2.10.2.3 Other than those listed above, provide a list and detailed description (including frequency) of the reports provided on a standard basis (at no additional cost). Attach samples.

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

ACCOUNTING REPORTS

At the end of each contract period, we determine the service fee for the period, including any direct expenses for late service fee payments or claim wires and charges for special services, such as customized reports, new business or printing. Generally, if the service fee calculated at period end is different from the service fee collected throughout the period, reconciliation is included in the accounting package. We provide the accounting 120 days after the end of the policy period.

The annual accounting will include the following exhibits:

- Master Services Agreement (MSA) Reconciliation
- Current and Prior Period Reserve Analysis

BANKING REPORTS

We provide the following monthly banking reports through secure e-mail no later than the 25th of the following month for the prior month's activity.

- Funds Summary Report - This report provides a current month and a year-to-date control-suffix breakdown of claims and the funding applied.
- Funds Request and Receipt Report - This report shows the daily wire transfer requests and receipts for a given month.

CLAIM REPORTS

We provide you with monthly claim reports, in a Microsoft Access format 10 business days following the end of the reporting period, electronically through the Internet. The electronic reports summarize claim activity by line of coverage, along with providing detailed claim information for each employee as well as claim totals for employees and dependents by Medicare status.

UTILIZATION REPORTS

As described above, Aetna Health Information Advantage makes performance experience data available in real time through the Internet.

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

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

Preformatted reports are also available. The reports offer a view of the current year's and the prior year's data, illustrating utilization and financial trends in a concise, graphical format. The reports are available monthly.

The standard preformatted report package provides data on the following:

- Plan performance (including Aetna pharmacy when our medical product is linked to a pharmacy plan) on key financial and utilization metrics, prior and current with some current Aetna book of business comparisons, such as paid per member and per employee, admissions per 1,000 members, bed days per 1,000 members, average length of stay, office visits per 1,000 members, etc.
- Executive Summary providing quick analysis on plan performance by summarizing the key information from the report package.

- Medical membership demographics by age bands and gender, prior and current with Aetna book of business comparison and current membership age band buckets by gender with plan paid comparison.
- Paid claims for medical catastrophic claimants with user specified dollar threshold, prior and current reporting periods and current trend with and without these catastrophic claimants. There is an additional detail report showing medical catastrophic claimants with a user specified dollar threshold that includes inpatient and ambulatory paid amounts and diagnosis code. We mask these reports to protect against individual identification.
- Detail by Major Diagnostic Category (MDC) including three reports: one total report showing facility and professional claims, one inpatient report and one outpatient report. Each report shows the prior and the current period.
- Select reports provide a comparison to our product specific book-of-business benchmarks, which are also adjusted for the age and gender of the State's population.
- Provider network experience, including discount savings by inpatient, ambulatory, physician and other for prior and current reporting period.
- Medical cost sharing showing COB, deductible, copays, coinsurance, employee-paid portion and employer-plan paid portion.
- Trend analysis, utilization and unit cost by medical cost category.
- Hospital Profile showing the top 25 hospitals ranked by total medical claims paid amounts.
- Health Profile showing top 25 diseases ranked by paid amounts and listing those diseases under the plan that are part of our disease management programs.
- Key statistics for Pharmacy by generic, brand single source and brand multi-source if medical plan linked to an Aetna pharmacy plan.

The Standard Report package can also be run with variations on time periods, account structure, product combinations, network service area, large claimant threshold and claim basis (incurred versus processed).

In addition to the product-specific standard reports, we offer a Summary by Product package that provides key information for all medical product lines, pharmacy and dental in one package.

CASE MANAGEMENT

We provide Medical Management Activity Reports on a calendar quarter basis 45 days following the close of each calendar quarter. They summarize activities, monthly, quarterly and year to date including: the number of members identified; cases created, accepted, opened and closed; goals identified and met; the average volume of complex and proactive case management days; focus, referral and case closure reasons.

Flexible Medical Model Report

The Flexible Medical Model report details the additional clinical outreach provided in our Flex 2 model, such as applicable clinical outreach related to:

- Pre-admission calls
- Post-discharge calls
- Predictive modeling (PULSE) scores
- High-dollar claim utilization
- Frequent emergency room visits
- Multiple providers and/or services
- Post Informed Health Line calls
- Outpatient chemotherapy and radiation treatments

The report is available via our online reporting tool 45 days after the close of the quarter.

ACTIONABLE INFORMATION REPORTS

Your Aetna account team uses the Actionable Information Report during the annual plan review meeting. The report provides a clear, easy-to-understand summary of plan performance, key clinical findings and cost drivers.

Unlike many of our competitors, we provide a complete set of adjusted book of business benchmarks. This annual report automatically flags any variance from those benchmarks. Armed with this information, you and your account team can discuss ways to adjust your health and wellness programs and communications to sustain or improve results.

The report runs on an incurred basis with a two-month lag. We recommend at least 12 months of your incurred data to compare to the benchmark. With two full years, we can compare your data year-over-year and to the benchmark.

The report displays clinical metrics into separate content areas, such as ambulatory radiology and medical pharmacy. This helps us rapidly identify areas where different products, programs and services can have an impact on affordability and quality.

Attachments: [Aetna Utilization Reports Sample.zip](#)

[Aetna Flexible Medical Model Report.pdf](#)

[Actionable Information Report Sample.pdf](#)

[Medical Management Activity Report.pdf](#)

[Aetna Accounting Exhibits Sample.xls](#)

[Aetna Banking Report Sample.pdf](#)

[Aetna Claim Report Sample.xls](#)

2.2.10.2.4 Are you able to accommodate requests for ad-hoc or customized reporting (including utilization information) at no cost to the State? If there is an additional cost, please indicate the cost on the rate sheet.

Answer: Yes. Customized reports are available upon request from Aetna Informatics. We assign a business consultant to respond to tailored information and analytic needs. We will provide the State with 50 prepaid hours for ad hoc reporting and other analytic projects. Once the prepaid hours are exhausted, we charge \$200 per hour for report generation/programming and \$350 per hour for analytic/consulting services.

Attachments:

2.2.10.2.5 If you are able to accommodate ad- hoc or customized reporting, what is the normal turnaround time to fulfill such request.

Answer: We prepare and deliver most ad hoc reports within three to five business days.

Attachments:

2.2.10.2.6 Are you able to provide reporting based on account code structure to allow the State to see trends in claim activity information by different organization units?

Answer: Yes. We will set up an account code structure to allow the State to view trends by each organization unit. This will be addressed in the set up process to establish the necessary structure to support the State's reporting needs.

Attachments:

2.2.10.2.7 Describe any custom reporting and data dashboards you have created for your clients, be specific and how they integrated into the full suite of services being proposed.

Answer: We offer online reporting through Aetna Health Information Advantage and our Actionable Information Reporting.

AETNA HEALTH INFORMATION ADVANTAGE

The ideal tool for benefits managers, Aetna Health Information Advantage places valuable information at their fingertips. Aetna Health Information Advantage allows the State to perform interactive data analysis on topics such as key measures, medical trend and membership. These topics, called modules, are produced at the customer level by funding arrangement and product type on an incurred basis with a two-month claim lag. The modules offer a high-level view of the current data as well as book of business and prior year comparisons. Each module can be drilled down into more detailed reporting and graphs allowing users to group and refine how they look at the data with options such as time period, products, age, gender, region, provider specific detail, etc.

To enhance the ease of navigation, our Aetna Health Information Advantage interface provides you with a direct link to other reports for programs/services such as: Aetna Disability Services, Case Management, Disease Management, Informed Health® Line, Beginning Right® Maternity, National Advantage Program, Aetna Behavioral Health and others.

The standard preformatted report package can also be run with variations on time periods, account structure, product combinations, network service area, large claimant threshold and claim basis (incurred versus processed). We update our data monthly.

We also offer a spotlighting feature within Medical Standard report which facilitates analysis by highlighting key indicators (i.e., green = good, yellow = caution, red = critical). The highlighting is based on the results of your plan. For example, if the plan's percent increase in medical paid amount per member is equal to or greater than 20 percent, that statistic will be shaded in red to indicate critical. The highlighted cells also include comments, which help to quickly analyze plan performance.

ACTIONABLE INFORMATION REPORT

The Actionable Information Report provides a clear, easy-to-understand summary of plan performance, key clinical findings and cost drivers.

The report displays clinical metrics into separate content areas, such as ambulatory radiology and medical pharmacy. This helps us rapidly identify areas where different products, programs and services can have an impact on affordability and quality.

We compare your population's numbers against our own benchmarks to see where the plan is coming

in too high or right on target. The report is color coded to make it simple. Green means that item is within normal range. The report also shows year-over-year trend for ongoing monitoring of your Aetna benefits. This helps us spot recent health and behavior changes in your population so we can act on it quickly, before it becomes too costly.

The report does not just report the problem. It is actionable because we also provide ways to improve your situation.

For example:

- There are higher than normal costs associated with diabetes. This may tell you there is a need for disease management programs, or improved efforts to educate your members to participate in the Aetna programs available to them.
- Out-of-network claims are higher than the benchmark in strong network geographies. It could be there is not enough incentive for members to use in-network services. Copay and coinsurance levels may need to be adjusted.
- The report shows higher-than-expected costs for end stage renal disease. Since Medicare covers that, we should check that we are properly coordinating benefits with Medicare.

The reports include the following content areas:

Medical/Pharmacy

- Membership Characteristics
- Impact of Membership Characteristics on Medical Cost
- Medical and Pharmacy Costs
- Spend by Medical Cost Category - Current period
- Percentage of Total Medical Paid Amount by Medical Cost Category
- Trend by Medical Cost Category
- High Cost Claimants
- Inpatient Hospital
- Ambulatory Services
- Physician Office Visits and Behavioral Health Specialist Visits
- Emergency Room
- Free Standing Radiology Year
- Medical Pharmacy
- Preventive Care
- Chronic Condition Prevalence
- Predictive Modeling (PULSESM) Score and Medical Costs
- Distribution of Members by PULSE Score
- Network Utilization
- Cost Sharing

Health and Wellness Programs

- Member Engagement in Disease Management Program
- Disease Management Program Chronic Conditions Managed
- MedQuery® Care ConsiderationsSM (gaps in care alerts) by Level
- MedQuery - Care Considerations by type

- Examples of Care Considerations
- Med Query Savings Trend
- Aetna Navigator® (member website) Utilization

Attachments:

2.2.10.2.8 Are reports available via the web?

Answer: Yes.

Attachments:

2.2.10.2.9 Indicate functions of your Web-based reporting product available to the client staff.

**Answer: 1: Send Eligibility Updates,
2: Extract Enrollment Information,
3: Run Standard Eligibility Reports,
4: Run Ad Hoc Reports,
5: Full Query Capability,
6: Run Premium Reports**

Detail:

Options:

1. Send Eligibility Updates
2. Extract Enrollment Information
3. Run Standard Eligibility Reports
4. Run Ad Hoc Reports
5. Full Query Capability
6. Run Premium Reports
7. Other: [Text]

Attachments:

2.2.10.2.10 If applicable, confirm you will handle all mandatory reporting to CMS and states that have surcharges such as New York and Massachusetts.

Answer: Confirmed.

Attachments:

2.2.11 Financial

2.2.11.1 Subrogation

2.2.11.1.1 Do you charge for subrogation?

Answer: Yes.

Attachments:

2.2.11.1.2 If you answered Yes to the previous question, please indicate the charge for subrogation.

Answer: We are offering subrogation as a performance based incentive. If the State of Alaska engages Aetna to provide comprehensive subrogation services, we will retain a fee of 30% of recovered amounts. We have an agreement with the firm of Rawlings & Associates to provide these services. If the state does not accept the incentive based payment structure for subrogation, Aetna would be unable to provide subrogation services.

Attachments:

2.2.11.2 Banking

2.2.11.2.1 Provide a sample of your administrative fee invoice.

Answer: 1: Attached

Detail:

Options:

1. Attached
2. Not Attached

Attachments: [Aetna Fee Invoice Sample.pdf](#)

2.2.11.2.2 Describe your process for printing checks, including whether they are produced daily, weekly, monthly or other. Describe whether the timing is different for members than for providers and your process for replacing a lost check when notified by a member or provider that they did not receive the check.

Answer: We mail member EOBs and checks daily when there is a member payment or request for additional information from the member. We produce EOBs in Erlanger, KY by an off-site print vendor.

We age and bulk in a schedule provider EOBs and checks, whether for network or non-network providers. This allows delivery within 24 days of the claim received date. We send the majority on either a weekly or biweekly schedule, and on a consistent day of the week determined by state location of the provider. A provider EOB accompanies each provider draft. The EOB breaks down the payment by patient and gives pertinent information about the payment and non-covered expenses.

Members can contact their health concierge and member services if they did not receive a check. We will work with the member to replace the lost check as soon as possible.

Attachments:

2.2.11.2.3 Describe whether the timing for printing checks is different for members than providers and your process for replacing a lost check when notified by a member or provider that they did not receive the check.

Answer: EOBs will go out daily, and not aged when there is a member payment or request for additional information from the member. Members can contact their health concierge and member services if they did not receive a check. We will work with the member to replace the lost check as soon as possible.

We age and bulk provider EOBs and checks, whether for network or non-network providers. This allows delivery within 24 days of the claim received date. We send the majority on either a weekly or biweekly schedule, and on a consistent day of the week determined by state location of the provider.

Attachments:

2.2.11.2.4 What measures are in place to ensure that reimbursements are issued to the proper party?

Answer: We have end to end quality measures in place to ensure payment accuracy. In addition to an extensive array of system controls, we perform the following prepayment audits:

- Trainee Audit - Initially, the business unit provides mentors/auditors to audit 100 percent of claims processed by trainees. As each trainee's results reach an acceptable level in a category, the percentage of claims reviewed decreases.
- Draft Authority Limit Audit - Each individual in the service center has a specific draft authority limit. Supervisory or management personnel review claims above that limit.
- Prepayment Review - We audit all claims equal to or greater than \$7,000. The quality auditors report to our National Customer Operations (NCO) Claim Quality department.
- Itemized Bill Review - For certain large inpatient facility claims from network facilities, we offer Itemized Bill Review (IBR), an additional feature of our National Advantage Program (NAP). We have partnered with a vendor to review these claims for billing errors prior to claim adjudication. IBR reviews inpatient facility bills with submitted expenses of \$20,000 or more incurred at a network facility (excluding per diem arrangements). We pay the claim based on standard billing practices and in accordance with the facility's contractual arrangements. The State must participate in NAP in order to elect IBR.

We perform the following audits on a post-payment basis:

- Stratified Quality Audit - Using an industry accepted stratified audit methodology, the population of processed claims are segregated into dollar categories (strata) based upon the amount paid. A sampling of claims is randomly selected from within each strata. Results are extrapolated over the entire population based upon the weight of each strata to the population.
- Daily Processor Audit - Our auditing staff audits claims through a system-generated, random selection process. We examine claims for payment, procedural or coding errors. We audit a minimum of 20 claims per processor each month. The quality auditors report to our NCO Claim Quality department.
- Auto-adjudicated Claim Audit - Our Quality Assurance Policy includes a monthly audit of auto-adjudicated claims at the office level (204 claims per claim office key, per quarter, if available) with a maximum of 10,000 audits per quarter at the enterprise level.
- Auditor Re-audit - Auditors are subject to a re-audit of their work based on a stratified sample. This audit validates the accuracy of the auditors and compliance with the audit program. Overall results are reported for Pay Incidence, Pay Dollar and Total Claim Accuracy.
- Bank-Cleared Claim Draft Audit - Our corporate office oversees our automated check auditing system that monitors each bank-cleared check.
- Corporate Audit - Any of our service centers may be subject to an audit by our Corporate Audit department on an unscheduled, unannounced basis to evaluate the effectiveness of controls over processes and procedures.
- Medical Bill Audit - We have a comprehensive medical bill audit program in conjunction with external suppliers that includes hospital bill audits; DRG audits for DRG code validation; and targeted contract compliance audits for inpatient and outpatient facility claims.

We provide an electronic claim file of paid facility claims greater than \$10,000 which the suppliers performs both an automated and manual review of the electronic file to identify claims paid using the

“percentage of billed charges” methodology.

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

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

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

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

In addition, we are also subject to SOX and SSAE 16 SOC 1 review.

Attachments:

2.2.11.2.5 Explain whether you offer direct deposit of participant benefit reimbursements and identify for which benefits covered by this proposal the direct deposit service is available.

Answer: Member direct deposit is available for FSA and DCAP. It is not available for member reimbursement at this time under the medical plan.

Attachments:

2.2.11.2.6 Describe your ability for accepting electronic fund transfers for member payment of premiums for COBRA/Direct Bill participants.

Answer: Participants may pay their monthly premiums by mailing a check or money order to PayFlex. As an alternative, participants can submit electronic payments to us through the participant web portal. Both one-time and recurring EFT options are available. When the one-time EFT option is used, the participant enters his/her checking or savings account type, account number, transit routing number and financial institution name. An EFT transaction for the full amount of premium due is automatically initiated as part of the next EFT processing schedule. When the recurring EFT option is used, the participant enters his/her checking or savings account type, account number, transit routing number and financial institution name. An EFT transaction for the full amount of premium due is automatically initiated on the 8th of each month, or on the next business day thereafter. Recurring EFT instructions remain in place until the participant changes them online.

Attachments:

2.2.11.2.7 Please confirm you will establish a separate bank account on the State’s behalf.

Answer: Confirmed.

Attachments:

2.2.11.2.8 Please confirm that you will set up the State's account structure based upon their requirements.

Answer: Confirmed.

Attachments:

2.2.11.2.9 Please confirm you will process claims and issue checks from the bank account you established on the State's behalf.

Answer: Confirmed.

Attachments:

2.2.11.2.10 Please confirm you will request an electronic transfer of funds from the State at regular intervals on a "checks cleared" basis and that the request will be by active employee claims and retiree claims; retiree claims will be split by medical and DVA expenses as well as by retirement system.

Answer: Confirmed. We have assumed daily.

Attachments:

2.2.11.2.11 Please confirm you will provide the State with a monthly report reconciling the account balance, claims drafts and electronic transfers.

Answer: Confirmed.

Attachments:

2.2.11.2.12 Do you require that self-funded plans use a specific bank for funding claims? If yes; indicate name of bank.

Answer: Yes. We use a joint benefit payment clearing account (i.e., a Single Account Multiple Participant or SAMP account) at Bank of America or Citibank Delaware. The State subscribes to this account by signing a banking agreement that we forward to our bank.

The State is identified as payer to show that benefit payments go directly from the State to employees. We are shown as the State's agent.

Attachments:

2.2.11.2.13 For self-funded plans, confirm that no imprest balance is required.

Answer: Confirmed.

Attachments:

2.2.11.2.14 What is the frequency for ACH transfers for claim funding?

Answer: We request funds from the State's designated bank when recorded claims total at least \$20,000 and on the first banking day of each month. We assume that based on the number of members, the State will be funding claims on a daily basis.

Attachments:

2.2.11.3 Direct Bill

2.2.11.3.1 Confirm you are able to bill and remit to the State premiums due on a monthly basis for any retiree whose retirement warrant is insufficient to pay the elected coverage, including divorced and widowed spouse continuing long term care coverage, when the member enrolls in the Direct Bill program. This question assumes the State will direct the Contractor as to the retiree's coverage elections. The State retains eligibility determination responsibility for Direct Bill.

Answer: Confirmed.

Attachments:

2.2.11.4 COBRA

2.2.11.4.1 Confirm you are able to administer COBRA continuation for members who must pay premium directly.

Answer: Confirmed.

Attachments:

2.2.11.4.2 Describe your ability for accepting electronic fund transfers for member payment of premiums for COBRA.

Answer: Aetna/PayFlex:

As a recognized leader in account administration, PayFlex Systems USA, Inc. was recently acquired by Aetna to offer the PayFlex Spending Account and COBRA administration solutions to their clients as well as continuing to provide on a stand-alone basis as well. The transaction was completed on October 3, 2011, making PayFlex a wholly owned subsidiary of Aetna and operating as an independent subsidiary.

Electronic Fund Transfers:

Participants can submit electronic payments through the participant web portal. Both one-time and recurring EFT options are available. When the one-time EFT option is used, the participant enters his/her checking or savings account type, account number, transit routing number and financial institution name. An EFT transaction for the full amount of premium due is automatically initiated as part of the next EFT processing schedule. When the recurring EFT option is used, the participant enters his/her checking or savings account type, account number, transit routing number and financial institution name. An EFT transaction for the full amount of premium due is automatically initiated on the 8th of each month, or on the next business day thereafter. Recurring EFT instructions remain in place until the participant changes them online.

Attachments:

2.2.11.4.3 Please indicate in the chart below your ability to provide the listed COBRA administration service. If there is an additional cost, please indicate the cost on the rate sheet.

Duties of Service Provider	Response
Notify each Qualified Beneficiary of the right to continue coverage	Yes
Accept directly from the client, Qualified Beneficiary (QB), or representative of a QB notice of a Qualifying Event (QE), second QE or SSA disability determination	Yes
Prepare and distribute COBRA election forms	Yes
Bill each COBRA participant on a monthly basis	Yes
Accept COBRA premium payments from participants and remit to the client on a weekly basis	Yes
Determine if COBRA participant has paid the required COBRA premium amount on time	Yes
Provide notice of nonpayment or insufficient payment to a COBRA participant	Yes
Provide monthly accounting to the client of all COBRA premium payments	Yes
Accept and respond to notice of QEs	Yes
Furnish records and information to the client as needed	Yes
Provide special messages to COBRA participants upon notice from the client	Yes
Distribute required open enrollment materials, SPDs, or other mass mailing per notice from the State	Yes
Maintain required backup documentation for all COBRA notices, forms, etc. per ERISA	Yes
Monitor and advise the client of state/federal continuation requirements	Yes
Implement procedures and methods to confirm a COBRA participant's continued eligibility for COBRA coverage	Yes
Inform the client of COBRA elections	Yes

Duties of Service Provider	Response
Notify QB of any available conversion privilege	Yes
Distribute notices of unavailability of COBRA coverage	Yes
Distribute notices of termination of COBRA coverage	Yes
Record and monitor COBRA elections and terminations	Yes
Notify the client when an individual ceases to be eligible for COBRA coverage	Yes
Provide customer service via phone and web	Yes
Receive, process and enter open enrollment elections from COBRA participants	Yes

Detail:

Attachments:

2.2.11.4.4 Please attach a flowchart of payment processes between your company and the client.

Answer: 1: Attached

Detail:

Options:

1. Attached
2. Not Attached

Attachments: [A_5.2.10.4.4 COBRA Process Flow Chart.pdf](#)

2.2.11.4.5 How long after receiving premium payments from COBRA participants, will you forward the payments to the client? To the extent any 'float' will accrue, indicate how it will be tracked, reported and credited.

Answer: On the 10th of each month or such day of the month as determined by the State, monthly Premium Remittance Register reports are produced and made available on the Employer Portal. Notification of availability will also be sent to the State contact via e-mail. The remittance includes all monthly premium amounts satisfied prior to the current remittance period OR all satisfied monthly premium amounts less the 2% administration fee and less our administration fees. Remittance is made via check or EFT directly to the State.

If payments are made directly to carriers, the same schedule applies. Monthly Premium Remittance Register reports are produced for each carrier payment and sent to the individual carriers.

If our fees exceed the amount of premium remittance collected in any month, our standard payment terms for outstanding fees owed are net 10 days.

Attachments:

2.2.11.4.6 Describe your quality control process for invoicing.

Answer: We support a standard monthly billing cycle. Additional billing cycle options are yearly, quarterly, semi-monthly (direct billing only) and weekly (direct billing only). Two types of premium billing options are available:

* Premium payment coupons that are sent to the participant at the start of the plan year (or point of COBRA election).

* Premium notices that are sent to the participant each month on a date that The State can define

(default is the 15th of each month).

Monthly premium calculation is automated by the platform and is based on the participant's election, rates and coverage levels provided by The State as part of the implementation process. In the case of a mid-month coverage effective date, the first month's premium amount is prorated. In the case of a retroactive benefit change, the first month's premium includes all retroactive months.

All COBRA premium payments are collected at our secure Distribution Center within the Omaha, Nebraska headquarters location. Checks are scanned and deposited into a PayFlex bank account via a file process. Checks are retained for 90 days and then securely destroyed by shredding. The premium amount, check number (if applicable) and month of premium payment are posted to the participant account in the COBRA platform. Premium payments are entered within 2 business days of receipt unless additional research is required. A daily bank reconciliation process is used to ensure the accuracy of payment processing and bank deposits. As part of this process we receive daily bank files and perform a reconciliation of transactions posted to our COBRA platform to actual cash activity at the bank. Any discrepancies are resolved.

Premiums are due on the first day of each month and are considered paid on time if the mail receipt date/EFT payment date is on or before the 30-day grace period end date. The COBRA platform automatically rejects any premium that is received by us after the grace period has expired. These late payments are returned to the participant and notification of COBRA termination is sent to the participant and appropriate carrier(s).

Attachments:

2.2.11.4.7 By which method do you send each of the following (regular mail, certified, etc.)?

	Response
COBRA initial notification	Notices are delivered to participants via First-Class mail. Initial Rights Notices also include “proof of mailing.”
Qualifying event notice	Notices are delivered to participants via First-Class mail. Qualifying Event packages also include “proof of mailing.”
Correspondence	Notices are delivered to participants via First-Class mail.

Detail: Participants may also elect to receive notices via email by electing the eNotify™ option on the participant portal. The eNotify™ option is available once the QE notice has been sent to the participant.

Note: The QE Notice, Initial Notice and Termination Notice are not sent via eNotify™

Attachments:

2.2.11.4.8 What payment options are available for participants?

Answer: 6: Check Online,
7: Automatic Debit,
8: Check by Mail

Detail: Participants may pay their monthly premiums by mailing a check or money order. As an alternative, participants can submit electronic payments through the participant web portal. Both one-time and recurring EFT options are available. When the one-time EFT option is used, the participant enters his/her checking or savings account type, account number, transit routing number and financial institution name. An EFT transaction for the full amount of premium due is automatically initiated as part of the next EFT processing schedule. When the recurring EFT option is used, the participant enters his/her checking or savings account type, account number, transit routing number and financial

institution name. An EFT transaction for the full amount of premium due is automatically initiated on the 8th of each month, or on the next business day thereafter. Recurring EFT instructions remain in place until the participant changes them online.

Options:

1. Credit by Phone
2. Debit by Phone
3. Check by Phone
4. Credit Card Online
5. Debit Card Online
6. Check Online
7. Automatic Debit
8. Check by Mail

Attachments:

2.2.11.4.9 Confirm you will provide eligibility for this group to other contractors as appropriate.

Answer: Confirmed.

Attachments:

2.3 State Objectives

2.3.1 Plan Design

2.3.1.1 Please describe how you can assist the State with identifying and implementing possible plan enhancements that would support the states objectives as identified in Section 1.0 of the RFP.

Answer: The State of Alaska has clearly articulated a vision and objectives that will transform health care delivery in the State. The vision and objectives, they do require the State to partner with an organization that is innovating and evolving at a rapid rate to fully support the short and long term objectives. Aetna is an organization that can support the objectives and continue to bring forth approaches and solutions critical to the State of Alaska's future success through four key pillars:

INNOVATION, DESIGN AND PERFORMANCE EXCELLENCE- Aetna is the administrator for 643 national account customers, 318 public and labor organizations, 197,467 Medicare customers, 1,257,110 Medicaid members, and 17,818,931 commercial members. This portfolio of customers is the result of continuously innovating and supporting our customers. Our insured book of business is also important as we also require all of the innovation and support, the same as our self-funded customers.

We have a culture of innovation at Aetna and have developed multiple areas of the organization to support organizational improvements from all of our employees. This ranges from innovation at every level of the organization to our Emerging Business Unit focused on developing critical customer solutions. This innovation has resulted in on-going enhancements in how we are improving our operations to both streamline the administrative processes and enable design solutions to support our customers. This begins with the simple measures of having our clinical policies be included in our network contracts and our claim system tied to those same policies. Our network and any custom network solutions are fully integrated into our claim system to streamline the payment process. Our leadership has empowered all Aetna employees to identify methods to improve our operations to deliver the highest quality program to our plan sponsors and members.

Our innovation, design and performance excellence enables us to support the following State of Alaska objectives:

- Embedding clinical decision support tools into daily practice
- Using information technology to support patient education, patient care planning, coordination of care, and monitoring of compliance
- Comprehensive collection, analysis and utilization of data to inform and guide policy and plan design decisions
- High accuracy in claims processing
- Quality customer service

CONSUMER ENGAGEMENT - The age of the consumer is here and Aetna fully recognizes this as a key area to cost management. We are creating the critical support for the member with the personnel and technology to provide information and advocacy through the method sought by the member. We truly believe that the support the State of Alaska requires to transform health care is through One Member at a Time. Our Health Concierge Service model is the My AlaskaCare Single Point of Contact. The My AlaskaCare SPOCs are specially trained personnel with the tools to be the member advocate and truly the “Concierge” role across the full benefit program continuum. Our technology is the other mechanism that puts the power of transparency, clinical decision support and provider directories (in and out of network) at the member's fingertips via web and mobile phones. For the State of Alaska, the My AlaskaCare SPOC and web and mobile tools are a key cornerstone to supporting your members both in and out of Alaska. It supports the advocacy and member experience across Aetna and all of the State of Alaska benefit programs essential to delivering upon State of Alaska objectives.

Our consumer engagement enables us to support the following State of Alaska objectives:

- Encouraging patients to engage in the management of their own health
- Providing them with resources and skills to obtain appropriate health care services
- Using information technology to support patient education, patient care planning, coordination of care, and monitoring of compliance

EVIDENCE-BASED MEDICINE - Aetna has not wavered from using evidence-based medicine to manage our customers' benefit programs on both a self-funded and fully insured basis. This begins with our disciplined approach to developing clinical policies based on evidence-based medicine. Our Clinical Policies are often used by TPAs and other insurance carriers, because of the disciplined approach and rigor around the on-going review process. Our Care Engine technology is the Clinical Decision Support the State of Alaska is seeking by ensuring evidence-based medicine is applied to all medical and pharmacy claims. The application of evidence-based medicine includes our dental program that leverages our Dental Medical Integration grounded on dental care that drives medical costs.

Our evidence-based medicine enables us to support the following State of Alaska objectives:

- Designing the delivery system to ensure the provision of effective, efficient clinical care
- Embedding clinical decision support tools into daily practice
- Using information technology to support patient education, patient care planning, coordination of care, and monitoring of compliance
- Increasing overall value through cost reduction and improved health outcomes and improved quality of health care
- Comprehensive collection, analysis and utilization of data to inform and guide policy and plan design decisions

PROVIDER COLLABORATION - Our network management is built on sound principles beginning

with evidence-based medicine approach to our clinical policies to our reimbursement approach in Alaska. Our experience in core network management and breadth of our book of business will further support the necessary network development in the State.

More importantly, we are in a material shift in health care delivery through the evolution of Patient Centered Medical Homes and Accountable Care Organizations. Aetna has been a leader in national quality networks through Aexcel and the on-going evolution of high performance networks. This experience and our supporting technology have enabled us to be a market leader in the development of Accountable Care Organizations and the infrastructure to support other Patient Centered Medical Home models. Our collaboration includes the early stage evaluation of an Accountable Care Organization in Alaska, which would benefit the State of Alaska.

Our provider collaboration enables us to support the following State of Alaska objectives:

- Designing the delivery system to ensure the provision of effective, efficient clinical care
- Embedding clinical decision support tools into daily practice
- Using information technology to support patient education, patient care planning, coordination of care, and monitoring of compliance
- Increasing overall value through cost reduction and improved health outcomes and improved quality of health care
- Comprehensive collection, analysis and utilization of data to inform and guide policy and plan design decisions

Our experience across these four cornerstones in Alaska and the lower 48 will allow us to support the State of Alaska's objectives across each of the RFP components. When integrating each of the RFP components, we can deliver a fully integrated comprehensive solution that will support the goals and objectives, which includes delivering the cost controls so critical to the future of the State of Alaska benefit program.

Plan Enhancement Support

The identification of the plan enhancements is a key area that Aetna will support the State of Alaska. There are several elements to identification of plan design enhancements that we bring to the table:

Data Analytics - We have robust reporting tools that will enable us to effectively evaluate the State of Alaska's data. We have the ability to report across all of the critical facets and will structure the State of Alaska account to fully support reporting needs. Our reporting addresses all of the key areas and supports break downs by plan, group, location, etc. to effectively evaluate drivers. We have data analytics resources and subject matter experts to support the full assessment process. We leverage core reporting through our ePSM tool that provides key metrics and our more robust reporting tool AHIA. AHIA is a comprehensive reporting tool built on our data warehouse and enables robust data mining to fully identify cost drivers and issues. For State of Alaska, we will deploy all of our reporting tools to support the identification of cost drivers.

Solution Identification - While data analytics is essential, we feel the more fundamental need for our plan sponsors is the solution identification. We have made material investments in our processes to determine issues and the solutions. This begins with the use of our experts in analytics, clinical, operations, network management, Accountable Care Solutions and wellness to name a few. We also have reports exclusively focused on a detailed program review that identify issues and customer opportunities that we call Actionable Information Report. The report identifies key solutions and opportunities for the State that align to the State of Alaska's goals for policy and design, consumer engagement and provider delivery. For the State of Alaska, we commit to using our Actionable

Information reporting approach as well as the full complement of our experts to develop recommendations for the State of Alaska.

Another fundamental element is the strategy and solution development process. As the State of Alaska is seeking significant change to transform health care in the State, we recommend a multi-faceted strategy and solution development process. We will facilitate the session with the State of Alaska and if appropriate, other State of Alaska vendor partners.

The Phase 1 of the strategy process is an annual review of the objective and short and long term goals. We will support the annual review and development of goals based on the market dynamics and leading edge approaches. We envision the goal development and strategy session will include our Account Team, Clinical Advisory Team and Alaska Advisory and Support Team to map out the strategy, barriers to success and general solutions. Through this framework, solutions begin to be framed addressing each of the areas of consideration in alignment with the State of Alaska's goals. Aetna will support the facilitation of the session and vetting national and Alaska specific solutions to support the goals. These solutions will be grounded in the tools and resources we bring to the table and specifically the level of advocacy Aetna can support through My AlaskaCare Single Point of Contact (Health Concierge) and technology to speed the deployment of solutions.

Upon completion of the session, we will take the goals and objectives along with the potential solutions to evaluate against the State's data. We will mine the State of Alaska's data to determine the impact of solutions and begin to address necessary change management to deploy the solutions. Through this analysis, we will develop a discussion guide along with an outline of multiple paths and expected outcomes and impact to discuss with the State.

The last phase of the strategy process is a comprehensive ideation process with the State of Alaska. The ideation session will be based on sound practices used by our Emerging Business area to align to similar practices used to finalize decisions on proceeding with a business. We will assess solutions and convergence of solutions to use a brainstorming approach to develop the “product” for deployment. The ideation process uses the facets on issues, solution and overall adoption. The goal is to refine or reject solutions to arrive at an overall package for the State. We will leverage experts from our Emerging Business area to help support this process and arrive at solutions that fully understand the behavioral components and member experience so essential for long term sustainability.

Our expectation is to arrive at comprehensive solutions that are specific to the State's issues and extend beyond basic plan design or programmatic changes. We believe the real value we bring is the evaluation of more aggressive changes and the timing for deployment. As the State of Alaska will see, there are many solutions as we define in question 2.3.2.1. As we assess the most pivotal areas of how we can support the State of Alaska it is grounded in several key areas:

- Consumer Engagement - We have conducted significant research in consumer engagement from our Health Fund Study results, Consumer Engagement Metrics to our experiences with product development. Our focused studies in behavioral health and overall brain health are also informing us on the impact and handling of stressors. We have the ability to support solutions through all forms of designs and consumerism inclusive of leveraging our expertise on successful Health Savings Accounts and Health Reimbursement Accounts plans as well as consumer solutions for traditional PPO plans. The transformation will require overall consumer engagement and aligns with our commitment to support this one member at a time.
- Network Solutions - A core area of change necessary in the State of Alaska is the overall approach to network. While Aetna brings a highly effective and broad Alaska network that balances cost and quality, there are areas of Alaska that have boycotted networks. To a certain extent, our unwavering

requirement for clinical and claim payment provisions has been a deterrent for some providers to contract. As we work with the State, we will focus solutions very specific to each borough in the State including the use of alternative arrangements as appropriate. Our expertise in Accountable Care Solutions, Patient Centered Medical Homes, Institutes of Quality for Bariatric and Cardiology, and High Performance Networks will inform solutions. A critical consumer facing tool for network solutions is our transparency tools.

- Tele-medicine - Another area of exploration is alternative providers and the role they can play for the State. Teledoc is an alternative provider option that can be leveraged for care delivery for members in rural locations as well as reduce emergency room utilization. Medical Home Exchange is another solution. These solutions reinforce an overall need to define a full strategy and align to an overall local provider base. Our expertise in these solutions and impact on networks will be evaluated with the overall network solutions for the State.
- Technology - The area of technology is rapidly expanding for us and will offer tremendous solutions for the State. iTriage is one of our solutions that is expanding over the next year and is a key tool for every State of Alaska member. Our technology and ability to integrate third party tracking (EOS Health for diabetes) for all areas will support the evolution of the State of Alaska's program.

While the active plan enables immediate solution deployment opportunities, we will also support the State in Pre-Medicare and Medicare design alternatives. We fully recognize the protected nature of the retiree medical program, but also recognize the plan lacks critical features to both manage costs and more importantly support retirees in health maintenance. We have extensive expertise with retiree populations to develop programs that fully balance preventive care, cost sharing and condition management to support retirees and their dependents in achieving their optimal health. We view our role as additional expertise and analytics to support the State in developing an optimal program for retirees that can be offered as a replacement or along-side the current plan.

We will support the State with the necessary solution development and analytics. The approach outlined and our support also materially changes the focus of quarterly meetings from a review of data to change measurement and solution refinement. The power of refinement is supported by the My AlaskaCare Single Point of Contact and ability to change their messaging to your members as they deliver the necessary advocacy to achieve your goals. Each year is a building block on achieving critical changes for your members and the provider network that is fully empowered by our people and solutions.

Once solutions are defined, we will use our implementation processes to deploy these solutions. The process will leverage our tools and capabilities as well as the communication budget for roll out. A critical element of any change will be the My AlaskaCare Single Point of Contact and the support the team will provide with both education and overall advocacy for the members. Leveraging our Alaska knowledge and experience along with Government and National Account experience will deliver effective design solutions to achieve the State's objectives.

Attachments: [Aetna Story 020813.ppt](#)

2.3.2 Policy Development

2.3.2.1 Please describe how you can support the State in policy development through the use of data driven analysis and best practice recommendations. Please include any additional resources your organization can provide.

Answer: Aetna has both experience as well as the underlying infrastructure to support the State in policy development. Our geographic footprint and the fact that we provide insurance coverage in Alaska and the lower 48 are benefits to the State in policy development. This experience and our disciplined approach with evidence-based medicine provide us with a unique position to support the State in policy development.

On a national basis, we remain focused on fostering compliance with the Affordable Care Act (ACA). We will continue to help our customers with the implementation of ACA. We will continue to advocate for workable regulations and needed legislative changes to avoid the unintended consequences of higher costs and needlessly complicated requirements on our customers. We will work with public policy leaders and legislators to fix the serious issues that continue to plague our health care system.

A significant element of policy development is the understanding of health care delivery and the variation by geography. The Account Team and advisory teams covering clinical and Alaska care delivery are a critical element to the policy development process. This team will leverage national and regional resources in the areas of clinical policy development, government affairs, Accountable Care Solutions, Primary Care Medical Home Enablement, Medicaid and Medicare program administration, health care reform, transparency and alternative payment approaches (e.g., reference based pricing and case rates) to name a few. Overall, we have the infrastructure and resources to support the State's policy development as well as a determination of pilot opportunities.

Our process will be to work with the State on developing the areas of policy development including the goals in specific areas. The team will leverage our national resources to identify best practices and approaches to impact the State's goals. Our sessions with the State will leverage the clinical and Alaska specific expertise to uncover opportunities. In addition, we will have participation by our subject matter experts to address emerging solutions in the market and address policies to support deployment of those solutions.

Once areas are identified we will work with our internal resources for the analysis of the data available. We will leverage our resources that handle our internal evaluation processes including data analytics, review of evidence, and understanding of provider and member impact. In addition, our data is made more robust by expertise we have in the establishment of Accountable Care Organizations and Patient Centered Medical Home enabled delivery systems.

We have supported organizations in the review and development of policies for their own organization as well as State legislation. While we do not provide legal advice, we have resources to support review and make recommendations on the type of changes that can change care delivery. Our role in health care reform emphasizes our desire to impact cost and quality in the health care delivery. The State of Alaska is in a unique position to drive health care delivery through policies that support the change. Our Alaska experience combined with the national resources can support the development of policy for the State of Alaska program only as well as for the State.

We envision a key component of the policies to be a potential demonstration of projects that explore changes to care delivery in the State. Our robust experience with Accountable Care Organizations and Patient Centered Medical Homes will be valuable in not only developing solutions, but guiding set up of changes in the delivery system.

Attachments:

2.3.3 Innovation

2.3.3.1 Briefly describe the four most important ways you propose to assist the State in controlling health costs in Alaska now and in the future.

Answer: The four most important ways we can support the State in controlling health care costs in Alaska now and in the future, aligns to our four pillars. Overall, we believe the State must align with an organization that materially takes the State beyond a transactional administrator and to an organization supporting its strategic direction. The State of Alaska has clearly outlined a vision and objectives that require an organization that provides the infrastructure, tools and resources to support the development and deployment of its strategy.

Aetna is uniquely situated due to its role in providing insurance coverage in Alaska today and the sophisticated customer base operating in Alaska and the lower 48. Our experience in Alaska and the lower 48 with government and commercial customers supports the State's strategies both now and in the future. The four most important ways we support the State are:

- **CONSUMER ENGAGEMENT** - Consumer engagement is not only one of the State's objectives, but a critical area of Aetna's strategic direction. This is a demand from our customers operating in Alaska and lower 48 as well as an area critical for Aetna under the Accountable Care Act. The ability to control costs is highly dependent on consumer engagement and alignment to supporting members through the optimal method for that member.

Consumer Engagement is one member at a time and a key cornerstone of our solutions for the State and controlling costs. Our proposed solutions and development are focused on both personnel and technology to address the various mediums members want and need to engage. We provide the critical level of advocacy and support that helps the member navigate their State of Alaska benefit program:

- o It begins with the My AlaskaCare Single Point of Contact, which is through our Health Concierge Service model. This model is our next level of customer service that transforms health care from a transactional service to full advocacy for your members. This team is designed to respond to all member inquiries and personalize each call, but more importantly act as the advocate across the full benefit offerings by the State of Alaska. This team is specially trained and tested to ensure they are fully qualified to support the member through every facet of the health care delivery system and across all of the State of Alaska's benefit program and vendors.

Health Care is very complex and the My AlaskaCare Single Point of Contact will support the member in navigating the delivery system and truly being the health care advocate. This team is trained to listen to verbal queues from each call and take the member call "personally." A simple way to think about it is a Concierge will communicate the time the parade starts just like any Service Representative, but will then take it to the next level and support the member in determining how they will get there, the time it will take, other logistical challenges and even schedule the transportation if necessary. As we think of the complexities of health care and supporting the State in achieving its objectives, this level of service and advocacy is essential.

We will also work with the State to define the messaging the My AlaskaCare Single Point of Contact will deliver to your members. The systems available to this team enable them to identify members calling the first time in the year to ensure critical messages from the State are delivered. For the State of Alaska, we are even suggesting a Welcome Kit that encourages the members to reach out to the My AlaskaCare Single Point of Contact Team to find out exactly what is available both via this team and other critical tools and resources. The Health Concierge model is in place today for organizations with Alaska membership and will be the ideal model to support care delivery and steerage in Alaska and the lower 48 for the State.

- o **On-line and Mobile Tools** - Another critical facet of consumer engagement is providing members

with tools to support health care decisions. Aetna has robust tools with clinical decision support, cost of care, provider search and personal health record. Our tools are designed to support our customers and members with the information critical to their needs.

In order to fully support members in accessing our on-line tools, we have developed the Ask Ann feature. This is the member's virtual assistant for the website to support them in easily locating the information or tools they are seeking.

A key tool that will support the State of Alaska in cost management is our member payment estimator. The member payment estimator is a tool that provides actual cost estimates for our network providers based on the provider's charges for a service and the member's actual benefit level based on that point in time. The tool will also provide information on out of network charge differences to highlight advantages of using network providers. It is currently available in Anchorage and Fairbanks and can be expanded with a partnership with the State to expand the network in Juneau. While other locations will still have access to average cost of care information, every member will have the ability to look up actual costs and use the member payment estimator for services in Anchorage, Fairbanks and our network locations in the lower 48. This is the perfect tool to drive support for your goals in creating a cost competitive landscape, by putting real information in the member's hands to drive care to providers in Alaska or supporting medical tourism to the lower 48.

Our iTriage tool is one of the Top 10 most utilized mobile health care tools. We have proposed a custom iTriage solution for State of Alaska that takes existing functionality and materially expands to provide a single site to meet members' needs and further engage the member. iTriage will provide State of Alaska members with plan sponsor information, condition look up, treating providers, messaging on optimal care for condition, and appointment setting for those registered providers. The treating providers can be customized to align to State of Alaska's preferred providers, support telemedicine (e.g., Tele-doc) and other preferred arrangement and partnerships, or merely suggest alternatives to the Emergency Room. The tool will continue to evolve and contain our full suite of tools at the member's fingertips. In the future, iTriage will house all of Aetna's mobile solutions including transparency.

o Experts - Between all of the Aetna companies, we have experts covering all facets of the mental, physical and clinical elements of consumer engagement. Our proposed annual strategy and deployment process reflect the complexities associated with member adoption of change and the critical time investment needed to develop the solutions that your State of Alaska members will embrace. We will provide the necessary expertise to develop solutions that both support the State of Alaska's objectives and will be embraced by your members through a consumer-oriented roll out. This support addresses all elements of design and incentives.

The ability to support cost management is dependent on consumer engagement. Members must make the changes necessary to achieve their optimal health. Our investments in the expertise to develop solutions are fully empowered by the personnel, tools and resources we make available to the members. Health care is extremely complex and success in both health improvement and corresponding cost reductions come from fully providing the members with the support they need. The role of Consumer Engagement will have a material impact on costs that will vary based on the State of Alaska's deployment decisions, but will likely be cost savings of 5% or greater.

- **EVIDENCE-BASED MEDICINE** - Aetna has placed extensive rigor on integrating evidence-based medicine throughout our operations. A significant area of cost likely impacting the State of Alaska is inappropriate care in the delivery system. The ability of an organization to support the State of Alaska in reducing inappropriate care is to have the approach and tools to support evidence-based medicine

delivery. This will have material financial impact on the State that we estimate to be at least a 3 to 5% reduction in cost over the current administrator.

Our support for the State of Alaska is based on tools and processes as well as our ability to support policy development and ensuring it translates all the way through to claim payment.

- o Aetna has over 600 (630 CPBs on Aetna.com) clinical policies in place today that are based on evidence based medicine. We have clinical resources focused on reviewing medical evidence and at least annually updating our clinical policies to address latest evidence. In addition, we work with providers in the event new studies support a change in the clinical policies. Our policies are embedded in our network contract requirements and claims payment that will either reduce or deny payment for services not aligned with our clinical policies. This has a direct cost reduction for the State of Alaska.
- o Our Care Engine technology is a part of our Health Care Management solution we are proposing to the State of Alaska and is available for the population the program is rolled out to. The Care Engine is a market-leading Clinical Decision Support tool that mines medical, lab, pharmacy and health assessment results to identify care considerations. The technology is constantly mining claim data and identifying care considerations that range in level and approach for outreach to providers. The Care Engine is connecting all claims and health risk assessments to provide information most individual providers do not have for a patient. We have over 1,100 clinical algorithms to analyze member data and identify potential errors, omissions and commissions of care.

Aetna's approach to evidence-based medicine will have a material impact on the State of Alaska's costs. Our investments in evidence-based medicine and our ability to support the State of Alaska in detailed policy development will have a year over year cost savings for the State.

- **PROVIDER SOLUTIONS** - Our network solutions cover the spectrum of simple network solutions to high performance networks to Patient Centered Medical Homes to Accountable Care Organizations. Aetna brings experience across every area of network development that will benefit the State of Alaska with resources dedicated to Network Management in Alaska and the lower 48. We have network management both residing in and focusing on Alaska.

Our provider solutions will have a material impact on the State of Alaska's current costs in Alaska and the lower 48. In fact, we anticipate our current network to save the State of Alaska 9.9% over the current administrator with other strategies generating additional savings. Our network programs include:

- o Standard and Custom Networks - Aetna has established a true PPO network in Alaska that utilizes fee schedules and reimbursement approaches consistent with the lower 48. Our approach has been to stay consistent in Anchorage and Fairbanks with standard network arrangements to provide a cost effective solution for our customers. Our processes and measures can be leveraged to support the State in developing a more comprehensive network that covers additional markets, such as Juneau. It is through a partnership with the State of Alaska and Aetna and the use of a standard or custom network solution that a cost effective network can evolve in Alaska.

Our network management team will work with the State in defining goals and approaches for network expansion in the State. Our goal would be to work with the State and our other plan sponsors to achieve a competitive network built on our core network reimbursement approaches and integrating all of our clinical policies and provisions. However, there may be decisions made solely for the State and those would support a custom State solution. Overall, we will work to define a roll-out process, address reimbursement levels and conduct hands on provider negotiations to support the State of Alaska's cost goals.

- o Patient Centered Medical Home - Aetna has processes to integrate Patient Centered Medical Homes

into our networks, but more importantly the structure to establish Patient Centered Medical Homes for providers. The benefit to the State is an organization that can effectively evaluate the infrastructure and support needed to implement a PCMH and operationalize in a benefit program. We will work with the State to determine potential policy or pilot programs to evaluate PCMH in key markets. We will work with the State of Alaska and providers to determine if and how Patient Centered Medical Homes are rolled out or if we use Medical Home Exchange. We believe this will have additional savings for the State and will support the evaluation and estimates of savings.

o Accountable Care Organizations - Aetna is actively involved in the establishment of Accountable Care Organizations. We currently have implemented, or are in the process of implementing, 16 Accountable Care Organizations and will begin working with over 30 more Accountable Care Organizations across the United States. Through our Aetna companies, Medicity and Active Health, we are able operationalize the Accountable Care Organizations with the underlying system integration and Care Management platform. We are in the early stages of an Accountable Care Organization in Alaska that would benefit the State of Alaska. The benefits of the Accountable Care Organization are a cost reduction due to efficiencies and comprehensive care that could benefit the State of Alaska in Fairbanks, Anchorage and locations in the lower 48.

- OPERATIONAL EXCELLENCE - Operations is often an overlooked facet of the cost management for an organization. As both an administrator and insurance carrier, we fully understand the importance in market leading operations and the impact this has on all facets of cost management and the consumer experience. As stated above, this begins with ensuring clinical policies are in our network contracts, our care management programs are based on these policies, and our claim system reimburses based on those policies. Our network, custom network solutions, and all contract and policy provisions are fully integrated into our claim system to both ensure accuracy of the payment process and ensure no policies or procedures are impacted by the network and or providers handled by a rental network or affiliate.

The savings of at least 3-5% from our evidence-based medicine is only delivered to the State of Alaska through ensuring our operations are fully integrated. Every facet of the operations is integrated to ensure payments are correct.

Another area of operations is our on-going enhancements to our customer service processes and clinical programs. We learn and build to align with the needs of our customers who need programs to both manage cost and quality, but enable the critical attraction and retention. Our National Account and Public Sector customers demand the level of service that Aetna delivers. Our proposed Health Concierge service model is the infrastructure for the My AlaskaCare Single Point of Contact and has won JD Powers award for service. The State will not only benefit from this development, but will be a driver of the development through the areas you are seeking with your objectives.

Operations brings everything together in a fashion that translates to an overall impact. We commit to working with the State to continuously measure and determine opportunities for improvement. Our resources and analytics will provide the State with critical information to make informed decisions and achieve the strategic objectives. We recognize success in achieving those objectives relies on a partner that continuously evolves and brings market leading approaches to the table. We commit to being that partner and bringing forth solutions specific to Alaska.

Attachments: [Executive Summary.pptx](#)

2.3.3.2 Please provide a white paper with information on innovative steps your organization is prepared to implement in order to assist the State is achieving its vision as stated in Section 1.0 of the RFP. Include any programs or innovations that have proven successful with other similar clients. Focus on cost containment and cutting edge health care support, as well as integration with other key vendor partners.

Answer: 1: Attached

Detail: Attached please find a white paper detailing the steps we will take to assist the State in achieving your vision.

We have also attached a summary of our 9th Annual Aetna HealthFund Study results, which shows significant cost savings for our consumer directed health plan customers.

Options:

1. Attached
2. Not Attached

Attachments: [2.3.3.2 - AHF Study.pdf](#)
[2.3.3.2 - White Paper.doc](#)
[Aetna Story 020813.ppt](#)

2.3.3.3 How is your organization leveraging Patient Centered Medical Homes? What are the outcomes of your programs?

Answer: We are a charter member of the Patient Centered Primary Care Collaborative (PCPCC) and have been a member of the PCPCC Executive Committee since its inception, signing the Joint Principles statement and participating in collaborative activities since 2007.

We are convinced that there is sufficient evidence to conclude that implementing the Joint Principles will transform our health care system in the intended way. While we support the effort to study the outcomes and objectively evaluate patient-centered medical homes, we are approaching these arrangements with conservative optimism. There are challenges associated with finding the appropriate medical group partners, aligning interests and determining measures that will incent material cost reductions while also meeting our financial, clinical and data needs. We will only pursue these arrangements when both parties are satisfied with these components. We are committed to participating in pilots in the geographic areas that align with our business interests.

We support the effort to promote primary care, sharing the position articulated by the PCPCC and other supporters of the patient-centered medical home and related initiatives that health care systems with strong primary care foundations deliver more effective and efficient care in a way that patients find more satisfying and accessible. We find it compelling that health systems with a strong primary care foundation deliver more effective and more cost-effective health care, have markedly less racial and ethnic disparity in the care delivered, and are preferred by patients.

We currently support three ways to implement patient-centered medical homes:

- Direct contracts
- Multi-health plan collaboratives
- Patient Centered Medical Home (PCMH) Recognition Program

DIRECT CONTRACTS

Our patient-centered medical home model is designed to select optimal provider partners and maximize the alignment of incentives. We believe patient-centered medical home partners must have the following attributes:

- The clinicians within a medical practice are a team that is collectively responsible for providing for a patient's health care and, when needed, arranging for appropriate care with other qualified providers. Care is continuous rather than episodic, proactive rather than reactive, and willing to take risk for the cost and quality of care for all members in a practice, but a minimum for those with chronic conditions.
- The partner must achieve NCQA Patient-Centered Medical Home recognition level 1 (ePrescribing utilized) upon execution of a contract and achieve level 3 (working electronic medical record (EMR) system) within 1 year; OR utilize the ActiveHealth suite of tools; OR hold equivalent certification (i.e., URAC, The Joint Commission).
- The partner must utilize an electronic health record (EHR), which will include patient information sources from an EMR, a patient's health risk assessment (HRA) and other patient-reported information.
- The group must be sufficiently staffed with qualified care management nurses/coordinators to gain the efficiencies and clinical improvements we require.

Our patient-centered medical home arrangements provide additional compensation to PCPs by way of a care coordination payment in return for a higher level of PCP engagement with the member. As a result, we expect more PCP evaluation and prevention visits, with the promise of achieving savings and benefits in other areas of the health care system:

- Reduced hospitalizations, both primary and readmissions
- Reduced ambulatory care, specialty, facility and other costs
- Improvements in transitions of care from one site of service to another (e.g., an inpatient facility to a skilled nursing facility)
- Greater patient-shared decision making and behavioral engagement
- Greater patient engagement in preventive health and wellness
- Use of Aetna clinical decision support tools to improve care management, tracking and adherence to evidence-based guidelines

Our standard patient-centered medical home model and policies include:

- A standard contract format, provider criteria, contract policies and guidelines
- Patient attribution rules for both HMO and non-HMO models
- A gain-share and risk/rewards financial model
- Data exchange of actionable information for practices to use
- Required and optional quality measures
- Required and optional efficiency measures to create savings that can be shared with providers and provide a benefit to customers

Measures

We have developed a standard set of measures for patient-centered medical homes. A network can collaborate with a given patient-centered medical home to choose measures based upon improvement needs and rewarding for top performance.

Examples of standard efficiency measures:

- Impactable, non-trauma admissions per thousand (excluding trauma/maternity/readmissions)
- 30-day readmission rate
- Potentially avoidable emergency room visits per thousand
- Percentage of outpatient laboratory services performed at independent labs
- Percentage of outpatient radiology performed at free-standing facilities
- Percentage of outpatient surgeries/procedures performed at preferred sites
- Generic prescribing rate

Clinical measures are also a part of the model to ensure that savings are a result of the right behaviors, and include:

- Diabetes
 - Diabetes: Lipid measurement
 - Diabetes: A lipid management: LDL-C control <100
 - Diabetes: LDL greater than 100 - Use of a lipid-lowering agent
 - Diabetes: HbA1C measurement
 - Diabetes: Hemoglobin A1c management
 - Diabetes: Medical attention for nephropathy
 - Diabetes: Retinal eye exam
- Cardiovascular
 - IVD: Complete lipid profile and LDL control <100
 - Annual monitoring - Angiotensin-converting enzyme (ACE)/angiotensin receptor blockers (ARBs)
 - Annual monitoring - Diuretics
- Preventative/Screening
 - Breast cancer screening
 - Cervical cancer screening
 - Colorectal cancer screening
- Pediatrics
 - Use of appropriate medication for people with asthma: adult and pediatrics
 - Appropriate treatment for children with upper respiratory infection
 - Tympanostomy tube hearing test
 - Diabetes annual HbA1C screening in pediatrics

Examples of current models

We are engaged with a large progressive medical group in central New Jersey that is simultaneously working with another large health plan and a locally dominant employer to implement a program that leverages our health information technology capabilities to promote the patient-centered medical home. This program involves the sharing of clinical information, which enhances our ability to optimize the Care ConsiderationsSM generated through our CareEngine® and financially reward the group for demonstrating superior outcomes resulting from improved processes of care. Diabetes was selected as the first chronic condition to which this effort is being applied. Results after the first year show promise.

Preliminary results:

- Emergency room visit rate reduced 8 percent
- Inpatient days reduced 25 percent
- Admissions reduced 16 percent
- Medical cost trend impact on inpatient, specialist, behavioral health, lab, imaging, injectables
- HbA1C score of <7.0: Percentage of diabetic members went from 36 percent to 58 percent in a year's time
- LDL score of <100: Percentage of diabetic members went from 38 percent to 68 percent in a year's time
- Blood pressure score of 130/80: Percentage of diabetic members went from 22 percent to 48 percent in a year's time

We have executed a patient-centered medical home amendment to an existing contract with a large independent practice association (IPA) in California for our PPO-based business. This initiative will rely on the use of electronic records/systems and will include efficiency and quality outcomes measures. We expect to achieve medical cost savings, which will be shared with the IPA and our self-funded customers. A care coordination payment will be paid to cover the practices' transformation into a patient-centered medical home through administrative, infrastructure and medical management requirements.

This year, we expect to implement several more patient-centered medical home amendments to existing contracts, and we expect to address customer initiatives around benefit plan design. We will continue to assess any new multi-health plan collaboratives and join those that meet Aetna standards.

MULTI-HEALTH PLAN COLLABORATIVES

We are a committed participant in multi-stakeholder (and multi-payer) patient-centered medical home pilots and expect the same standards as for direct contracts.

We will participate in the Pennsylvania site of the Centers for Medicare & Medicaid Services (CMS) Multi-Payer Advanced Primary Care (MAPCP) Demonstration. Overall, eight selected states will participate. Our participation in the Pennsylvania site will be as an add-on to the commercial Pennsylvania Chronic Care Initiative, which is described below.

We currently participate in the following commercial collaboratives:

- Colorado - The Colorado Multi-Payer, Multi-State Patient-Centered Medical Home Pilot, which began May 2009, is a 3-year pilot led by the Colorado Clinical Care Guideline Committee. This multi-stakeholder collaborative (health plans, providers, business group) is focused on an American College of Physicians (ACP) patient-centered medical home model. All participating health plans combined expect 30,000 members in commercial, Medicaid and Medicare plans. The Center for the Study of Services (CSS) will provide a patient survey as a baseline measurement guide and an additional survey 18 months into the pilot to measure changes. We are currently awaiting results of the pilot based on savings and clinical measures. The Harvard School of Public Health is performing the evaluation.
- Maine - The Maine Patient-Centered Medical Home Pilot, which began November 2009, is a 3-year statewide pilot led by the Maine Healthcare Management Coalition and covers approximately 50,000 commercial and Medicaid members. The claims data is sent quarterly to "Heath Dialog" for aggregation, which will be used every 6 months as an improvement tool, not for assessment or financial reward. Offices must achieve NCQA Patient-Centered Medical Home Level 1. Quality and

efficiency measures are being developed. Our expected measures include 26 clinical measures and 23 cost measures, such as PMPM inpatient and outpatient, primary care and specialist PMPM, emergency department utilization, and imaging.

- New York - The Hudson Valley Medical Home Project, is a multi-payer effort led by Taconic Health Information Network and Community (THINC). We expect the pilot to encompass 236-physicians, who must achieve NCQA Patient Centered Medical Home recognition level 2 or 3. We will pay a care coordination payment on full-risk members and possibly self-funded as well, covering commercial, Medicaid and Medicare plans. Phase 2 requires specific funding for case management where THINC will oversee a project that is designed to demonstrate that medical homes with embedded case managers following standardized protocols can increase quality and decrease cost outcomes in adult populations with chronic, complex medical conditions. This is expected to launch sometime in 2012.

Measures for this pilot include breast and colorectal cancer screening, chlamydia screening, HbA1c testing, diabetic measurements, pharmacologic therapy for asthma patients, appropriate antibiotic use for children with upper respiratory infection (URI), and appropriate testing for children with pharyngitis. We will send claims data to the New York Quality Alliance (NYQA), which sends the data to the THINC Regional Health Information Organization (RHIO) to prepare the measures. We believe each practice has an EMR system and would then expect outcomes measures to be included.

- Southeastern Pennsylvania - The Pennsylvania Chronic Care Initiative, which began May 2008, is led by the governor's initiative "Chronic Care Model", developed in conjunction with the MacColl Institute. This pilot was originally a 3-year pilot, but was extended due to participating in the CMS MAPCP. The pilot incorporates patient-centered medical home standards and covers commercial, Medicaid and Medicare members. The University of Pennsylvania plans to evaluate this pilot with results to be published April 2012. Quality and efficiency measures are being developed as part of the next phase to hold the practices accountable for cost and quality. The collaborative has been selected as one of the 8 States for the CMS MAPCP, which will add Medicare Advantage patients.

- Maryland - This patient-centered medical home pilot is a statewide 5-year pilot (effective August 1, 2011) that was established by House Bill 929. Lt. Governor Brown chairs the patient-centered medical home workgroup and is a strong advocate of health care reform. This multi-health plan initiative (includes United, CareFirst and Kaiser Permanente) will pay a care coordination payment per the recognition level, based on quality and efficiency measures, and the patient count level. The initiative covers commercial and Medicaid members, with Medicare being pursued, and both full-risk and self-funded plans with no opt out. The Maryland Health Care Commission will choose an evaluator, which will evaluate this initiative after year two and then conduct an annual rolling two-year assessment. The collaborative includes Maryland Insurance Administration, Medicaid, the attorney general, and consumers, providers and health plans. Consulting services are funded by a grant from National Academy for State Health Policy (NASHP). The initiative anticipates converting from a care coordination payment to shared savings in year two or three.

- Washington State - The Medical Homes Multi-Payer Reimbursement Model is a multi-payer collaborative, which started May 2011. This collaborative consists of eight national and regional plans, including Medicaid and an expected scope of eight to ten practices (fee-for-service business, both full-risk and self-funded). The group will be paid a care coordination payment, and there will be two efficiency measures (emergency room and inpatient admission) set with minimum targets for practices to share in the savings, and quality measures that if met enable practices to share in any savings beyond the minimums set. The quality measures include diabetes HbA1c testing, diabetes LDL-C screening, diabetes nephropathy screening, cardiovascular condition LDL-C testing, cardiovascular cholesterol lowering medication, depression medication adherence at 12 weeks, and

depression medication adherence at 6 months. Program drivers include the State of Washington and Boeing (plan sponsors). The University of Washington will be the program evaluator.

These multi-stakeholder efforts share certain operational features that we believe are crucial for success:

- Convening entity that oversees and establishes the program
- Uses the NCQA Physician Practice Connections - Patient Centered Medical Home (PPC-PCMH) tool to determine whether a primary care practice qualifies as a medical home
- Clearly established model for enhanced payments
- Formal evaluation designed to assess a spectrum of outcomes, including financial outcomes (perhaps the most important feature)

PCMH RECOGNITION PROGRAM

Using a unilateral agreement, we will implement a broad-based program across several local markets, starting with Connecticut and North Jersey in January 2012, followed by several others throughout the year.

Recognizing that group-by-group negotiations will lead to slow program expansion, we are launching a PCMH Recognition Program model that will support rapid expansion of medical homes in a market and will allow us to quickly partner with the approximately 13,000 primary care providers who have received recognition as a medical home across the country.

The model targets primary care groups that have received levels 1-3 recognition by NCQA as medical homes. Attribution reporting will be performed to link members to these targeted providers, and a unilateral amendment will be sent to the physician groups that will offer to pay a PMPM care coordination payment in return for the group agreeing to coordinate the care of attributed Aetna commercial members consistent with recognized patient-centered medical home guidelines. The performance of these groups will be compared to the non-patient-centered medical home recognized providers, and the performance of the groups receiving care coordination payments will be monitored. Gain-share components will eventually be incorporated but will not be a part of the initial expansions. If a group reaches our minimum attributed patient count for a direct contract, we will then pursue one with that group. This approach will dramatically increase our patient-centered medical home footprint nationally and may eventually be an attractive option for large customers who wish to encourage employee utilization of patient-centered medical home providers.

Attachments:

2.3.3.4 How is your organization supporting the creation of Accountable Care Organizations?

Answer: We are at the forefront of designing and piloting accountable care organizations (ACOs) in partnership with integrated delivery systems, academic medical centers and other provider groups. We have industry leading care management tools and services to enable a health care organization to transform the way they deliver care from an unsustainable volume-based fee-for-service model to a highly efficient system able to be rewarded for the value they create.

TECHNOLOGY AND SUPPORT

We offer best-in-class proprietary technology solutions, care management programs and payment models to health care providers to align incentives to deliver higher quality care at lower total costs. We have experience with pay for performance, patient-centered medical homes, bundled payments at centers of excellence and provider network tiers based upon value. Our proprietary attribution methodology allows accountability for providers even in open access plan designs. We can support our customers' employees in their navigation of ACO structures with benefit design, advanced online tools for provider comparisons and mobile technology.

We developed a comprehensive software toolkit for improved clinical decision support, electronic medical record sharing across platforms and geographies (using cloud-based services), consulting services, and infrastructure architecture to create, manage and operate ACOs. We have invested in technology that can ingest claims and clinical data to find potential gaps in care and deliver information to the clinician at the point of care. In addition, our acquisition of Medicity solidifies our commitment to support a more accountable health care system. Medicity's reach into more than 780 hospitals, large physician base and extensive clinical systems integrations adds new and compelling technology to our existing suite of ACO solutions.

We realize accountable care is not just about health care providers and payers. It is extremely critical that patients are engaged in their care and overall wellbeing. iTriage®, another fully owned Aetna subsidiary, provides consumer-facing technology in the form of a mobile phone application. Through iTriage's industry leading mobile application, patients are connected to medical care. iTriage offers a mobile platform that helps patients process their symptoms, research the possible causes, identify the appropriate level of care and locate the provider best suited for their condition. All of this is done at the time of decision, on a device they have with them all the time (their mobile phone). iTriage can be customized to add additional member-specific data (network providers, EOBs, claims, etc.) to support members as they make decisions.

COLLABORATIONS

Our entrance into accountable care began in 2007 when we started working with physician groups, specialists and health care facilities to create a more personalized, connected and accountable way to provide health care. Today, our early ACO models are yielding favorable results.

We now have more than 60 provider collaborations across the country covering existing Medicare Advantage (MA) members. In addition, we have ACO contracts with two leading delivery systems in the mid-west and one in the southeast to leverage our care management programs for our Medicare Advantage members. The ACO contracts include gain sharing and risk arrangements that foster mutual accountability to reduce costs while meeting or exceeding mutually agreed upon quality measures.

The breadth of capabilities and member populations within our ACO pipeline ranges from our full suite of solutions across commercial, Medicare, Medicaid and hospital employee health plans to more limited engagements. Importantly, we do not require our ACO collaborators to purchase any software or programs; in fact, if the ACO has sufficient resources to be successful, we will focus only on the payment reform components of our strategy.

In addition to our Medicare collaborations referenced earlier, we have broader ACO collaborations in place with a number of health systems, independent practice associations and other provider groups. One of our ACO success stories was exemplified on March 10, 2011, when Aetna and Carilion Clinic, the largest health care provider in southwest Virginia announced their intention to collaborate in an ACO initiative. The new model of health care delivery helps lower costs through more effective

patient outreach and a new payment model that rewards providers for collective patient outcomes.

Another significant ACO collaboration was first introduced publicly on November 21, 2011 when we announced our relationship with Banner Health in Phoenix, AZ. Our ACO collaboration with Banner includes a commercial health plan offering under the name of Aetna Whole HealthSM, and is being marketed in select Arizona counties through the newly-established Banner Health Network. The Banner Health Network model is focused on wellness and improving patient care outcomes through better coordination, a team-based care management approach and improved access to patient information. In May 2012, we expanded our relationship with Banner to include full technology support for more than 200,000 Banner patients.

A more recent partnership with Inova Health System was announced on June 22, 2012. This exclusive ACO collaboration with Inova will establish Innovation Health Plans, a jointly owned health plan serving more than 1.1 million residents in Northern Virginia. The partnership will help to promote clinical integration of the health care community. Inova Health System will engage Inova and community physicians to focus on wellness promotion and patient outcome improvement through better care coordination and streamlining access to patient information. Aetna will support Inova with technology that makes it easier for physicians to exchange and monitor their patients' care across all settings. As part of our ACO collaboration with Inova, new commercial and Medicare HMO and PPO products will be offered in 2013 that give employers and consumers access to less expensive, more coordinated care.

ALASKA OPPORTUNITIES

Aetna has been engaging in dialogues with key stakeholders in Alaska regarding the development of accountable care delivery and payment models. The outreach to date has resulted in the identification of one major health system in Anchorage interested in expanding dialogues regarding the formation of care delivery models focused on accountable care. We are in the early stages of design. In addition, we are working with a hospital system with facilities in lower 48 and Alaska for which we have launched an Accountable Care Organization in lower 48 and looking to roll out to all facilities over time. Aetna would invite the State of Alaska to participate in the design and implementation of any new delivery and reimbursement models.

Attachments:

2.3.3.5 Is your organization planning to create its own private exchange? If so, what is your target market?

Answer: Aetna is always exploring new and innovative ways to improve access to high quality health benefits, and we believe private exchanges are one opportunity. We are evaluating the possibility of establishing our own private exchange, but we have not announced any plans to do so at this time.

Attachments:

2.3.3.6 Is your organization planning to or participating in any private exchanges today? If so, which ones?

Answer: Currently, we are in discussions with several parties who are considering offering a private exchange. While we have not yet made any final decisions, we are discussing how Aetna might be a participating carrier if the parties proceed in establishing an exchange.

Attachments:

2.3.3.7 Is your organization planning to participate in the public/State exchanges? If so, which states?

Answer: We have dedicated significant resources to ensure we are prepared for the health care reform related changes that will occur by 2014 (i.e., with the implementation of the health insurance exchanges). As the marketplace continues to evolve, our mission continues to be to deliver value for our customers, whom we put at the center of everything we do. As such, we have been, and will continue to be, involved in the discussions around the appropriate design of health insurance exchanges so that they meet the access and affordability needs of individuals and small group employers (2 to 50 employees). We are committed to the individual and small group markets, and believe our strategy will allow us to maintain viable and affordable product offerings for these customers.

In general, we support insurance exchanges that increase competition and help consumers choose the plan that best suits their needs. We believe that exchanges should:

- Provide convenience and transparency so the consumer can choose a plan that addresses specific needs.
- Empower consumers by involving them more directly in health-related economic decision making, and choosing plans and providers.
- Avoid adding cost to consumers and cost of insurance.
- Complement the existing competitive marketplace.

As states move toward implementing exchanges, we will assess their ability to achieve the goals outlined above. Ultimately, we intend to compete on exchanges that are designed effectively, and improve competition, transparency and consumer engagement, while offering a competitive selection of affordable health insurance plans that meet the diverse needs of consumers.

As of December 2012, we plan to participate in up to 15 exchanges, but we continue to evaluate and monitor state and federal progress as exchanges develop.

Attachments:

2.3.4 Performance Incentives

2.3.4.1 In accordance with Section 3.2 of the RFP, please describe in detail any proposals you are including with your cost proposal relative to fee increments for accomplishing state objectives as outlined in Section 1.0 of the RFP such as:

- a. Cost Containment Fee Increment. An annual fee increment in an amount to be proposed by the Offeror to be awarded if cost growth per member declines xx% from the prior fiscal year and claims processing accuracy audits show claims processing accuracy exceeds 98% for the fiscal year.
- b. Cost Reduction Fee Increment. An annual fee increment in an amount to be proposed by the Offeror to be awarded if overall claims costs are less than xx% from the prior fiscal year and claims processing accuracy audits show claims processing accuracy exceeds 98% for the fiscal year.

Note that these are examples and the State is willing to review other proposed performance incentives.

Answer: We are pleased to provide our performance based incentives to the State of Alaska. We understand the State of Alaska's goals and our role in ensuring those goals are achieved. As such, we

have structured our performance based incentives in a pay for performance manner.

The performance based incentives are aligned to key areas of service delivery that are essential for the State of Alaska's program success. We recognize the administrator role and our ability to deliver are critical to the State's goals, but more importantly the State of Alaska cannot afford to pay for services that do not deliver the essential cost and quality measures for success.

Our maximum performance based incentives along with our proposed fees reflect the total fees required to provide the quoted services to the State of Alaska. Stated another way, we have reduced our fees and placed those dollars at risk for our performance. This approach ensures the State of Alaska is not responsible for paying for services that are not meeting key metrics for overall program success.

Due to the nature of the services provided and alignment of the State of Alaska's program with Medicare, we have structured several performance based incentives across the Active and Pre-Medicare Retirees only. We have defined each of the guarantees below. For complete details on each of the Performance Based Incentive Guarantees, please refer to the attached guarantee documents.

1. Discount Performance Based Incentive Guarantee

- Minimum Performance Based Incentive = \$0.00 PEPM
- Maximum Performance Based Incentive = \$5.00 PEPM
- Population Covered = Active and Pre Medicare Retirees Only
- Performance Period = July 1, 2013 to June 30, 2014 and each successive year for 5 year period. We are willing to renew beyond 5 years based on mutually agreeable provisions.
- Performance Basis = This metric is based on the performance of our network management and delivery. The maximum performance based incentive reflects our network management fee.
- Performance Guarantee Year 1:

Total Overall Discount Achieved Cumulative Earn Back (per subscriber per month)

21.30% - 22.29% \$1.00

22.30% - 23.29% \$2.00

23.30% - 24.29% \$3.00

24.30% - 25.29% \$4.00

25.30% or Greater \$5.00

- Performance Guarantee Year 2 - 5: The guarantee will be adjusted to reflect the network delivery changes driven by State of Alaska and Aetna. The adjustment will reflect network delivery expansion, payment methodologies (e.g., bundled payment) and other material changes (e.g., Accountable Care Organization) that impact discount levels.

2. Claim Based (Trend) Performance Based Incentive Guarantee

- Minimum Performance Based Incentive = \$0.00 PEPM
- Maximum Performance Based Incentive = \$7.50 PEPM
- Population Covered = Active and Pre Medicare Retirees Only
- Performance Period = July 1, 2013 to June 30, 2014 and each successive year for 5 year period. We are willing to renew beyond 5 years based on mutually agreeable provisions.
- Performance Basis = This metric is based on the performance of multiple facets of the organization. The maximum performance based incentive reflects fees for account management, operations and program delivery.
- Performance Guarantee Year 1: If Actual Aggregate claims are at or below Target Claim Trend Aetna will Earn Back \$5.00 PEPM in monthly fees. If Aetna Exceeds the Target Claim Trend by 250 basis point or greater, Aetna will Earn Back an additional \$2.50 PEPM in monthly fees, up to a maximum Earn Back of \$7.50 PEPM.
- Performance Guarantee Year 2 - 5: The guarantee will utilize third party trend and account for key strategic, operational, delivery and design changes impacting trend. Trend and all provisions agreed upon prior to commencement of performance year.

3. Clinical Performance Based Incentive Guarantee

- Minimum Performance Based Incentive = \$0.00 PEPM
- Maximum Performance Based Incentive = \$2.80 PEPM
- Population Covered = Active and Pre Medicare Retirees Only
- Performance Period = July 1, 2013 to June 30, 2014 and each successive year for 5 year period. We are willing to renew beyond 5 years based on mutually agreeable provisions.
- Performance Basis = This metric is based on the performance of our Care Management and delivery. The maximum performance based incentive reflects our Care Management fee.
- Performance Guarantee Year 1: In addition to amounts placed at Risk, Aetna has reduced our base fees
- Performance Guarantee Year 2 - 5: The guarantee will be adjusted to reflect any changes to the Care Management program. The adjustment will reflect care management programs and performance.

4. AlaskaCare Single Point of Contact (Health Concierge) Performance Based Incentive Guarantee

- Minimum Performance Based Incentive = \$0.00 PEPM
- Maximum Performance Based Incentive = \$1.00 PEPM
- Population Covered = Active, Pre Medicare Retirees and Medicare Retirees
- Performance Period = July 1, 2013 to June 30, 2014 and each successive year for 5 year period. We are willing to renew beyond 5 years based on mutually agreeable provisions.
- Performance Basis = This metric is based on the performance of our Health Concierge and State of Alaska's member satisfaction with the Health Concierge. We are offering State of Alaska Health Concierge on a reduced fee basis. The maximum performance based incentive reflects the fee reduction for Health Concierge.
- Performance Guarantee Year 1: If State of Alaska members express 90.0% or greater satisfaction in the Aetna Health Concierge, Aetna will Earn Back \$.50 PEPM toward the base PEPM fee. If member satisfaction with the Health concierge is 91.0% or greater, Aetna will Earn Back an additional \$0.50 PEPM, to a maximum of \$1.00 PEPM toward the base fee.
- Performance Guarantee Year 2 - 5: Aetna will offer the same guarantee, provided that health concierge services are retained.

5. Subrogation Performance Based Incentive Guarantee

- Minimum Performance Based Incentive = \$0.00
- Maximum Performance Based Incentive = None
- Population Covered = Active, Pre Medicare Retirees and Medicare Retirees
- Performance Period = July 1, 2013 to June 30, 2014 and each successive year for 5 year period.
- Performance Basis = We are offering subrogation as a performance based incentive. If the State of Alaska engages Aetna to provide comprehensive subrogation services, we will retain a fee of 30% of recovered amounts. If the state does not accept the incentive based payment structure for subrogation, Aetna would not be able to provide subrogation services.
- Performance Guarantee Year 1 - 5:

Aetna has proposed these performance based incentives to reflect a pay for performance approach. In the event the State of Alaska rejects any of the performance based incentives, Aetna reserves the right to review the proposed fees. In addition, Aetna is open to discuss the proposed provisions of each guarantee or new guarantees as program strategies and designs are deployed in future years.

Attachments: [CONFIDENTIAL Claim Based Earn Back Guarantee.docx](#)
[CONFIDENTIAL Demonstrating Value Scorecard.docx](#)
[CONFIDENTIAL Medical Discount Guarantee.doc](#)
[CONFIDENTIAL State of Alaska Concierge Incentive.doc](#)
[Medical Performance Guarantees.doc](#)

[REDACTED State of Alaska Concierge Incentive.doc](#)
[REDACTED Medical Discount Guarantee.doc](#)
[REDACTED Claim Based Earnback Guarantee.doc](#)
[REDACTED Demonstrating Value Scorecard Guarantee.doc](#)

2.4 Cost

2.4.1 Fees

2.4.1.1 Confirm you have submitted a cost proposal based upon an administrative fee charge on a per Employee and per Retiree per month basis.

Answer: Confirmed.

Attachments:

2.4.1.2 Confirm you have completed the rate table, and included any additional costs identified within the questionnaire.

Answer: Confirmed.

Attachments:

2.4.1.3 Confirm that your rates are guaranteed for at least 3 years.

Answer: Confirmed.

Attachments:

2.4.1.4 You understand that any response except "Yes" within this section may result in an adjustment to the pricing terms and fees you input in other sections within this RFP and/or may disqualify your offer from being considered.

Answer: Confirmed.

Attachments:

2.4.1.5 Medical Claims Administration and Managed Network Pricing Tables

Please confirm you have completed the Excel worksheets in Attachment F1 and provided the completed worksheets as an attachment in section 2.5 Response/Required Documents. Detailed instructions are provided in the worksheet.

Answer: 1: Confirmed

Detail:

Options:

1. Confirmed
2. Not Confirmed

Attachments:

2.4.2 Discounts / Networks

2.4.2.1 Medical Active and Retiree Network Claims and Disruption Worksheets

Please confirm you have completed the Excel worksheets in Attachment J1 & J2 and provided the completed worksheets as an attachment in section 2.5 Response/Required Documents. Detailed instructions are provided in the worksheet.

Answer: 1: Confirmed

Detail: The follow worksheets are considered trade secret, proprietary and confidential. As stated in our proposal response, they should not be publically released:

-CONFIDENTIAL_Attachment_J1_-
_Medical_Active_Network_Claims_and_Disruption_Worksheet.xlsx
-CONFIDENTIAL_Attachment_J2_-
_Medical_Retiree_Network_Claims_and_Disruption_Worksheet.xlsx
-CONFIDENTIAL_Attachment_J3_-
_Dental_Active_Network_Claims_and_Disruption_Worksheet.xlsx
-CONFIDENTIAL_Attachment_J4_-
_Dental_Retiree_Network_Claims_and_Disruption_Worksheet.xlsx

We have also included a redacted version of each file, with the confidential information removed. Only redacted files, may be released in an open records requested.

We have included a separate file with a password to open the full confidential files. This password should only be shared on a need to know basis, and should not be released publically.

Options:

1. Confirmed
2. Not Confirmed

Attachments:

2.5 Response Documents - Medical

2.5.1 Please complete an attach the following file labeled "Attachment F1 - Medical Claims Administration and Managed Network Pricing Tables and Example.xlsx"

Attachment [Attachment F1 - Medical Claims Administration and Managed Network Pricing Tables and Example.xlsx](#)

Answer: 1: Attached

Detail: We have also included a redacted version of each file we consider confidential, with the confidential information removed. Only redacted files, may be released in an open records requested.

Options:

1. Attached
2. Not Attached

Attachments: [Attachment F1 -
_Medical_Claims_Administration_and_Managed_Network_Pricing_Tables_and_Example.xlsx](#)
[COBRA-Direct Billing Proposal.doc](#)
[FSA Proposal.doc](#)
[Medical Fee Exhibit.xlsx](#)
[Medical Financial Assumptions.doc](#)
[VSP Providers by City.xls](#)
[VSP Signature Plan \(Managed Vision\).doc](#)

2.5.2 Please complete an attach the following file labeled "Attachment I1 - Medical Claims Administration and Managed Network Implementation and Performance Guarantees.xlsx"

Attachment [Attachment I1 - Medical Claims Administration and Managed Network Implementation](#)

[and Performance Guarantees.xlsx](#)

Answer: 1: Attached

Detail: We have also included a redacted version of each file we consider confidential, with the confidential information removed. Only redacted files, may be released in an open records requested.

Options:

1. Attached
2. Not Attached

Attachments: [Attachment II -](#)

[_Medical Claims Administration and Managed Network Implementation and Performance Guarantees.xlsx](#)

[CONFIDENTIAL Claim Based Earn Back Guarantee.docx](#)

[CONFIDENTIAL Demonstrating Value Scorecard.docx](#)

[CONFIDENTIAL Medical Discount Guarantee.doc](#)

[CONFIDENTIAL State of Alaska Concierge Incentive.doc](#)

[Medical Performance Guarantees.doc](#)

[REDACTED State of Alaska Concierge Incentive.doc](#)

[REDACTED Medical Discount Guarantee.doc](#)

[REDACTED Claim Based Earnback Guarantee.doc](#)

[REDACTED Demonstrating Value Scorecard Gaurantee.doc](#)

2.5.3 Please complete an attach the following file labeled "Attachment J1 - Medical Active Network Claims and Disruption Worksheet.xlsx"

Answer: 1: Attached

Detail: The follow worksheets are considered trade secret, proprietary and confidential. As stated in our proposal response, they should not be publically released:

-CONFIDENTIAL_Attachment_J1_-

_Medical_Active_Network_Claims_and_Disruption_Worksheet.xlsx

-CONFIDENTIAL_Attachment_J2_-

_Medical_Retiree_Network_Claims_and_Disruption_Worksheet.xlsx

-CONFIDENTIAL_Attachment_J3_-

_Dental_Active_Network_Claims_and_Disruption_Worksheet.xlsx

-CONFIDENTIAL_Attachment_J4_-

_Dental_Retiree_Network_Claims_and_Disruption_Worksheet.xlsx

We have also included a redacted version of each file, with the confidential information removed. Only redacted files, may be released in an open records requested.

We have included a separate file with a password to open the full confidential files. This password should only be shared on a need to know basis, and should not be released publically.

Options:

1. Attached
2. Not Attached

Attachments: [CONFIDENTIAL Password for J.1 J.2 J.3 J.4.docx](#)

[CONFIDENTIAL_Attachment_J1_-](#)

[_Medical Active Network Claims and Disruption Worksheet.xlsx](#)
[REDACTED Attachment J1 - Medical Active Network Claims and Disruption Worksheet.xlsx](#)

2.5.4 Please complete an attach the following file labeled "Attachment J2 - Medical Retiree Network Claims and Disruption Worksheet.xlsx"

Answer: 1: Attached

Detail: The follow worksheets are considered trade secret, proprietary and confidential. As stated in our proposal response, they should not be publically released:

-CONFIDENTIAL_Attachment_J1_-
_Medical_Active_Network_Claims_and_Disruption_Worksheet.xlsx
-CONFIDENTIAL_Attachment_J2_-
_Medical_Retiree_Network_Claims_and_Disruption_Worksheet.xlsx
-CONFIDENTIAL Attachment_J3_-
_Dental_Active_Network_Claims_and_Disruption_Worksheet.xlsx
-CONFIDENTIAL Attachment_J4_-
_Dental_Retiree_Network_Claims_and_Disruption_Worksheet.xlsx

We have also included a redacted version of each file, with the confidential information removed. Only redacted files, may be released in an open records requested.

We have included a separate file with a password to open the full confidential files. This password should only be shared on a need to know basis, and should not be released publically.

Options:

1. Attached
2. Not Attached

Attachments: [CONFIDENTIAL Password for J.1 J.2 J.3 J.4.docx](#)
[CONFIDENTIAL Attachment J2 -](#)
[_Medical Retiree Network Claims and Disruption Worksheet.xlsx](#)
[REDACTED Attachment J2 - Medical Retiree Network Claims and Disruption Worksheet.xlsx](#)

2.6 Reference Documents - Medical

2.6.1 Attachment G1 - Medical Claims Administration and Managed Network Scoring Methodology.docx

Document: [Attachment G1 - Medical Claims Administration and Managed Network Scoring Methodology.docx](#)

2.6.2 Attachment H1 - Medical Claims Administration and Managed Network Scoring Methodology Example and Discounted Allowed Charges Example.xlsx

Document: [Attachment H1 - Medical Claims Administration and Managed Network Scoring Methodology Example and Discounted Allowed Charges Example.xlsx](#)

2.6.3 Attachment J5 - Medical Disruption Scoring Example.xlsx

Document: Can't find reference to document

3 Pharmacy Benefit Management Services

3.1 Company Profile

3.1.1 General

3.1.1.1 Describe your company's ownership structure. Explain why your organization is best suited to provide Pharmacy Benefit Management (PBM) services.

Answer: The ultimate parent of our companies is Aetna Inc., a publicly traded Pennsylvania corporation. Aetna has over 35,000 employees nationally with 15 of those in Alaska.

Aetna is best suited to provide the services the State of Alaska is seeking in this RFP, due in large part to the overall breadth of the Aetna group of companies. The State of Alaska's objectives to transform healthcare in the State of Alaska require an organization that can support this along with all of the State of Alaska's objectives. Aetna's strategic direction, investments and full breadth of the Aetna portfolio will be leveraged to support the State of Alaska. We believe the transformation will take place one member at a time through our support in engagement through the program or method for which that member can be engaged.

The State of Alaska clearly needs an organization that has the full breadth of resources and capabilities to deliver both in Alaska and the lower 48. We are an organization that is not only known for its medical claim and network administration for many of the Fortune 100 and Public entities, but we also have active and retiree fully insured book of business. Our role in the State of Alaska covers each of these and provides the State of Alaska with a partner that will bring other plan sponsors to the table to support the health care transformation.

The Aetna portfolio that will benefit the State of Alaska includes:

Aetna - Aetna is a key player in the push for cost and quality in the health care delivery system in Alaska and the lower 48. We have made material investments in all facets of supporting the consumer and focusing on evidence-based medicine. Aetna is building solutions for today and tomorrow through a health concierge model that will provide the State of Alaska with "My AlaskaCare Single Point of Contact", web and mobile technology to engage every member by providing them with both essential information as well as the level of advocacy critical to behavior change and improved health.

Aetna is a key administrator and insurance carrier in the State of Alaska and throughout the lower 48. Our structure is a single organization that owns and operates a National network and most of the solutions critical to meet the State's needs. Our network resources will work with the State of Alaska to define the optimal strategies to achieve your objectives. We will leverage network contracting, plan design and resources to improve overall effectiveness of the delivery system through our Accountable Care Solutions team. We place extensive rigor on evidence-based medicine across medical, pharmacy, leave and disability, voluntary and dental solutions that will support the State of Alaska's goals to fully impact health care delivery.

ActiveHealth Management an Aetna Company - ActiveHealth is the creator of the Care Engine which is the market leading Clinical Decision support tool. The tool is based on evidence-based medicine and fully connects medical, pharmacy and health assessment information to identify Care Considerations as well as gaps in care. ActiveHealth is a critical facet of our Accountable Care Solutions in delivering the clinical decision support to the Accountable Care Organization through their Care Team platform. Our data warehouse solution is also through Active Health's Health Data & Management Solutions organization.

Medicity an Aetna Company - Medicity is our health information exchange (HIE) and is the leading innovator and largest provider of HIE technology - with more than 750 hospitals, 125,000 physicians and 250,000 end users in its connected ecosystem. Medicity's solutions empower hospitals, physicians and HIEs with secure access to and exchange of health information - improving the quality and efficiency of patient care locally, regionally and nationally. In short, it is the "pipes" that enable an entire delivery system to be connected and operate as an Accountable Care Organization. While critical for an ACO, it can also bring together a delivery system for a plan sponsor such as the State of Alaska to connect the Alaska delivery system.

Aetna's structure fully enables the acquisitions and innovations needed to support the State of Alaska's goals on both a short term and long term basis. It is all based on the Values that guide all of the Aetna companies:

- Integrity - We do the right thing for the right reason
- Excellence - We strive to deliver the highest quality and value possible through simple, easy and relevant solutions
- Inspiration - We inspire each other to explore the ideas that can make the world a better place
- Caring - We listen to and respect our customers and each other so we can act with insight, understanding and compassion

Overall, Aetna is best suited to provide pharmacy benefit management services as a direct result of our people and solution. Aetna Pharmacy Management (APM) is an internal business unit of Aetna Health Management, LLC. Aetna Health Management is a subsidiary of Aetna Inc. We are a publicly held corporation that provides integrated benefit solutions. As an integrated carrier, we take a holistic approach to member health. As part of the broader Aetna Inc. organization, we look beyond simply processing pharmacy claims and focus on health solutions to maximize value.

We will work with the State of Alaska to manage pharmacy costs as if they are our own, as only a leading integrated health plan can, while delivering competitive pricing, and innovative quality management. We can provide the State of Alaska with the capabilities and focus of our pharmacy experience with the benefit of an integrated approach to patient management. Furthermore, we can simplify the member experience through the My AlaskaCare Single Point of Contact approach.

In addition, we deliver care that is affordable, aligned, flexible and proactive. We offer innovative programs, designs and contracting strategies, including:

- Effective generic promotion
- Innovative formulary design and aligned rebate contracting
- Flexible retail and mail order options
- Quality clinical management
- Member safety and improved health outcomes

We designed our formulary based on our overall philosophy of putting the member at the center of everything we do. While we consider cost in formulary development, we also factor in rebates and therapeutic advantages of certain drugs. Our goal is to drive down total costs, which means we may cover a more expensive drug because the drug offers significant clinical and therapeutic advantages.

Our benefit plan designs offer varying degrees of member cost sharing, some of which encourage equivalent generics when appropriate. You may choose among single-tier, two-tier, three-tier, four-tier and five-tier plan designs for in-network benefits, depending on your needs. Moreover, we can customize our formulary based on the State of Alaska's unique needs.

Integration and Technology

Integrated medical and pharmacy intelligence is more than just a theory. It's an integral element of what we do, and how we do it, today:

- From using medical and lab data in real time to manage cost and quality through our pharmacy point of service Smart Edits
- To connecting innovative engagement programs like Pharmacy Advisor Counseling with our disease management programs
- To our comprehensive approach to assisting members with the most complex conditions through the Aetna Specialty Health Care ManagementSM team

Smarter claims systems ensure medical and pharmacy policies are followed:

- Diagnosis Validation on all specialty drug claims to ensure the diagnosis is consistent with clinical policies for medical and pharmacy
- Ensure single billing by checking for recent claims paid under the pharmacy benefit before reimbursing providers
- Ensure accurate bill coding for new drugs that take time to be identified in the medical claims system
- Confirm standard dosing on claims by requiring information about dose and frequency of a prescribed medication

Clinical management systems ensure coordination of care:

- One holistic member view provides clinicians with all available information on their patient. This provides the best opportunity to identify and act on the most important needs of the member.
- Seamless referrals, documentation and coordination make care simpler for the member and provider; improving efficiencies.

Specialty Health Care Management

From simple to complex - Specialty Health Care Management - is where integration is critical. It's not about just having the information; it's about bringing the information together for the ease and usefulness of the member. It's a way of comprehensively looking at the member data to fill the gaps and to do it in a coordinated and simple way.

Our smarter, unified claim system focuses on both transactions and patient management, supporting a holistic view and treatment of our members. Features include:

- Competitive pricing at Aetna Specialty Pharmacy® with comprehensive contracting strategies
- System capabilities to support over 850 clinical policies for medical and pharmacy
- People that have the power of our systems to help coordinate care for members in need

Dedicated nurses in our Specialty Health Care Management program are able to leverage medical and pharmacy benefits in the following ways:

- Understanding a member's total health picture and identifying underlying issues and taking meaningful next steps
- Using our vast medical and pharmacy resources to drive coordinated, optimal care for members so that we address their specific needs
- Reviewing claim data and using referrals from the medical care management team to identify those members who need intervention and support

- Educating members and ensuring that the appropriate utilization and adherence of the drug treatment regimen are being followed

Aetna is an organization built to support the development of the State of Alaska's short and long term strategy and more importantly to bring forth and deploy strategies to reduce costs, engage members and improve the overall health of the population. We pride ourselves on developing partnerships to deliver long term success and this will be critical for the State of Alaska's health care transformation.

Attachments: [Executive Summary.pptx](#)

3.1.1.2 Describe how your company meets and exceeds the minimum requirements listed in Section 2.7 of the RFP.

Answer: In the bullets below, we have described how we meet and exceed the minimum requirements listed in Section 2.8 of the RFP Introduction and Instructions.

- We support a large number of customers with over 6,000 employees who have been with APM for more than 5 years.
- As a named reference below, Dow Chemical has over 20,000 retirees and has been with APM for 25 years.
- We process over 100,000 pharmacy point of sale claims per month for many groups. One such group has been with APM for 8 years and covers over 280,000 total members.
- We process approximately 50,000 pharmacy mail order claims per month for Dow Chemical who we have served for 25 years.
- We provide claim administration for pharmacy services and managed pharmacy network services for many government employers. The named reference in the question below is for the City of Seattle who has been with APM for 3 years and has nearly 20,000 total members.

Please find additional supporting information attached on how Aetna meets all the State of Alaska's minimum requirements.

Attachments: [1.a Signed Attachment B - Offeror Information and Certification.pdf](#)

[1.b Attachment B - Offeror Information and Certification.docx](#)

[2. Subcontractor Commitment Letters.zip](#)

[3. Minimum Qualification Question 2.1.1.2 Response- CONFIDENTIAL.doc](#)

[3. Minimum Qualification Question 2.1.1.2 Response- REDACTED.doc](#)

[4. State of Alaska Business Licence.pdf](#)

[5. State of Alaska Certificate of Authority.pdf](#)

[6. Legal Clarifications \(Deviations\).doc](#)

[7. Plan Clarifications.xlsx](#)

[8. Confidentiality Request.docx](#)

3.1.1.3 Provide client references for whom you provide (or have provided) the same services you are proposing to the State that meet the following qualifications. The same reference may be used to meet one or more qualifications but five distinct references must be provided.

- A client with more than 6,000 employee participants for at least 5 years;
- A client with at least 20,000 retiree participants for at least 5 years;
- A client you have processed over 75,000 claims per month for at least 5 years;
- A client you have had for two years or less;
- A client whose contract has ended with you in the last two years;
- A governmental client for at least 3 years; and
- Two clients you currently provide self-insured EGWP services for with at least 1,000 Medicare Eligible Retirees.

Reference information should be in the following format:

Name of client	Client 1	Client 2	Client 3	Client 4	Client 5	Client 6	Client 7	Client 8
Name of client						N/A	N/A	N/A
Type of business	Business Services	Public Administration	Services - General medical and surgical hospitals	Manufacturing	Public Administration	N/A	N/A	N/A
Beginning year of providing service to client	1987	2009	2011	2010	2005	N/A	N/A	N/A
Number of participants (total Lives)	93,930	19,334	19,247	16,000	16,394	N/A	N/A	N/A
Name, address and telephone number of the designated client representative						N/A	N/A	N/A
Types of coverage or plans provided; and	Integrated medical and pharmacy	Integrated medical and pharmacy	Integrated medical and pharmacy	Integrated medical and pharmacy	Self-insured EGWP effective 1/1/13. Medical, pharmacy, Life, FSA, COBRA, EAP	N/A	N/A	N/A
Reason for Termination (if applicable)	N/A	N/A	N/A	Cost	N/A	N/A	N/A	N/A

Detail: CONFIDENTIAL - The names, addresses and phone numbers of Aetna active references are confidential.

Attachments:

3.1.1.4 Describe a situation in which you brought a client's pharmacy benefit trend down. This client should be similar to the State of Alaska in size, as well as in industry.

Answer: As a leading integrated health insurer, we have over 4.5 million fully insured pharmacy members where we are at-risk. We work to optimize pharmacy trend, but we care the most about positively affecting overall costs and member health outcomes. As such, we maintain a holistic,

integrated approach that is critical not only to our success, but also for our self-funded customers similar to State of Alaska. Our consultative customer support has yielded success across our book of business, yet remained aligned to the unique needs and overall benefit strategy for each customer. This approach is also aligned with our Aetna Values, which permeates our culture and keeps those we serve at the center of everything we do.

Case Study - One Customer With Out-Of-Control Trend

Before joining Aetna in 2006, a large public entity had experienced several years of double-digit annual trend increases in both pharmacy and medical benefits. Their membership was experiencing a disease prevalence rate 2.5 times Aetna's book of business prevalence rate. Our proposed solutions had to simultaneously address costs and combat high disease prevalence, as well as offer more appealing plan options.

Early in the relationship we embarked upon a comprehensive strategy for this customer, which included several specific solutions for the medical and pharmacy benefits too numerous to mention in this brief overview. Among the first steps, the customer implemented our rapid retrospective DUR program, Aetna Rx Check®. This program allows for early identification of therapeutic duplication, medication overuse, drug interactions and other cost saving opportunities. The number of cases has averaged over 5% of total membership, and has contributed significantly to lower costs and better health outcomes.

Furthermore, the customer implemented Diabetes America, a medical home for diabetic care. The plan waived the diabetic medication copays and covered supplies at 100%.

Managing Specialty Pharmacy Costs

Specialty pharmacy continues to challenge nearly all customers, and was particularly ominous in this case. To control specialty drug costs and management, we implemented Aetna Specialty CareRxSM which requires members to obtain all specialty drug refills through Aetna Specialty Pharmacy®. Today, Aetna Specialty Pharmacy fills nearly 50% of their specialty drugs; with commensurate improvements in compliance and health outcomes. The following are some examples of the compliances rates we have achieved with this customer's population taking specialty drugs:

- 99% compliance for Crohns Disease
- 99% compliance for Hepatitis
- 99% compliance for HIV
- 94% compliance for Rheumatoid Arthritis

Our package recovery, precertification and copay assistance also continue to yield substantial savings.

Encouraging Generic Utilization

To incent generic use, and raise member awareness of generics, we implemented our Save a Copay® program. This voluntary therapeutic interchange program waives member copays for up to six months if they switch to a generic from a targeted brand drug. Average savings for the last 12 months have been over \$350 per converted member.

In 2009, medical and pharmacy plan designs were revised, including implementation of coinsurance with minimums and maximums for pharmacy cost shares. Moreover, we incented generics with this revision. To better align with coinsurance and incent members towards voluntary mail order use, we worked with the plan sponsor to develop and deploy a custom MAC pricing list.

Aetna's Result - Beginning to End

By choosing Aetna to provide integrated pharmacy and medical benefits, this customer's pharmacy costs substantially decreased. This customer's pharmacy trend went from the double digits down to 5%, based on the clinical programs outlined above which were implemented such as Aetna Rx Check, Save a Copay and Aetna Specialty CareRx. Over the past 5 years, our clinical programs have saved this customer an average of nearly 3% annually. Increased medication adherence has created a demonstrable cost avoidance and savings for members with hypertension, high cholesterol and diabetes. More importantly, overall benefit trend has decreased tremendously, from over 15% in 2006 to 3.5% in 2011.

Over six years into this relationship, we enjoy a collaborative relationship, and we continue to be consultative with our interactions. We frequently meet with this customer to not only support everyday operations of the plan, but to identify clinical and cost trends early on. This approach has allowed the customer to combat trend, address emerging trends and issues, and focus on the overall health of their members.

Attachments:

3.1.2 Account Management Team

3.1.2.1 Please submit a written narrative providing a thorough description of the proposed account management structure. Your narrative must include the following:

- I. An organizational chart depicting the account management structure.
- II. The individuals who will comprise the account management team.
- III. For each individual on the proposed account management team:
 - a. name
 - b. title
 - c. physical work location where normally based
 - d. years of industry experience
 - e. years with organization
 - f. level of educational attainment
 - g. resume
 - h. years in current position
 - i. level and scope of decision making authority.
- IV. How often the account management team will meet with the Project Director and/or his designee(s) and whether the account management team will meet in person with the State on a quarterly basis in Alaska or other locations to be specified by the State.
- V. Maximum number of accounts assigned to each member of the account management team.
- VI. List other projects and or plans anticipated to be implemented by each member of the account management team during 2013/2014 and evaluate their impact on each member's ability to implement the scope of work set forth in the RFP relative to PBM services.

Answer: We are committed to providing the State of Alaska with a single account team that will meet your medical and pharmacy needs. Linda Gable, your medical account executive, and your medical account manager will serve as your primary contacts for medical and pharmacy benefits. This single account team eliminates redundancies and increases efficiency. One company managing your medical and pharmacy benefits means simplified administration.

The following members of your pharmacy account team will support your medical account team:

- Pharmacy Vice President Customer Management (VPCM)
- Clinical Account Executive (CAE)

- Pharmacy Account Manager

The pharmacy team will promote your pharmacy plan objectives, quickly resolve issues and increase member satisfaction. Rather than assigning each individual a number of accounts, we assign team members specific regions and market segments. We balance team workloads and feel confident that additional responsibilities would not be a distraction from our focus on the State of Alaska. We have included the requested information in our Samples and Brochures section of this proposal.

Michael Petryna, R.Ph, MBA, CEBS - Pharmacy VPCM

Michael is a Pharmacy Vice President, Client Management with APM. He supports Aetna Public and Labor segment sales and account teams in the pharmacy sales process and the unique needs of this market segment. He provides strategic pharmacy oversight to the segment and supports specific cases in the unique operational, financial, and clinical analysis involved in selecting, implementing and optimizing pharmacy benefits.

Michael has extensive managed care experience, most recently as a managed markets strategic marketer for a large pharmaceutical manufacturer. He has served in a clinical role with a large blues plan interfacing with organized medical groups and other functions supporting pay for performance and other quality initiatives. He also has extensive retail pharmacy operational and leadership experience with a national chain. Finally, he has served over 27 years with the United States Navy, both in the active and reserve components, where he currently holds the rank of Commander. Serving in numerous leadership capacities he has extensive ambulatory and specialty pharmacy experience in supporting healthcare delivery throughout the military healthcare system. Furthermore, he has operational pharmacy experience in multinational humanitarian operations, the advising & training of foreign military medical leadership, and post-disaster response.

Michael has worked in the pharmacy industry since 1994 and has been with Aetna since 2007.

A registered pharmacist, Michael earned his Bachelor of Science, Pharmacy, and his Master of Business Administration (with a focus in marketing and strategy) from the University of Colorado.

Michael will meet with the State of Alaska in-person on a quarterly basis. If necessary, he will meet more frequently to help address your projects and goal. Some of the ways he will serve you include:

- Presenting consultative benefit design and program strategy to address ways to decrease drug spend and increase pharmacy plan value
- Supporting the medical sales and account teams in developing a pharmacy business plan
- Serving as the unique operational, financial and clinical analysis involved in selecting, implementing and optimizing pharmacy benefits

Kristi Coulter, R.Ph.m, MHA - Pharmacy CAE

Kristi will serve as your designated CAE, she is a licensed pharmacist and is based in Seattle, WA. Kristi came to Aetna in 2005 after working with a number of county and state government agencies, she has 10 years of industry experience. At Washington State Labor and Industries, she was the Consulting Pharmacist assisting with pharmacy benefit design and implementation. Prior to that time, she worked at Public Health - Seattle and King County as the Senior Pharmacist where she oversaw drug procurement, distribution and pharmacy software management. She has experience with clinical, administrative and information technology.

Kristi received her Pharmacy degree from the School of Pharmacy and a Masters in Health Administration from the School of Public Health and Community Medicine both at the University of Washington. She is a member of the Academy of the Managed Care Pharmacy and the Washington State Pharmacy Association.

Kristi will provide you with a thorough understanding of your drug spend and trend, as well as offering strategies for clinical programs. She will work with you by:

- Evaluating your pharmacy plan, drug utilization review results, assisting in preparing an evaluation of plan performance; and is available for quarterly in-person meetings (or more frequently if needed)
- Providing a strategy for clinical program recommendations
- Estimates of potential savings for prescription drug plan options
- Supporting case management staff with pharmacy information and consulting
- Answering general ad-hoc pharmacy program questions; informing you about new drugs and how they are covered by the plan

Michelle Gutierrez - Pharmacy Account Manager

Michelle will serve as your designated Senior Pharmacy Account Manager. She lives in Arizona and is responsible for the Western region of the United States. She has 15 years of PBM industry experience and has been with Aetna since 2007. Michelle holds a National PTCB Pharmacy Technician Certification, and an Arizona Pharmacy Technician License.

Michelle will oversee the servicing and continuity of your pharmacy benefits program. She will meet your needs by:

- Providing consultative support for a strategic approach to pharmacy benefit and cost management
- Facilitating operational projects or inquiries
- Assisting with the implementation of pharmacy benefits plan, as well as program changes or updates
- Informing you of any new product enhancements and responding to inquiries regarding plan performance
- Assessing the ongoing pharmacy benefit plan services to ensure that your needs are met
- Providing pharmacy plan utilization analysis for you, and coordinating all of your reporting requirements
- Serving as a liaison for service level support

Additional Resources

To support your overall needs, an experienced staff of pharmacy program management professionals provide support for the pharmacy team. Pharmacy professionals are available for clinical support, retail, mail order and specialty pharmacy, ad hoc reporting, plan analysis, drug literature searches and assessments of clinical coverage criteria. Together, the pharmacy management team provides the support needed to help promote cost-effective pharmacy benefit management and member

satisfaction.

Further, by using our website at www.aetna.com, you can easily communicate with us for account management and member services in a cost-efficient, paperless, real-time processing environment. We promote the cost efficiencies of one-stop shopping for account management and member services by integrating pharmacy with medical product information and services through a single Internet site. In fact, 42 percent of APM customers cite the integration of medical and pharmacy products as the primary reason for renewing their agreements with Aetna.

We have also included an Org Chart for the team that will support the State of Alaska if Aetna provides all lines of coverage.

Attachments: [Question 3.1.2.1 - Pharmacy Account Team - Resumes.doc](#)
[State of AK - Org Chart.ppt](#)

3.1.3 Organizational Capacity

3.1.3.1 Confirm you, as the Offeror, have reviewed and understand the information presented in Introduction section of the RFP.

Answer: Confirmed.

Attachments:

3.1.3.2 Identify and describe, how all aspects of the work for each function identified below will be organized and staffed.

- A. Company Profile
 - a. HIPAA Compliance
 - b. Communications
 - c. Information Technology
 - d. Integration with Vendors
- B. Patient Value Chain
 - a. Networks
 - i. Retail Networks
 - 1. Broad National Retail Networks
 - 2. Retail-90 Networks
 - 3. Price Sources for Retail Network
 - ii. Mail Order
 - 1. Shipping and Handling
 - 2. Member Payments
 - iii. Specialty Pharmacy
 - 1. Definitions of Specialty Drugs
 - 2. Distribution Alternatives and Operations
 - iv. Required Attachments
 - b. Pricing
 - i. Maximum Allowable Cost (MAC)
 - ii. Average Wholesale Price (AWP)
 - iii. Drug Classification
 - iv. Retail Pricing
 - v. Mail Order
 - vi. Specialty Pharmacy Pricing
 - vii. Rebates

- c. Eligibility and Enrollment
- d. Customer/Member Service
 - i. Pharmacist Availability
 - ii. Specialty Drugs
- e. Claims Processing
- f. Coordination of Benefits
- g. Clinical Programs
 - i. Drug Utilization Review (DUR) Programs
 - ii. Formulary
- h. Medicare Part D
 - i. Medicare Part D Administration
 - ii. Retail Network
 - iii. Formulary
- i. Quality Control
 - i. Performance Guarantees
- j. Appeals
- k. Data Analysis
 - i. Data Collection
 - ii. Reporting
- l. Financial
 - i. Subrogation
 - ii. Banking
- C. State Objectives
 - a. Plan Design
 - b. Policy Development
 - c. Innovation
 - d. Performance Incentives

For each function, please provide the following information:

- a. A work flow chart depicting how the work associated with each function will be performed and a narrative describing the processes depicted in each flow chart. In your narrative please specifically address, for each function:
 - i. The role of customer service and communications.
 - ii. Special expertise, if any, that you can provide the State with respect to each function.
 - iii. Your experience and background in performing each specific function.
 - iv. How your system technologies uniquely position you to perform each specific function.
 - v. What innovation you can provide to the State with respect to each specific function.
 - vi. How you will coordinate with other Contractors who may be awarded Contracts under this RFP.
 - vii. If applicable, specify how the process will be different for members outside of Alaska.
- b. Whether the specific function will be managed and staffed by you, a subcontractor or joint venturer.
- c. If the function will be managed and/or staffed by a subcontractor or joint venturer, please identify the subcontractor or joint venturer and identify how long the subcontractor or joint venturer has been providing the service to a client of similar size to the State.
- d. If the function will be managed and/or staffed by a subcontractor or joint venturer, explain how communication and coordination occurs between your organization and subcontractors or joint venturers who will provide the functional service.
- e. Describe your organization's process for quality oversight of all subcontracted vendors and joint venturers and provide sample corrective actions used if performance needs to be improved.

- f. Please include an organizational chart depicting all personnel or positions that will be assigned to accomplish each function.
- g. Please identify the geographic location where the work associated with each identified function will be performed, including which functions will be performed exclusively in Alaska.
- h. For any function that will not be performed exclusively in Alaska, please identify the total number of positions that will be based in Alaska for each function.
- i. Please identify the proposed point-of-contact for each function.
- j. Please identify customer service hours of operation for each function. Specify hours of operation by Alaska Standard Time and the applicable time zone where the function will be performed if not in Alaska.
- k. Please identify for which functions you will provide onsite support. For example, open enrollment meetings and health fairs.
- l. If the Project Team includes the role of a pharmacy director, or similar position, please provide the following information:
 - a. The role of the Pharmacy Director in each function.
 - b. A description of how the Pharmacy Director will support the pharmacy management process and assigned staff.
 - c. Whether the Pharmacy Director will be subject to the review and approval of the Project Director.

Answer: Please refer to the attached "RESPONSE TO 3.1.3.2" document for a complete description of our capabilities to provide each function requested above.

Attachments: [Aetna Specialty Pharmacy Leadership Org Chart .pdf](#)

[Appeals Resolution Flow Chart.ppt](#)

[Banking Flow Chart.ppt](#)

[Enrollment Flow Chart.ppt](#)

[APM Member Services Org Chart.ppt](#)

[Fresno Service Center Organizational Chart.ppt](#)

[Information Technology Flow Chart.pdf](#)

[Internal claim audit flow chart .doc](#)

[Mail Order Organization Chart.ppt](#)

[Mail Order Workflow.ppt](#)

[Member Experience Org Chart.ppt](#)

[Network Diagram.pdf](#)

[RESPONSE TO 3.1.3.2.doc](#)

[Reporting Organization Chart.ppt](#)

[Specialty CSR and Pharmacist Org Chart.pptx](#)

[Aetna Medicare Part D Org Chart.pptx](#)

[Internal Claim Audit Team Org Chart.doc](#)

[Network Claims Flow Chart.doc](#)

[Paper Claims Flow Chart.doc](#)

[Subrogation Flow Chart.pdf](#)

[State of AK Organizational Chart.ppt](#)

3.1.3.3 Provide a copy of your standard Administrative Services Organization contract.

Answer: 1: Attached

Detail:

Options:

1. Attached
2. Not Attached

Attachments: [Question 3.1.3.3 - Sample SAS State of Alaska.doc](#)

3.1.4 Implementation Plan

3.1.4.1 Identify and describe, by function, how you will execute a successful execution for each aspect of the work set forth in Section 1.04 of the RFP instructions relative to the PBM services component. For each function, please provide:

- I. A work flow chart depicting how the implementation work associated with each function will be performed and a narrative describing the processes depicted in each flow chart.
- II. Whether the specific function will be managed and staffed by you, a subcontractor or joint venturer.
- III. If the function will be managed and/or staffed by a subcontractor or joint venturer, please identify the subcontractor or joint venturer and identify how long the subcontractor or joint venturer has been providing the service to a client of similar size to the State.
- IV. If the function will be managed and/or staffed by a subcontractor or joint venturer, explain how communication and coordination occurs between your organization and subcontractors or joint venturers who will provide the functional service.
- V. Describe your organization's process for quality oversight of all subcontracted vendors and joint venturers and provide sample corrective actions used if performance needs to be improved.
- VI. An organizational chart depicting the implementation management team structure.
- VII. Whether you will provide an Alaska-based implementation project manager during the term of the implementation.
- VIII. The individuals who will comprise the implementation management team.
- IX. For each individual on the proposed implementation management team:
 - a. name
 - b. title
 - c. physical work location where normally based
 - d. years of industry experience
 - e. years with organization
 - f. level of educational attainment
 - g. resume
 - h. years in current position
 - i. level and scope of decision making authority
 - j. whether the individual management team member will be exclusively assigned to the implementation until completion.
 - k. For those individuals not assigned exclusively to the implementation, please identify the amount of time they will be devoted to the implementation.
- X. The geographic location where the work associated with each identified implementation function will be performed, including which implementation functions will be performed exclusively in Alaska.
- XI. For any implementation function that will not be performed exclusively in Alaska, please identify the total number of positions that will be based in Alaska for each implementation function.
- XII. The proposed point-of-contact for each implementation function.
- XIII. Timeline for implementation
- XIV. How often the implementation team will meet with the Project Director and/or his designee(s) and whether the implementation team leader will meet in person with the State on a monthly basis in Alaska or other locations to be specified by the state.

Answer: 1. Please refer to the implementation plan included with this proposal. We have included an implementation plan based upon your timeline of a 7/1/13 effective date and a decision date of 3/29/13. We have the people and processes to continue to support a 7/1 effective date. We would want to work with the State to determine an implementation date for the actives to ensure a smooth transition. We have included an implementation plan for integrated pharmacy services and stand alone.

2. Aetna will manage and staff the implementation function for the State of Alaska. In June of 2010, we entered into a strategic agreement with CVS Caremark. This agreement allows us to draw on each other's core strengths. Part of this agreement includes CVS Caremark supporting Aetna to load plan designs on the new claim platform, RxClaim. It's important to note that Aetna owns the implementation process and oversees CVS Caremark's work of loading plan designs.

3. While Aetna will manage and staff the implementation process, CVS Caremark will provide some back-end administrative support. In June of 2010, Aetna announced that we entered into a 10-year strategic agreement with CVS Caremark. We began implementing new customers on the RxClaim platform in 2012.

4. Aetna will perform all customer-facing aspects of the implementation. We will then provide all details and information around the pharmacy benefit to our strategic partner, CVS Caremark. We direct CVS Caremark how to set up the benefit. Once complete, CVS Caremark provides us with a full testing bed, along with access to the RxClaim system. We then review the testing, including the review of adjudication for visual confirmation on how the system is set up. We then sign off on plan benefit set up. If we need to make any adjustments, we work directly with our dedicated CVS Caremark team to make changes.

5. Aetna will manage and staff the implementation function for the State of Alaska. We oversee all aspects of the implementation and directly access all systems for testing and quality checks. We do work with our strategic partner, CVS Caremark, to load plan designs to the RxClaim system. Once complete, CVS Caremark provides us with a full testing bed, along with access to the RxClaim system. We then review the testing and sign off on plan benefit set up.

6. Please refer to the implementation organizational chart included with this proposal.

7. The assigned implementation manager, Laura Ocegueda, will serve as the transition project manager. Laura is located in California and will manage the project. The State's account management team will also be an integral part of the implementation process and will be available to meet on-site with Alaska as needed. The pharmacy account manager, Michelle Gutierrez in Arizona. The remaining primary account team members will be located in Alaska and Washington.

8. Please see below for specific information for each of the implementation team members.

9. Please see below for specific information for each of the implementation team members.

1. Name - Laura Ocegueda

2. Title - Senior Implementation Manager for National Accounts - Public & Labor Plan Sponsor Services

3. Physical work location - Teleworker/California

4. Years of industry experience - 27 years

5. Years with organization - 27 years

6. Level of Educational Attainment - Bachelor's of Science
7. Resume - Please see below
8. Years in current position - 10 years
9. Level and scope of decision making authority - Laura has decision making authority. For anything non -standard she will seek approval either from management or other business partners
10. Whether the individual management team member will be exclusively assigned to the transition until completion. - No. A designated Implementation Manager will be assigned to the transition and will remain engaged for approximately 30-45 days following the effective date. The Account Team and Plan Sponsor Administration team will assume ongoing responsibility for managing your account.
11. For those individuals not assigned exclusively to the implementation, please identify the amount of time they will be devoted to the transition - On average, 35% but may increase based on project scope.

Resume - Laura Ocegueda joined National Accounts Customer Implementation Management Services in July 2002. Her current responsibilities include overall project management for Aetna's new and existing plan sponsors' benefit programs. Her responsibilities include management of all implementation team activities between customers and service personnel relating to the coordination and installation of new and revised services for National Account customers.

Prior to joining CIMS, Laura was an Account Executive in the San Francisco Sales Organization. As an Account Executive she had overall responsibility for client retention, growth, negotiating renewals, and cross selling of new products for her assigned book of business.

Laura is a graduate of California State University at Hayward where she earned a Bachelor of Science degree in Business Administration

1. Name - Sara Kesler
2. Title/function - Sr. Billing Consultant
3. Physical work location - Teleworker/Walnut Creek, CA office
4. Years of industry experience - Please see the included biography for Sara Kesler
5. Years with organization - Sara has been with Aetna since 2006
6. Level of Educational Attainment - High School Diploma
7. Resume - Please see below
8. Years in current position- 6
9. Level and scope of decision making authority - For anything non -standard she will seek approval either from management or other business partners
10. Whether the individual management team member will be exclusively assigned to the transition until completion. - Yes
11. For those individuals not assigned exclusively to the implementation, please identify the amount of time they will be devoted to the transition - Not applicable

Resume: Sara joined the Aetna team in January of 2006. Sara is a Senior Billing Premium Consultant on the National Accounts Team. Sara handles Traditional Premium Billing and Reconciliation.

Sara came to Aetna with many years of experience having been employed in the banking/accounting/bookkeeping field for over twenty five years. Sara was employed initially in the banking field eventually being promoted to Operations Manager and Assistant Vice President. Sara worked for many years for a Certified Public Accountant and was employed prior to joining Aetna as a billing specialist for a firm of attorneys, billing for three locations that included multiple attorneys and paralegals.

Sara has completed several work related classes to assist her in her working environment which includes Excel, Word, Quicken, QuickBooks Pro, Accounting I, Accounting II, Mastering Payroll and Word Perfect.

1. Name - Christina Bryfogle
2. Title- Claim Data Specialist, Christina will install plan sponsor benefits in the claim adjudication system
3. Work Location - Allentown, Pennsylvania. Christina handled the Automatic Claims Adjudication System (ACAS) installation for this plan sponsor in the past and we would like to be able to capitalize on her experience.
4. Years of industry experience - 13 years
5. Years with organization - 13 years
6. Level of Educational Attainment - 12 years plus
7. Resume - Please see below
8. Years in current position - 6 years
9. Level and scope of decision making authority - No direct reports. Will be able to decide if benefits are supportable or not. For anything non -standard she will seek approval either from management or other business partners.
10. Whether the individual management team member will be exclusively assigned to the transition until completion. - Christina will not be exclusively assigned to State of Alaska
11. For those individuals not assigned exclusively to the implementation, please identify the amount of time they will be devoted to the transition - The time amount spent will depend upon the needs of State of Alaska

Resume: Christina began her career with Aetna in May of 1999 as a claims processor. Two years later she was selected to become a Quality Analyst, performing internal quality audits for claim processors. In this role Christina developed a passion for Quality which is seen in all tasks that she performs. In 2005, Christina was selected to join the Manual Plan Set-up team (MPSU). Christina has been on the MPSU team for 6 years. Her experience and dedication to quality is evident in each customer build she performs on the ACAS.

1. Name - Deborah Smith
2. Title- Automatic Claims Adjudication System (ACAS)Regional Liaison for Public & Labor. Deborah will attend customer installation meetings, verify system supportability of benefits, and monitor case activity through to claim readiness
3. Work Location - Blue Bell, PA
4. Years of industry experience - 14 years
5. Year with organization - 14 years
6. Level of Educational Attainment - 12 years plus
7. Resume - Please see below
8. Years in current position - 5 years
9. Level and scope of decision making authority - No direct reports. Will be able to decide if benefits are supportable or not. For anything non -standard she will seek approval either from management or other business partners
10. Whether the individual management team member will be exclusively assigned to the transition until completion. - Deborah will not be exclusively assigned to State of Alaska
11. For those individuals not assigned exclusively to the implementation, please identify the amount of time they will be devoted to the transition - The time amount spent will depend upon the needs of State of Alaska

Resume: Deborah began her career with Aetna in March 1998 as a claims processor. She became one of the first in the Blue Bell office to be trained to process on the ACAS platform. In 2001 Deborah became a member of the Manual Plan Set-up team actually building the plans on the ACAS platform.

In 2007, Deborah became the Regional Liaison, overseeing the implementation process for plan sponsors handled out of the Mid-Atlantic and Northeast Markets. This involved assisting plan sponsors with system support answers for benefits, providing timelines for claim readiness and following up with each area to make sure deadlines were reached.

In 2012, Deborah was selected as the Public & Labor Regional Liaison performing the same tasks.

1. Name - Terisita (Tet) Go
2. Title - Plan Set Up
3. Physical work location North Hollywood, California
4. Years of industry experience: 19.5 years
5. Years with organization: 19.5 years
6. Level of educational attainment: 12 years plus
7. Resume: Please see below
8. Years in current position: 10 years
9. Level and scope of decision making authority: Tet will have decision making authority but for anything non -standard she will seek approval either from management or other business partners
10. Whether the individual management team member will be exclusively assigned to the transition until completion: Tet will not be exclusively assigned to State of Alaska
11. For those individuals not assigned exclusively to the implementation, please identify the amount of time they will be devoted to the transition: The time amount spent will depend upon the needs of State of Alaska

Resume: Tet is the Plan Coordination Consultant for the Los Angeles national market.

Tet joined Prudential Healthcare in 1993 as a Claims Examiner for the ASO team. In 1996, Tet was certified as a Plan Description Record Specialist. In 1997, Tet was appointed to do the revalidation of quality reviewed plans. Under Aetna, Tet was the Installation Support Consultant for middle market and was trained as a PCC when the LA center became a national site.

Prior to joining Prudential, Tet held various positions for sixteen years with Carnation Company. The last position she held at the Carnation Company was as a Payroll Administrator.

Tet received an Office Automation Specialist Certificate from Glendale Community College.

1. Name - Sandra Lloyd
2. Title - Benefit Consultant
3. Physical work location where normally based - Pittsburgh, California
4. Years of industry experience: 26 years
5. Years with organization: 11 years
6. Level of educational attainment : 12 years plus
7. Resume: Please see below
8. Years in current position: 7 Years
9. Level and scope of decision making authority: Sandra will have decision making authority but for anything non -standard she will need to seek approval either from management or other business partners
10. Whether the individual management team member will be exclusively assigned to the transition until completion: Sandra will not be exclusively assigned to State of Alaska
11. For those individuals not assigned exclusively to the implementation, please identify the amount of time they will be devoted to the transition: The time amount spent will depend upon the needs of State of Alaska

Resume: Sandy began her career with Aetna in June 2001. She is currently a Work-at-Home Benefit

Consultant located in Pittsburg, California (40 miles east of San Francisco). In her current position she is responsible for negotiating contracts and benefit language, drafting Administrative/Master Services Agreements, and drafting benefit plans.

Sandy started her career with Aetna as an Administrative Assistant in Law & Regulatory Affairs, where she was promoted to Paralegal after obtaining her Paralegal certification. Prior to coming to Aetna, she was a Legal Secretary with highly rated law firms in Texas and California that specialized in diverse fields such as: Patent, Trademark and Copyright, Oil and Gas, Estates and Trusts, Business and Corporations, Bankruptcy and insurance defense litigation, and personal injury/property damage insurance prosecution.

1. Name - Barri Frank
2. Title - Eligibility Consultant and ID card consultant
3. Physical work location where normally based: Antioch, California
4. Years of industry experience: 12 years
5. Years with organization: 12 years
6. Level of educational attainment: Bachelor Degree
7. Resume: Please see below
8. Years in current position: 12 years
9. Level and scope of decision making authority: Barri will have decision making authority but for anything non -standard she will seek approval either from management or other business partners
10. Whether the individual management team member will be exclusively assigned to the transition until completion: Barri will not be exclusively assigned to State of Alaska
11. For those individuals not assigned exclusively to the implementation, please identify the amount of time they will be devoted to the transition : The time amount spent will depend upon the needs of State of Alaska

Resume: Barri is a Senior Eligibility Consultant in Walnut Creek, CA. She joined Aetna in August of 2000 and is currently responsible for processing electronic eligibility into Aetna systems. Barri is also involved with the coding of product ID cards which are distributed to Aetna members. In addition, she responds to customer, vendor or claims inquiries for information and/or problem resolution.

Prior to joining Aetna, Barri spent three years as a health insurance/benefit analyst for a contract security company in Oakland, CA. In addition to her benefits background, Barri has six years accounting experience.

Barri's professional and consultative customer focus has been recognized numerous times over the years by internal partners, Account Management Teams and Plan Sponsors. She has been formally recognized with two Aetna Ways Excellence Award nominations for her "best in class" service. Barri graduated from the University of Iowa with a Bachelor of Arts degree in English. She also has an associate's degree in accounting.

10. Please see above for specific information for each of the implementation team members.

11. The majority of the implementation functions will be done outside of Alaska, but staff can visit Alaska for any essential activities, if on-site is needed. The State's account team will be an integral part of the implementation and will be available to meet with the State as needed. The account team will be comprised of local resources as well as 4 Alaska-based sales support consultants and an Alaska Advisory Team.

12. A contact list is included in the Implementation Schedule identifying each functional contact involved in the implementation.

13. Please refer to the Implementation Schedule included with this proposal. We have included an implementation plan based upon your timeline of a 7/1/13 effective date and a decision date of 3/29/13. We have the people and processes to continue to support a 7/1 effective date. As the retirees are a 1/1 plan year, we would work with the State and the current administrator for the processes and data feeds needed for a smooth mid-year transition.

14. Our project plan assumes a weekly implementation project call, leveraging all of our project management tools. At a minimum we have assumed the account team will meet in person with the State on a monthly basis. We will work with the Sate on defining all of the face to face meeting dates based on final notification and implementation date.

Attachments: [Implementation Org Chart.ppt](#)
[State of Alaska Implementation.doc](#)
[State of Alaska Implementation Pharmacy Only.doc](#)

3.1.4.2 Will you provide welcome kits as part of the implementation? If so, please identify and describe all information that will be contained in the welcome kits. If there is an additional cost, please indicate the cost on the rate sheet.

Answer: 1: Yes

Detail: We provide all new members with Member Welcome Kits to help them get the most from their pharmacy benefits. We may also send these kits when you make changes to your plan design.

Each kit includes:

- A welcome letter that outlines the member's pharmacy plan design in clear, easy-to-understand language
- A Pharmacy Benefits Guide that includes plan-specific pharmacy information; explains our pharmacy programs and terminology; and provides an overview of Aetna Rx Home Delivery and Aetna Specialty Pharmacy
- An Aetna Rx Home Delivery brochure
- A courtesy reply card for members to request a printed copy of our formulary

We will work closely with you to determine the best methods of communicating with members. Our Aetna Customized Communications Group (CCG) is available to assist with specialized communication requests. Fees for customized communications services vary depending on scope and complexity.

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.1.4.3 Offeror must perform comprehensive systems testing and quality assurance audits, with results reported to the State, prior to the contract effective date as part of the base administrative fees with no additional charge to the State. If there are any costs, please detail.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.1.4.4 Please confirm that your cost proposal includes the cost of all implementation expenses. If not, please identify all additional costs on the rate sheet.

Answer: Confirmed

Attachments:

3.1.4.5 Please confirm that you will provide run-out administration, including communications and data support for transition to new Contractor, for a period of 12 months following contract termination. If there is an additional cost, please indicate the cost on the rate sheet.

Answer: Aetna has included the cost for the following: runout administration and open refill files. Aetna has included the cost of providing open refill files for mail order and specialty claims, current step therapy and precertification files, and a standard universal claim file with claims history. Any additional services will require additional charges.

Attachments:

3.1.4.6 Within your implementation team, is employee compensation tied directly to performance?

Answer: 2: No

Detail:

Options:

1. Yes
2. No
3. Partially

Attachments:

3.1.4.7 Please outline your procedures for loading patient payment histories from the prior carrier. If there is an additional cost, please indicate the cost on the rate sheet.

Answer: The standard 1600 file used by PBMs to transition patient information does not include patient payment history; therefore, we are unable to load this information in to our system. We will work with your current vendor to transfer open refills using the 1600 file.

After consulting with you, we will work directly with your former vendor to smoothly transition open refills. Please note that prescriptions excluded from this process include specialty drugs that Aetna Rx Home Delivery does not fill, Class II through Class V controlled substances, expired prescriptions and prescriptions with no refills remaining.

We do not charge a fee to accept an open refill file transfer.

Attachments:

3.1.4.8 Please confirm that you will be able to provide ID cards without Social Security Numbers to all members prior to the effective date of the Contract if the State chooses. If there is an additional cost, please indicate the cost on the rate sheet.

Answer: Confirmed.

Attachments:

3.1.4.9 At State option, if Offeror is not requested to provide ID cards, Offeror agrees to coordinate and provide information required by a third party vendor at no charge to the State.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.1.5 HIPAA Compliance

3.1.5.1 Confirm your organization is in compliance with and will administer the proposed benefit plan (s) in accordance with all applicable legal requirements, including HIPAA, COBRA, DOL, ERISA, and state and local mandates.

Answer: Confirmed.

Attachments:

3.1.5.2 Describe how you maintain confidentiality of patient and plan data.

Answer: We consider member health information confidential and have policies, procedures and technologies in place to protect it against unlawful use and disclosure.

When necessary for a member's care or treatment, the operation of our health plans, or other related activities, we use member health information internally, share it with our affiliates and disclose it to health care providers (physicians, dentists, pharmacies, hospitals and other caregivers). We may also provide the information to other insurers, third party administrators, payors (employers who sponsor self-funded health plans, health care provider organizations and others who may be financially responsible for payment for the services or benefits the member receives under our plan), vendors, consultants, government authorities and their respective agents. These parties are required to keep member health information confidential as provided by applicable law. We train employees who handle member health information regarding our confidentiality privacy policies and procedures.

We do not disclose member health information, except as permitted by law or with the member's consent.

Aetna and participating providers need access to member health information to fulfill a number of important and appropriate functions, including, claims payment, misuse prevention, coordination of care, data collection, performance measurement, compliance with state and federal requirements, quality management, utilization review, research and accreditation activities, preventive health, early detection and disease management programs.

Our Notice of Privacy Practices, which provides detailed information about our policies concerning

disclosure of member information, are available on our website at www.aetna.com/about/information_practices.html.

Aetna.com Website

Aetna has adopted and adheres to stringent security standards designed to protect non-public personal information at aetna.com against accidental or unauthorized access or disclosure. Among the safeguards that Aetna has developed for this site are administrative, physical and technical barriers that together form a protective firewall around the information stored at this site. We periodically subject our site to simulated intrusion tests and have developed comprehensive disaster recovery plans.

Aetna Navigator Website

Aetna Navigator is a secure site employing secure socket layer (128-bit encryption) which is the industry standard for Internet security.

Aetna Mobile Applications

Authentication methods for Mobile application are consistent with the same as Web application.

Secure E-Mail Encryption

Attached is our secure E-mail Privacy Practice document.

Attachments: 2.1.5.2 Secure Email.pdf

Attachments:

3.1.5.3 Confirm you are currently receiving eligibility files in the HIPAA 834 format.

Answer: Confirmed.

Attachments:

3.1.5.4 Are your eligibility and claim systems compliant with recently updated HIPAA regulations?

Answer: Yes.

Attachments:

3.1.5.5 Please list the dates in which your eligibility and claims systems were reviewed or validated against the updated HIPAA regulations.

Answer: We are in full compliance with the requirements that have been issued to date. This includes review and validation of our eligibility and claims systems. Following is a brief summary:

Privacy

As of the April 14, 2003 Privacy Rule compliance deadline, we had taken all steps necessary to comply with the Privacy Rule requirements, including:

- Naming a chief privacy officer and establishing a Privacy Office.
- Implementing new and/or revised company-wide privacy policies and procedures.
- Training impacted personnel.
- Implementing system changes and workflows to provide members with (i) access to their health information, (ii) an accounting of many types of disclosures, (iii) a process for requesting amendments to their health information, and (iv) the ability to request restrictions or have confidential information mailed to an alternative address.
- Delivering a Privacy Notice to full risk subscribers.
- Adopting specific disciplinary procedures and sanctions for employees who violate our Privacy

Policies.

Transactions and Code Sets

As of October 16, 2003, we were positioned to support HIPAA compliant electronic transactions and code sets. We have the flexibility to accept both compliant and non-compliant electronic claims, consistent with guidance provided by the Centers for Medicare and Medicaid Services (CMS).

Security

To prepare for the HIPAA Security Rule, we performed a thorough risk assessment of our systems (including our eligibility and claim systems) and operations and developed and executed a remediation plan. We were compliant with the HIPAA Security Rule as of the April 20, 2005 compliance date.

Unique Identifiers

Aetna has been compliant with the unique Employer Identifier Number (EIN) requirement since July 30, 2004.

As of May 23, 2007, we were ready to accept and process HIPAA standard electronic transactions that comply with the National Provider Identifier (NPI) regulations. Effective March 16, 2009, to comply with HIPAA regulations, we began rejecting electronic claims and encounters submitted without a billing provider NPI. If a "pay to" provider is identified on a claim, the NPI for that provider must also be included. We continue to work diligently with providers to educate them and bring them into compliance according to the HIPAA regulation.

The Payer regulation is not final. Once finalized, we will have two years to comply.

Attachments:

3.1.5.6 Was an outside auditor/reviewer employed for HIPAA review/validations of these two systems?

Answer: No. We do not employ an outside auditor for HIPAA validation. HIPAA compliance is managed internally and Aetna is in compliance with all required regulations.

Attachments:

3.1.5.7 How soon after the contract award will you provide the HIPAA companion guide for creating eligibility files that load to your system?

Answer: The State of Alaska's assigned eligibility consultant can forward the EDI record layout upon award of contract or during the implementation period.

Attachments:

3.1.5.8 Confirm your ability to administer HIPAA creditable coverage notices.

Answer: Confirmed.

Attachments:

3.1.6 Communications

3.1.6.1 Confirm that you are able to customize all communication/educational materials to include the AlaskaCare logo as the prominent feature.

Answer: 1: Confirmed

Detail:

Options:

1. Confirmed
2. Not confirmed

Attachments:

3.1.6.2 Can you provide communication materials in an electronic and editable format for use by the State in their communications? If there is an additional cost, please indicate the cost in the rate sheet.

Answer: 1: Yes

Detail: We will provide the electronic files at no additional cost.

Options:

1. Yes
2. No

Attachments:

3.1.6.3 Please confirm all communications/educational materials will be submitted to the Project Director, or his designee, for review and approval before dissemination to members. If you cannot confirm, please explain.

Answer: 1: Confirmed

Detail:

Options:

1. Confirmed
2. Not confirmed, please explain: [Text]

Attachments:

3.1.6.4 Please describe the process that will be implemented to ensure that internal reference source(s) provided to your personnel are consistent with the State's documentation such as employee communication materials, open enrollment information, plan documents, etc.

Answer: During the implementation, we use an electronic internal document to assist with information gathering and coding. We will do this in consultation with you, the account team and claim contact, referencing customer plan documents and SPDs as needed to clarify benefits. We will require your signoff prior to coding. Post-implementation, we will compare the State of Alaska's SPD against our system to validate accuracy and consistency.

Attachments:

3.1.6.5 What is the average number of work days from placing an order to time of delivery for the following communication materials?

	Average Days to delivery
Employee ID cards	8.5
Enrollment forms	0
Claims forms	0
Provider Directories	0
Program Descriptions	0

Detail: It take an average of 7 to 10 business days for members to receive ID cards. Members have immediate access to enrollment forms, claim forms, retail pharmacy locations and program descriptions in real time through our member website, Aetna Navigator.

Attachments:

3.1.6.6 Please attach sample member communication materials, including a sample ID card and sample member welcome letter.

Answer: 1: Attached

Detail:

Options:

1. Attached
2. Not Attached

Attachments: [Question 3.1.6.6 New Member Welcome Letter.pdf](#)
[Question 3.1.6.6 Aetna Integrated ID Card.xls](#)

3.1.6.7 Is the creation, customization, production, and distribution of the materials itemized below included in your cost proposal?

1. If there is an additional cost for any of the items listed below, please indicate each additional cost on the rate sheet.
2. Will each of the items listed below be made available online?
3. Please identify any additional communication and/or educational materials not listed below that are included in your cost proposal, and provide an example of each where possible.
4. Please identify any additional communication and/or education materials not listed below that you can provide for an additional fee. Please indicate each additional cost on the rate sheet.

	Can Provide?	Included in Fees? If no, include fee on rate sheet.	Can Customize?
Employee ID Cards	1: Yes	1: Yes	1: Yes
Replacement ID Cards	1: Yes	1: Yes	1: Yes
Claim Forms	1: Yes	1: Yes	1: Yes
Provider Directories	1: Yes	1: Yes	1: Yes
Summary Annual Reports	1: Yes	1: Yes	1: Yes
Summary of Material Modifications	1: Yes	1: Yes	1: Yes
Annual Benefit Statements	1: Yes	1: Yes	1: Yes
General Letters and Correspondence Sent to Employees	1: Yes	1: Yes	1: Yes

Detail: Please note we can accommodate customization of forms but additional fees will apply.

Attachments:

3.1.7 Information Technology

3.1.7.1 Offeror shall maintain the identified State's list of data elements necessary to meet the State's claims review and reporting requirements.

Answer: Confirmed.

Attachments:

3.1.7.2 The Offeror shall provide all necessary data for the State to comply with or participate in programs (whether optional or mandated) implemented as part of any local, state or federal government health care reform legislation. Required data shall be provided at no additional cost to the State. This includes future program options such as Employer Group Waiver Programs (EGWP) or wrap plans that the State determines is advantageous to the State, its benefit plan and/or membership and decides to participate.

Answer: Confirmed.

Attachments:

3.1.7.3 The Offeror must make all data available in a State approved electronic format. In addition, all schemata and file definitions must be made available to the State upon request.

Answer: Confirmed.

Attachments:

3.1.7.4 Upon determination and identification of system problems, programming problems, or transfer problems, the Offeror shall notify the State immediately upon identification of issue. The Offeror shall also make every effort necessary to correct such problem immediately or as soon as possible, including but not limited to: working nights; weekends; and holidays, to minimize any negative impact to employees, retirees, or dependents and to maintain continual operations of the program.

Answer: Confirmed.

Attachments:

3.1.7.5 The Offeror must accept data transmissions from designated State vendors and agree there will be no additional fees, unless outlined in the Administrative Fee table in the cost proposal, to establish the interface and/or any other IT services in the initial set-up or to accept changes to the file layout during the term(s) identified as part of the award. The Offeror must reconcile each data feed and work with the appropriate vendors to keep the data accurate and consistent among all parties at no additional cost to the State, and will work with the State and its respective vendors to identify opportunities to improve data transmission requirements that will result in improved operational efficiencies and program effectiveness.

Answer: Confirmed. Depending on the final selection, we would include the cost for third-party data integration in our fees.

Attachments:

3.1.7.6 Describe how your company will use its systems technologies to perform each aspect of the work set forth in Section 1.04 of the RFP instructions relative to the Pharmacy Claims Administration and Managed Network.

Answer: Our flexible health improvement services can accommodate any combination of plan designs and reporting alignments. The following technology is a differentiator in the industry:

- High Availability Facility - The Data Center eliminates most infrastructure single points of failure, thus providing more reliable and available applications and systems. Infrastructure components include telecommunication access (voice and data), utilities feeds and alternate sources. In addition, the data center is equipped with security features, including biometrics access technology.

- ISO Certification - In July 2000, the Data Center in Scottsdale, AZ, was awarded ISO 9002:1994 certification following an ISO9002 audit by Deloitte & Touche. The Data Center and the entire IS Operations and Infrastructure organization is beginning its 7th year under the ISO 9001:2000 standard.

- Enhanced System Management, Monitoring and Reporting - We support an enhanced monitoring

and management capability associated with the pharmacy network, customer network, claims processing and back-end systems. This includes telecommunications interfaces, as well as systems and application-level management and reporting (ad hoc and scheduled).

- Proactively Monitored Pharmacy Connectivity - We proactively monitor and manage our pharmacy network through state-of-the-art software. The result is a network environment that is available 99.95 percent of our scheduled uptime.

- Proactively Monitored Customer Connectivity - The customer network interfaces are monitored and managed through the Enterprise System Management Framework. These network interfaces include a variety of connectivity options, such as point-to-point services, Internet, Value-Added Networks and frame relay services.

- Effective Use of Automation - The ability to centralize and automate operational activities eliminates the potential for error introduced by manual operations.

- System Scalability - We select technologies based on their ability to scale and meet the high Online Transaction Processing and batch process demands of our customers. Benchmark and scalability testing is integral to implementation services.

- Audits and Controls Assessments - We audit our technology and business operations several times a year, internally and externally. Included in the external review is a yearly SAS 70 audit. We conduct other internal and external that ensure ongoing financial, security and information technology best practices compliance.

- Operational Excellence - We are committed to continual process improvement and operational excellence. Areas of focus for operational excellence include ISO 9002 certification for our data center, audit and assessment improvements, project management, change management, availability management, problem management, operational excellence reviews, and report and disaster recovery.

Attachments:

3.1.7.7 Does your automated data processing capability include the ability to interface with the State's health reporting eligibility system when fully operational?

Answer: Confirmed. We work with many customers who use third party enrollment vendors; however, we do not directly interface with their systems. The State can extract data and send our proprietary 2000-byte file layout, our new Consolidated Eligibility Format file or an ANSI standard layout for electronic processing. Because electronic submission tends to be more efficient and accurate, we encourage the State to implement an electronic submission method, regardless of the human resources information system you use. This process is available for initial and subsequent enrollments.

Additionally, our account team has the ability to access your system to review eligibility. We will have our personnel use your system to check eligibility when it has not yet been loaded into our system.

Attachments:

3.1.7.8 Describe the proprietary software that will be used in administration of this Contract, as well as any services or software purchased or licensed from outside vendors to update your system.

Answer: We entered in to a 12-year strategic agreement with CVS Caremark in June of 2010. When we looked at ways to increase the value of our PBM program, we wanted an agreement that would

allow us to maintain ownership of many of our core capabilities, while benefitting from the scale, flexibility and technical capabilities that a large, independent organization like CVS Caremark can provide.

In determining how to bring the strengths of each of our organizations together, we looked at areas we could leverage Caremark's technology and buying power to benefit our customers and members. We are moving to the Caremark RxClaim system to enhance our clinical programs, and develop new additional generic solutions and adherence programs that will provide cost savings for you and potentially improve member health. We have also used our proprietary reporting system and enhanced it with CVS Caremark's technological capabilities. Our organization retains the management of all programs and services we offer. As with any private-label arrangement, all services are seamless and the only interaction is between APM, our customers and members.

This arrangement has allowed us to continue to provide customers with high-value, integrated pharmacy plans driven by total cost and quality management, clinical superiority, a holistic, member-centric experience and market-leading products.

RxClaim System Technology

The RxClaim processing system uses the IBM System i5 model 570 hardware. Redundancy is built into the system, including:

- A primary and secondary processor for production
- A development processor for development
- Fully redundant disk storage systems

The system i5 model 570 is IBM's most advanced 64-bit RISC technology and employs five notable system concepts:

1. Layered Machine Architecture - This architecture insulates users from the hardware characteristics and enables migration to new hardware technology without impacting the application programs.
2. Object Orientation - Everything that can be stored or retrieved on the machine is known as an object. Objects exist to make users independent of the machine's internal structure.
3. Single-Level Storage - Main storage and disk storage appear contiguous by implementing a device-independent addressing mechanism when an object is saved or restored on the system. This means that extra storage can be added without affecting application programs.
4. Hierarchy of Microprocessors -The System i5 features a large number of microprocessors in addition to the main system processor. Each input/output device type on the System i5 has its own microprocessors, enabling data to be written or read while the main processor executes another application.
5. Operating System (OS) -The i5/OS is a single entity that fully integrates all software components (relational database, communications and networking capabilities, etc.) needed to support claim processing.

Uninterruptible power supply systems and diesel-driven power generators support all systems to ensure 24/7 operations. Because it is predicated on scalability, the system's architecture is designed to accommodate significant increases in processing requirements.

We maintain a multiplicity of technology systems, which can be grouped into three primary functional areas:

- Data warehousing and decision support
- Claims adjudication
- Mail-order fulfillment

Each functional area requires very specific technologies to address its particular systems requirements.

Data Warehousing and Decision Support

Data warehousing technology provides access to ad hoc queries and reports - whether clinical, administrative or financial in nature. A few highlights of our data warehousing systems are as follows:

- Uses a Sun Enterprise 10000 server running Sun Solaris operating system.
- Enhances access from the Sun server to the EMC disk servers through a SAN consisting of 4 Brocade switches utilizing 18-fibre channels
- Employs Oracle as its relational database management engine
- Uses online data resources that currently include nearly 2.1 million drug pricing records with historical information, spanning 5 years, multiple therapeutic classification systems, more than 95,000 pharmacy entities with name, address and classification information

Claims Adjudication

The integrated retail and mail-order claim adjudication network consists of a varied infrastructure composed mainly of many WAN/LAN architectures and a drive for customer services.

- WAN Media - The WAN media involve Integrated Services Digital Network (ISDN), T-1, and Frame Relay services.
- LAN Services - The LAN services are mainly NT Ethernet, servers, remote access, hubs and switches. The protocols in the network are designed for different implementations and uses.
- IPX -IPX is used for customer-specific LANs, NetBEUI is used by NT and peer-to-peer-based systems, and System Network Architecture (SNA) typically is used by the IBM mainframes and minis.
- Internet Protocol (IP) - IP, which is used by most network devices and systems, provides for multi-host and single-host communications.

The network is composed of some of the best products from leading vendors in the telecommunications industry. Systems are designed to include redundancy features and are closely monitored for both long-term performance and fault management. You can choose from the following options:

- Telnet connectivity is available using a frame relay or dial-up process. Both NetTerm and Rumba are supported.
- Connect: Direct operates on the System i5 mainframe, as well as the AIX and NT environments, for claim data exchange with our customers.
- System Network Architecture/Distribution Service (SNADS) provides protocol for sending information from one user to another or one system to another at different times.

- Secure Transport is an encrypted method used to exchange files with us. Methods of exchange include https and ftps. Process automation is accomplished through Secure Transport customer software. File exchange is supported by this software or a web browser supporting 128-bit SSL encryption.

The primary method of file transfer utilizes Point-to-Point Protocol (PPP) with dial-up and/or leased lines (i.e., T/1 frame). The preferred point-to-point hardware solution includes Cisco routers and firewalls for connectivity and security.

The current VPN solution uses Nortell hardware. We also can create B2B solutions with Cisco devices using industry standards.

Attachments:

3.1.7.9 Describe your system access security process with members, providers and the State.

Answer: Members, providers and the State of Alaska can communicate with us through the Internet. Firewalls and other hardware protect all Internet capabilities from outside intrusion. The data center features 128-bit encryption and the latest virus-prevention technology. Furthermore, it is a completely redundant center with 24/7 support. Whitehat Security offers further validation of our security.

All access to internal systems must pass through industry standard Cisco ASA5540s firewalls. These firewalls are configured using industry best practices. Only ports and services that are necessary for specific applications are configured as open/allowed on all firewalls. Firewall logs are monitored on a regular basis. In addition, managed IDS solution is used to monitor and protect any access to the infrastructure. IDS monitoring is on a 24/7 basis, with immediate response to any intrusion alerts. A rapid response team investigates all alerts.

Customers are required to obtain individually assigned IDs and passwords in order to access data. For the transmission of information from the pharmacy to our company and back, a private network is in place at no additional cost to you.

For all transmissions of medical or financial information, we use some of the strongest encryption technology currently available on the Internet. We have licensed the Global Server ID product from VeriSign. VeriSign is a leading provider of Internet-based trust services and digital certificate solutions that other websites, enterprises, electronic commerce service providers and individuals use to transmit and conduct secure communications and electronic commerce over the Internet.

IronPort encryption solution is deployed for the transmission of e-mails containing confidential information.

Members must register online using their plan/group code, member ID and self-assigned password, which is approved against our database before access is permitted.

Additional security measures require covered spouses to register separately from the primary cardholder. To order new prescriptions or refills, users enter credit card information and we transmit this information for verification, using encryption technology and VeriSign Certification.

Attachments:

3.1.7.10 Describe the advantages of your Internet home page, including access and capability to communicate with the State and members on information regarding:

- a. Claims status
- b. Eligibility (name, address, covered dependents, etc.)
- c. Providers (including name, location, education background and credentials, gender, specialty, languages spoken, standard rates for selected procedures, patient satisfaction levels, etc.); and
- d. Health improvement and education information

Answer: Through our secure member website, www.aetnavigators.com, the State, their employees and their dependents can access the following tools, information and services.

Prescriptions and Benefits

We personalize prescription and benefit information for members at the plan level. This means that we provide members who log onto the site with accurate information specific to their plan, such as drug costs and coverage information.

Members are able to:

- Check drug coverage and price, including therapeutic alternatives
- Print ID cards
- View online formulary
- View benefit information
- Check drug interactions
- Download forms (claim and mail order forms)
- Find a local pharmacy (customer network-specific) and access maps/driving directions
- Learn how to start a new prescription with Aetna Rx Home Delivery®
- Order mail order refills online
- Check mail order status
- Search drug information
- View 24-month drug history
- Gain e-mail access to member services
- View secured member messaging via the member's online Message Center
- Read e-mail alerts regarding available refills, expiring refills and shipped prescription refills
- Set e-mail alerts
- Access our interactive savings tools, including the Savings Center and price-a-drug solutions, to identify savings opportunities and price and compare brand drugs, preferred drugs and generic drugs

Health and Drug Information

We also offer members a comprehensive health and wellness section, including content produced in-house as well as content aggregated from best-in-class third-party vendors. This award-winning site provides members with valuable information to help them better manage their own health and conditions in addition to their drug regimens. Those interested in learning more about managing their health will be able to:

- Utilize self-care centers and dozens more condition centers to find valuable information quickly
- Access our “Ask A Pharmacist” interactive feature
- Access answers to hundreds of frequently asked questions
- Access interactive tools, quizzes, animated guides, calculators, videos and podcasts
- Read more than 30,000 health and wellness articles provided by outside vendors
- Find answers in a comprehensive Drug Center that provides information on the safe use of medicines, questions to ask your physician and understanding potential risks and side effects of the drug(s)

Bilingual Website

Our online tool also provides members with the ability to manage their prescriptions online in Spanish. Members can perform the following:

- Refill mail order prescriptions
- Check order status
- View prescription history
- Access/order new prescriptions
- Access the Savings Center
- Check drug costs
- Find local pharmacies
- Access prescription plan information
- Print forms and ID cards
- Manage accounts and family member prescriptions

Mobile Website

We have redesigned some of the most popular features of our intranet site to create a mobile version for members on the go. Members can access these features through their cell phones and Smartphone, or iPod Touch and iPad devices. When members log in to their secure site, they can:

- View their medical and pharmacy claims
- View their personal health record
- Check drug prices
- View their ID card
- Contact us by telephone or e-mail

The most popular features of our website have been streamlined to speed up on-the-go web surfing. For example, when searching for a claim, we provide the member with their five most recent claims as a starting point. We then offer them the opportunity to search further. These mobile web capabilities highlight our commitment to simplify our online features and add convenience for our members.

Attachments:

3.1.7.11 Please indicate which of the following member services are available on your website by noting “yes” or “no” in the space provided.

	Yes/No	Comments
Order refills and renew retail prescriptions	2: No	N/A
Order refills and renew mail order prescriptions	1: Yes	N/A
Order refill and renew specialty pharmacy prescriptions	1: Yes	Our active refill service supports member compliance. Through this service, we contact members seven days before their next refill date. This allows members a chance to discuss their treatment progress and be assured their next refill is on its way. During the active refill process, we ask members questions to ensure they are taking the correct dose. We also work to discover whether they are experiencing any unmanageable side effects that

	Yes/No	Comments
		might interfere with compliance.
Order new prescriptions (when allowed by law)	2: No	While members are not able to submit new prescriptions using our member website, physicians are able to submit prescriptions through e-prescribing.
Purchase Over the Counter (“OTC”) medications	2: No	N/A
Prescription refill reminders	1: Yes	N/A
Order status for mail order prescriptions	1: Yes	N/A
Order status of specialty prescriptions	2: No	We always call members in advance regarding the expected specialty drug shipment to determine a convenient delivery time and date. We use UPS and FedEx to provide reliable and consistent, high-quality services. We use a direct computer link with these couriers so we can immediately determine the status of packages.
Claims history	1: Yes	N/A
Review financial information - deductible	1: Yes	N/A
Review financial information – out of pocket	1: Yes	N/A
Print claims history	1: Yes	N/A
Look-up medication information	1: Yes	N/A
Locate a network pharmacy	1: Yes	N/A
Review eligibility information	1: Yes	N/A
Review benefits information	1: Yes	N/A
State-specific/member-specific cost information: Total prescription cost	1: Yes	N/A
State-specific/member-specific cost information: Total State prescription cost	1: Yes	N/A
State-specific/member-specific cost information: Total member prescription cost	1: Yes	N/A
Member- and State-specific cost and calculated savings information about lower-cost generic alternatives for multi-source brands (i.e., generic equivalents and generic or preferred brand therapeutic alternatives) available for consideration	1: Yes	N/A
Member- and State -specific cost and calculated savings information about lower-cost alternatives for single-source brands (i.e., generic or preferred brand therapeutic alternatives) available for consideration	1: Yes	N/A
Member-and State -specific cost and	1: Yes	N/A

	Yes/No	Comments
calculated savings information about a lower-cost channel (e.g., Mail) for consideration		
Potential Gaps in (or omissions of) Care (e.g., diabetic without a claim for a medication that is recommended in treatment guidelines, like an Angiotensin Converting Enzyme Inhibitor)	2: No	While we do not offer gaps in care member communications online, we reach out to members and providers in the mail to address gaps in care. Through MedQuery, we identify opportunities across numerous conditions to enhance care by analyzing pharmacy, medical, lab and demographic data. We then send physician communications, called Care Considerations, which empower physicians with information to help them close gaps in care. We review data weekly, comparing it against treatment recommendations to identify potential gaps.
Medication non-adherence alert (alert when a gap in therapy/day supplies according to claims history is identified)	2: No	<p>Instead of offering online adherence alerts, we send adherence information via mail and telephone. We have briefly described some of our adherence programs below:</p> <p>Adherence to Drug Therapy We engage members through education and reminder communications. This solution monitors over 34 different drug classes used to treat 9 conditions.</p> <p>Pharmacy Advisor Counseling We alert mail-order pharmacists to telephonically counsel members regarding diabetes and cardiovascular conditions. We provide the pharmacist with the information they need regarding the member right away. The pharmacists receive training to be able to address diabetes, as well as high blood pressure, high cholesterol, coronary artery disease and congestive heart failure and will be able to see any applicable gaps in care or refill-related issues and address them with the member.</p> <p>Specialty Pharmacy Adherence Support Our nurses receive monthly reports for members taking specialty drugs. They review these reports to identify members not filling their prescriptions. A nurse calls a member who is not complying with their treatment, encourages them to take their medication and provides support to the member. The nurse tracks the conversation with the member, and may contact the prescribing physician to discuss the lack of compliance.</p>

	Yes/No	Comments
Applicable drug exclusions	1: Yes	N/A
Price for medications that are excluded	2: No	Our formulary provides coverage across all drug classes.
Prior authorization list	1: Yes	N/A
Price for medications requiring prior authorization	1: Yes	N/A
Notation during medication look-up about coverage limitations (e.g., excluded, requires prior approval, subjected to step therapy or quantity limitations)	1: Yes	N/A
List of drugs with quantity limits	1: Yes	N/A
Price for prescriptions with quantities over the quantity limit	1: Yes	N/A
List of drugs that are subject to Step Therapy protocols, if applicable	1: Yes	N/A
Price for second-line medications that are subject to Step Therapy protocols, if applicable	1: Yes	N/A
Description of your company's clinical management programs	1: Yes	N/A
Chat with a Customer Service Representative	1: Yes	N/A
Chat with a Pharmacists	1: Yes	N/A
Order replacement ID cards	1: Yes	N/A
Order paper claim forms	1: Yes	N/A
Instructions for requesting reimbursement for paper claims	1: Yes	N/A
Instructions about how to get started / use the mail pharmacy	1: Yes	N/A
Instructions about how to get started / use the specialty pharmacy	1: Yes	N/A
Instructions about how to file an appeal	1: Yes	N/A
Other	N/A	N/A

Detail:

Attachments:

3.1.7.12 Explain your process of providing a secure electronic portal for members and providers to contact you via e-mail for customer service inquiries.

Answer: A dedicated CSR Internet team is staffed to respond to all e-mail inquiries from our comprehensive member website. Additionally, our “Ask a Pharmacist” feature enables members to ask questions of clinical pharmacists in a confidential and secure environment.

Security

Our website's data center includes firewalls and other hardware that protect all of our Internet capabilities from outside intrusion. It features 128-bit encryption and the latest virus-prevention

technology. Furthermore, it is a completely redundant center with 24/7 support. Our website also carries the Whitehat Security seal of approval, having passed this robust security assessment.

Members

Members can register online using their plan/group code, member ID, and self-assigned password, which is approved against and must match our eligibility database before access is permitted. Members also answer challenge questions, and have the ability to setup how often they are asked.

Additional security measures require covered spouses to register separately from the primary cardholder. To order new prescriptions or refills, users enter credit card information and we transmit this information for verification, using encryption technology and VeriSign Certification.

Attachments:

3.1.7.13 Describe your company's use of current system technologies to notify customers of issues that relate to them.

Answer: Member Service Access is our web-based portal that will deliver pharmacy based applications and information specifically for you and your users. Available through a secured site, you can access your applications through a single login ID and password. This eliminates the need to maintain multiple credentials for various applications.

Information can be tailored to your specific requirements. This means that when accessing Member Service Access, each user that you have designated to receive access to the tool will only view information relevant to you. For instance, you can include all of the following features, or choose just those tools that are important to you.

Online Decision Support Tool

You will be able to access all of the following through this tool:

- Standard management reports
- Ad hoc, user-created management reports
- Drug claim analysis
- Drug savings reports
- Drug utilization reports
- Pharmacy and physician profiling reports
- Monitor effectiveness of prescription benefit and health management programs
- Forecast costs
- Download, store and print all reports
- Review clinical newsletters

Member Services Online

The Member Service Online will enable you to proactively manage pharmacy benefits, at an individual level, for your member population. Real-time additions and updates can be entered directly into the system and are effective immediately.

Users can perform the following functions:

- Eligibility Inquiry
- Eligibility Maintenance
- Plan Benefit Override (Precertification) Maintenance
- Plan Benefit Override (Precertification) Inquiry
- Price a Drug
- Look up a Pharmacy

Open Enrollment Site

You will have access to co-branded websites that include a pharmacy locator, selected APM formulary and basic plan design information.

Personalization

Through this website, you can access:

- Drug payment and coverage (The State of Alaska contribution and annual cost, if applicable)
- Benefit summary with custom verbiage and link
- A customized member FAQ section
- Display of custom logos and customized messaging

RxPipeline®

RxPipeline is a comprehensive, web-enabled, searchable database of brand pipeline and first generic pharmaceuticals. The State of Alaska can use this application to remain current on new therapies and plan-appropriate drug benefit designs. You can view daily news of significant pipeline activity and utilize customizable queries to conduct, save and edit the pipeline or first generic searches. The State of Alaska will be able to select APM publications and reports of interest.

Attachments:

3.1.7.14 Describe any on-line comparative reporting tools you make available to assist members in choosing elective care providers and facilities.

Answer: For educational and decision-making purposes, registered members of Aetna Navigator, our member website, can use Price-A-Drug through the Estimate the Cost of Care (ECC) suite of interactive web-based cost tools. Members can calculate the estimated price of a specific drug, view detailed information about that drug and learn of any potential interactions. Price-A-Drug is also accessible on mobile phones.

The ECC tool helps members make well-informed decisions and, in some cases, even lower their out-of-pocket expenses. The tool is particularly helpful for members in coinsurance and high-deductible plans in which out-of-pocket expenses can vary.

Members can compare the difference in cost between retail pharmacies and mail order. Members also can compare the estimated difference in out-of-pocket costs between a brand drug and the generic equivalent, if one is available.

We estimate drug prices based on the member's specific plan design, the reimbursement rate in the state where the drug will be dispensed, the prescribed quantity and dosage. To calculate an estimated price, the member begins by simply clicking on the pricing tool. The ECC tool is accessed through Aetna Navigator and the subscriber and dependent names, dates of birth and state of residence are prefilled. The member enters the appropriate drug name and dosage information. The ECC tool will then return the following information for both the retail and mail order pharmacies:

- Total estimated drug cost
- Member's share of the estimated cost, based on member plan design
- Drug type, whether the drug is a brand or generic
- Hyperlink to a detailed drug information database

- Formulary alternatives if the member prices a non-preferred brand drug
- Advisory messages providing, for example, information regarding medication quantity limits or coverage exclusions for specific drugs, when applicable to the member's plan

The ECC tool provides easy-to-understand information that reflects current drug prices and comparisons members can use to calculate savings. Drug prices are updated every week, and changes to the medication list are made as they occur (i.e., NDC changes, prescription to over the counter, brand to generic, etc.).

My Pharmacist tool through iTriage

In addition to the Price-A-Drug tool, we offer iTriage, a recent Aetna acquisition. This provides patients with consumer-facing technology in the form of a mobile phone and web patient engagement platform. My Pharmacist functions like an expert pharmacist where members can easily:

- Search for drug information
- Compare prices
- Get suggestions for lower cost generics
- Refill prescriptions with bar code by smart phone
- Set reminders to take medication
- Get information on missed doses, side effects and drug-to-drug interactions

Attachments:

3.1.7.15 Indicate services you offer to members and providers via e-mail and electronically.

Answer: We provide a variety of services to members and providers via e-mail and electronically.

Members

We personalize prescription and benefit information for members at the plan level. This means that we provide members who log onto the site with accurate information specific to their plan, such as drug costs and coverage information. Members are able to:

- Check drug coverage and price, including therapeutic alternatives
- Print ID cards
- View online formulary
- View benefit information
- Check drug interactions
- Download forms (claim and mail order forms)
- Find a local pharmacy (customer network-specific) and access maps/driving directions
- Learn how to start a new prescription with Aetna Rx Home Delivery®
- Order mail order refills online
- Check mail order status
- Search drug information
- View 24-month drug history
- Gain e-mail access to member services
- View secured member messaging via the member's online Message Center
- Read e-mail alerts regarding available refills, expiring refills and shipped prescription refills
- Set e-mail alerts
- Access our interactive savings tools, including the Savings Center and price-a-drug solutions, to identify savings opportunities and price and compare brand drugs, preferred drugs and generic drugs

Pharmacies

We require pharmacies in our retail network to have online access to the claim processing system. Member eligibility flows from the mainframe to our pharmacy claim system, where it becomes available for online processing within 24 to 48 hours.

Once a claim is processed, we have it automatically edited against a single member profile. The system provides the dispensing pharmacists with eligibility and plan coverage, including copayment or coinsurance amounts, usually within three seconds. We also have prospective and concurrent DUR performed on each claim to help the pharmacist identify potential problems.

In the event of any issue, pharmacists are instructed to call our toll-free Pharmacy Help Desk, where CSRs are available 24 hours a day, 7 days a week, 365 days a year.

Physicians

Through e-prescribing, we empower physicians with real-time information that helps them choose the most cost-effective drug therapy based on the member's condition and health plan. Our overarching strategy is to promote integration of pharmacy information, as well as clinical decision-support tools using evidence-based medicine as a base, such as our Care Considerations program.

- **How it Works** - An electronic connection between any prescribing physician and APM is created before the physician writes the prescription.
- **Surescripts® Connection** - We are fully connected with Surescripts and pay for the eligibility transactions to allow each prescribing physician to verify APM prescription benefits and obtain the member's prescription history. Over 100 electronic prescribing vendors utilize Surescripts to provide member specific health insurance information at the point of prescribing.
- **Current Utilization** - Approximately 16.7 percent of prescribing physicians in Aetna's network are using an electronic prescribing application to check eligibility and prescribe medication.

Attachments:

3.1.7.16 Describe electronic services methods you use to educate members in accounts you currently manage of similar size to the State of Alaska about health care issues that impact plan costs.

Answer: The primary way we electronically educate members about health care issues that impact plan costs is through our member website, Aetna Navigator. We offer members a comprehensive health and wellness section, including content produced in-house as well as content aggregated from best-in-class third-party vendors. This award-winning site provides members with valuable information to help them better manage their own health and conditions in addition to their drug regimens. Those interested in learning more about managing their health will be able to:

- Utilize self-care centers and dozens more condition centers to find valuable information quickly
- Access our "Ask A Pharmacist" interactive feature
- Access answers to hundreds of frequently asked questions
- Access interactive tools, quizzes, animated guides, calculators, videos and podcasts
- Read more than 30,000 health and wellness articles provided by outside vendors
- Find answers in a comprehensive Drug Center that provides information on the safe use of medicines, questions to ask your physician and understanding potential risks and side effects of the drugs

My Pharmacist tool through iTriage

We also offer members iTriage which provides them with consumer-facing technology in the form of a mobile phone and web patient engagement platform. My Pharmacist functions like an expert pharmacist where members can easily:

- Search for drug information
- Compare prices
- Get suggestions for lower cost generics
- Refill prescriptions with bar code by smart phone
- Set reminders to take medication
- Get information on missed doses, side effects and drug-to-drug interactions

Attachments:

3.1.7.17 Provide an overview of your documentation, storage, retrieval and recovery of electronic files.

Answer: A recovery site is utilized for critical business functions. All data is sent offsite to a secure storage facility in real time. Several days of information are stored offsite at any point in time, allowing for multiple recovery scenarios if needed.

We have described the process of system backups below:

Replicating Data

The data from the production data center is replicated in real time to a remote disaster recovery center. The High Availability recovery solution replicates critical production data from the primary production system to a redundant system in the data center. As a result, there is a 2-4 hour recovery window.

Current system backup includes comprehensive disaster prevention and recovery measures that are maintained at state-of-the-art levels. As a result, the integrity of both the computer database and claim system is ensured. This also ensures the integrity of the telecommunications network that links all network pharmacies to the data center.

Backing Up Software

In addition to the replication of data, backups of the critical application software and databases required for processing are taken nightly, and full saves are executed weekly. Critical data are backed up nightly, and duplicate copies of all business-critical data required for business resumption are stored off site. To eliminate single points of failure, we use fault-tolerant processors in addition to redundant environmental control systems.

Attachments:

3.1.7.18 Explain your Computer Disaster Recovery plan. Provide the most recent outside assessment of its readiness.

Answer: Formal disaster recovery plans and procedures are maintained. Because disaster recovery planning and testing is performed internally, we are unable to share results externally. The following are in place:

- Escalation policies that can immediately be put in place
- Real-time replication of critical retail adjudication
- System backups for all hardware configuration used (including appropriate measures to safeguard against system damage due to fire)

Fast Adjudication Recovery

The current disaster recovery plan for the retail adjudication environment calls for complete recovery within 24 hours of a disaster declaration and is tested at least annually. The recovery typically occurs in less than 24 hours.

Comprehensive Monitoring

Support personnel monitor the system 24/7. In addition, an automatic pager alert system makes support personnel immediately aware of any system failures.

Should any one of the following components or functions fail, the system automatically pages the appropriate staff.

- Node processor failure
- Communications or terminal server failure
- Journal process failure
- Critical batch or print queue stopped
- Disk warning threshold exceeded

Computer/Systems Recovery Capabilities

In the unlikely event that a disaster causes data center destruction, it will implement the comprehensive Disaster Recovery Plan, which encompasses all system applications. Documented procedures for implementation and recovery of any affected application are published and maintained through regular review and exercises.

Alternate locations serve as a recovery site for the claim processing system. If something affects the primary center, all claims will be routed to the appropriate alternate location for processing on the backup equipment.

Member Service Support

The Member Services center currently has uninterrupted power supply (UPS) backup and full diesel generator backup. The diesel generator has been sized to carry all telecommunications, computer, lighting and air conditioning for the entire facility.

Your members will have access to multiple call centers that feature redundant capabilities in the event of a major catastrophe. CSRs at all locations are fully trained to answer questions about the members' prescription drug program and resolve issues or questions regarding prescription claims and all components of their plan.

Internet

To maintain continuous operation of information systems and Internet sites, there are comprehensive disaster prevention and recovery measures. These measures maintain the integrity of the computer database, claims processing system, telecommunications network and Internet sites.

To ensure the ability to re-establish Internet sites, incremental backup files of Internet software and critical applications are updated daily. These files can be used to restore Internet sites in the event of total site loss.

Precautions and contingency plans, in combination with disaster recovery analysis and business continuity staff and equipment plans, ensure that Internet operations are always maintained at the highest levels.

Retail Network

In the event of downtime, the network pharmacist would have the following options to process and fill a prescription:

- **Make a Phone Call** - The pharmacist can call the Pharmacy Help Desk or access the Interactive Voice Response (IVR) unit to verify eligibility, coinsurance or copay, and the negotiated reimbursement rate to determine the appropriate charge.
- **Wait for System Restoration** - The pharmacist can retain the claims data and submit them when the system is available. This allows for the most accurate determination of the negotiated charge.
- **Help Complete a Paper Claim** - The pharmacist can charge the member the retail price and assist the member in completing a paper claim form for submission directly to us. Based on program guidelines, we will reimburse the member.

Mail Service

Because the regional distribution model operates in a virtual, automated, paperless environment, we expect member disruption to be minimal during a natural disaster.

Multiple Facilities Workload Balance to Meet Member Needs

During an unforeseen disaster, service will continue to operate without serious setbacks. Each mail-order dispensing facility can fill prescriptions in one location and dispense from the same location or any other location.

Under this structure, all dispensing facilities become a single facility with each individual facility having immediate online access to member profiles and prescription information for all members. If an operational challenge occurs at one facility, immediate fulfillment support will be enlisted from the other facilities to ensure continuity. This support includes the review and verification of member information online and the physical fulfillment of member prescriptions from the supporting pharmacy, if necessary, without ever physically moving member paper documentation. This fulfillment occurs while following all pharmacy protocols and standards of quality.

Flexible Staffing to Meet Member Needs

If a facility closes, support facilities can increase work shifts to accommodate increased volume.

Depending on the anticipated length of closure, there are plans for increasing pharmacy personnel to the level necessary to sustain continual prescription fulfillment.

The contingency plan also includes a back-up of the operating system and databases on a regular basis. One copy of the operating system backup is kept on site, with the prior generations stored at an off-site location.

Retail Network Support to Meet Member Needs

In addition, an operational plan exists to transfer member prescriptions to a local retail pharmacy for fulfillment. Under this, member data from the mail-order claim processing system are retrieved from backup media. Once the backup claims data have been uploaded, they are provided electronically to CSRs. With up-to-date claim information, CSRs can continue to address member inquiries regarding order status, copays, eligibility and drug coverage.

In this situation, a member who requests a prescription refill is connected to one of the pharmacists. The pharmacist accesses the member's medication file and transfers the prescription to the member's local retail pharmacy for fulfillment. If the prescription cannot be transferred because of state

pharmacy restrictions, the pharmacist works with the member to obtain a new prescription from the member's physician. In either case, online systems are appropriately adjusted to ensure that members pay only their mail-order copay when obtaining a maintenance prescription from a local retail pharmacy.

Attachments:

3.1.7.19 Do you provide unlimited on-line eligibility entry and update functionality to authorized State staff?

Answer: 2: No

Detail: The State can verify eligibility using our Aetna systems and then they can work with our eligibility consultant to add members on an emergency basis. Additionally, our staff has the ability to access your system to review and update eligibility. We will have our personnel use your system to update eligibility so it will be updated when we receive your regularly scheduled electronic eligibility files.

Options:

1. Yes
2. No

Attachments:

3.1.7.20 Do you conduct manual eligibility updates at no charge to the State?

Answer: 1: Yes

Detail: The State's eligibility consultant can assist in manually enrolling members on an as-needed basis. Manual updates appear immediately in the eligibility system.

Options:

1. Yes
2. No

Attachments:

3.1.7.21 Offeror must allow access to its point-of-sale system by authorized representatives of the State to assist in adjudication of claims, including real-time viewing and issuing of prior authorization, real-time viewing of submitted claims (denied and adjudicated) and various reference screens. The materials must be printable from the site by the State.

Answer: Yes.

Attachments:

3.1.7.22 The State's data is their data, not the Offeror's and will be considered proprietary and will not be shared, except at the State's request, or sold to any entity without full knowledge and express written consent.

Answer: 1: Yes

Detail:

Options:

1. Yes

2. No. Explanation: [Text]

Attachments:

3.1.7.23 Are all data feeds for set-up and on-going maintenance included in your pricing? If not, please include the fees on the rate sheet.

Answer: 1: Yes

Detail: We have included data feeds to communicate between Aetna, the State of Alaska and Buck.

Options:

1. Yes
2. No

Attachments:

3.1.7.24 Please indicate any additional charges for any required manual interventions (workarounds) due to system interface incompatibility, file format issues, plan compliance, etc. on the rate sheet.

Answer: 2: No additional charges

Detail: Manual interventions with external vendors may incur an additional fee. We would need to discuss the specific workarounds in greater detail.

Options:

1. Additional charges indicated
2. No additional charges

Attachments:

3.1.7.25 Does the online system allow the State to assign different levels of access internally?

Answer: Yes.

Attachments:

3.1.8 Integration with Other Vendors

3.1.8.1 Are you able to accept electronic feeds of data or referrals from other vendor partners? If there is an additional cost, please indicate the cost on the rate sheet.

Answer: 1: Yes, included in base pricing

Detail:

Options:

1. Yes, included in base pricing
2. Yes, for an additional fee (indicated on rate sheet)
3. Yes, for an additional fee IF the number of contracted data feeds are exceeded (indicated on rate sheet)
4. No

Attachments:

3.1.8.2 Are you able to provide electronic feeds of participation data to an outside data aggregator or vendor partners? If there is an additional cost, please indicate the cost on the rate sheet.

Answer: 1: Yes, included in base pricing

Detail:

Options:

1. Yes, included in base pricing
2. Yes, for an additional fee (indicated on rate sheet)
3. Yes, for an additional fee IF the number of contracted data feeds are exceeded (indicated on rate sheet)
4. No

Attachments:

3.1.8.3 Are you willing to provide monthly interface with the data integration vendor or other vendors for claims and utilization data? If there is an additional cost, please indicate the cost on the rate sheet.

Answer: 1: Yes, no additional cost

Detail:

Options:

1. Yes, no additional cost
2. Yes, additional cost (indicated on the rate sheet)
3. No

Attachments:

3.1.8.4 Does your program/system have the capability to share data with the following vendors or programs?

- Answer: 1: Biometrics,**
2: Case Management,
3: Demand Management/Nurse Line,
4: Disease Management,
5: EAP/Behavioral health,
6: Health Advocacy/Health Coach,
7: Health Plans/TPA,
8: Health Risk Appraisal,
9: Healthcare savings/FSA,
10: Labs,
11: Maternity Management,
12: Mental Health / Substance Abuse,
13: Nurse and/or doctor line,
14: On site clinics,
15: Providers,
16: Utilization Management,
17: Wellness/Lifestyle management

Detail:

Options:

1. Biometrics
2. Case Management
3. Demand Management/Nurse Line
4. Disease Management
5. EAP/Behavioral health
6. Health Advocacy/Health Coach
7. Health Plans/TPA
8. Health Risk Appraisal
9. Healthcare savings/FSA
10. Labs
11. Maternity Management
12. Mental Health / Substance Abuse
13. Nurse and/or doctor line
14. On site clinics
15. Providers
16. Utilization Management
17. Wellness/Lifestyle management
18. Other, please specify: [Text]

Attachments:

3.1.8.5 Please describe how you will coordinate with other Contractors, if any, to manage functions such as data sharing, eligibility, coordination of benefits and payment of medical, pharmacy and healthcare claims.

Answer: We encourage the State of Alaska to consider the many benefits of an integrated carrier. Should you carve out portions of the benefit plans to other carriers, we will establish all necessary data feeds to manage functions such as data sharing, eligibility, coordination of benefits and payment of claims. We will include this in our pricing, depending on the final vendors selected.

Attachments:

3.1.8.6 Are you capable of designing exports to the FSA vendor to process FSA claims based off medical claim data that is stored within your system?

Answer: Yes.

Attachments:

3.1.8.7 Please provide examples of FSA data coordination that you have done with other customers.

Answer: When we administer both the pharmacy benefit plan and flexible spending account (FSA), we offer the following automated FSA claim processes that can enhance service to members with FSAs and pharmacy benefits:

Streamline

Our streamline feature automatically reimburses members for out-of-pocket pharmacy expenses they incurred at the pharmacy. At the beginning of the plan year, members can elect to have all eligible pharmacy expenses automatically applied to the FSA. Expenses payable under our pharmacy plan are first determined according to IRS regulations. The claims are then considered for payment under the FSA, and the member is reimbursed directly once the claim has been processed by the pharmacy platform. The streamline feature eliminates the need for members to submit a paper claim form and then wait for reimbursement from their FSA. We offer this service at no cost to State of Alaska.

Aetna FSA Debit Card

Using this feature, members can pay for out-of-pocket pharmacy expenses directly from their FSA with the swipe of a debit card at the point of service. This feature eliminates the need for members to pay out of pocket, submit a paper claim form and then wait for reimbursement from their FSA. The debit card feature is available to State of Alaska for a fee.

Attachments:

3.1.8.8 Offeror agrees to coordinate clinical management with the medical administrator, wellness and disease management vendor, and any other vendor or administrator the State contracts with to provide services for its members health administration and management services.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

3.1.8.9 Describe your procedures for implementation of ongoing treatment plans.

Answer: The State of Alaska's employees and their dependents will be able to continue their prescribed treatment plans. Our proposed formulary includes nearly all drugs. We will also work to transition mail order and specialty drug prescriptions to Aetna Rx Home Delivery and Aetna Specialty Pharmacy.

To ease the member's transition to our prescription drug plan, we include Transition of Coverage (TOC) that allows members to continue their active drug therapy without experiencing a disruption due to the APM step therapy and/or precertification DUR programs.

TOC minimizes the impact to members when plans change their benefits. Members who were taking a specific drug prior to Aetna will be able to fill that prescription for 90 days. There are some medications, such as specialty drugs that are included on our National Medical Precertification List and certain analgesics, that for clinical and safety reasons, will not be overridden by the TOC.

Attachments:

3.2 Patient Value Chain

3.2.1 Definitions

Please provide your response to the below definitions. Please note: ALL of the following definitions are considered mandatory requirements by the State, and any deviation from required definitions shall result in disqualification from the bidding process.

3.2.1.1 "**Pass-thru pricing**" will mean that the amount you pay the pharmacies in the retail network may not be different from the amount paid to you for retail network pharmacy claims by the State (thus, prices will vary by pharmacy) and you are required to pass-through 100% of Rebates to the State in addition to offering minimum guarantees for the rebates on a per claim basis that State will receive.

Answer: 1: Yes

Detail: We agree with the clarification of a minimum guarantee for the rebates on a per brand claim basis that the State will receive.

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.1.2 **Single-Source ("SS") Brands** will be defined as products that have not lost their patent protection (i.e., a product available from the innovator, the manufacturer with the New Drug Application approval) or are available from only one manufacturer.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.1.3 **Multi-Source ("MS") Brands** will be defined as innovator products that have lost their patent protection and are available from at least two sources: the innovator (one with the New Drug Application approval) and at least one other with either an Abbreviated New Drug Application approval or a marketing agreement for an authorized / branded generic.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.1.4 **Brands** will be defined as SS-Brand and MS-Brand products as defined above. For purposes of your drug classification and pricing offer, Brands shall be identified using the Medi-Span indicators as follow:

- (1) "M" in the Medi-Span Multi-Source code AND any value except "G" in the Medi-Span Brand-Name code; OR
- (1) "O" in the Medi-Span Multi-Source code AND any value except "G" in the Medi-Span Brand-Name code; OR
- (2) "N" in the Medi-Span Multi-Source code AND "T" in the Medi-Span Brand- Name code.

Answer: 1: Yes

Detail: We agree with the following clarification:

Aetna also adjudicates the "B" brand name codes as brand. For purposes of adjudication, pricing, and financial guarantees, Brands shall be identified using the Medi-Span indicators as follows:

(1) "M" in the Medi-Span Multi-Source code AND any value except "G" in the Medi-Span Brand-Name code; OR

(1) "O" in the Medi-Span Multi-Source code AND any value except "G" in the Medi-Span Brand-Name code; OR

(2) "N" in the Medi-Span Multi-Source code AND "T" or "B" in the Medi-Span Brand- Name code. Aetna also adjudicates the "B" brand name codes as brand

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.1.5 Single-Source ("SS") Generics, for purposes of pricing term offers and guarantees in this RFP, will be defined as the non-innovator product that is available from two sources: the innovator (one with the New Drug Application approval) and another with either an Abbreviated New Drug Application approval or a marketing agreement for an authorized / branded generic.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.1.6 Multi-Source ("MS") Generics, for purposes of pricing term offers and guarantees in this RFP, will be defined as non-innovator products that are available from three or more sources: the innovator (the manufacturer with the New Drug Application approval) and two or more manufacturers with Abbreviated New Drug Application approvals or marketing agreements for an authorized / branded generic.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.1.7 Generics will be defined as SS-Generic and MS-Generic products as defined above. For purposes of your drug classification and pricing offer, Generics shall be identified using the Medi-Span indicators as follow:

(1) "Y" in the Medi-Span Multi-Source code; or

(2) "N" in the Medi-Span Multi-Source code AND "B" in the Medi-Span Brand- Name code; or

(3) "N" in the Medi-Span Multi-Source code AND "G" in the Medi-Span Brand- Name code

Answer: 1: Yes

Detail: We agree with the following clarification:

Aetna adjudicates “N” in the Medi-Span Multi-Source code and “B” in the Medi-Span Brand-Name code as brands, not as generics. For purposes of adjudication, pricing, and financial guarantees, Generics shall be identified using the Medi-Span indicators as follow:

- (1) “Y” in the Medi-Span Multi-Source code; or
- (2) “N” in the Medi-Span Multi-Source code AND “G” in the Medi-Span Brand- Name code

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.1.8 "**Rebates**" will include Rebates and Other Manufacturer Revenue for purposes of your offer (and your Pricing Offer), which is defined as all revenue you receive from outside sources related to the State’s utilization or enrollment in programs. These would include but are not limited to access fees, market share fees, rebates, formulary access fees, administrative fees and marketing grants from pharmaceutical manufacturers, wholesalers and data warehouse vendors.

Answer: 1: Yes

Detail: We agree with the following clarification:

Other Manufacturer Revenue does not include revenue received from fee-for-service contracts from drug manufacturers. State of Alaska will receive 100% of rebates directly attributable to the pharmacy drug utilization of its members.

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.1.9 "**Maximum Allowable Cost (MAC)**" shall mean and refer to, for generic drugs (and brand drugs that are dispensed in a generic formulation), the maximum allowable cost reimbursed to the Participating Pharmacy, as established by the Offeror. Client will delegate to the Offeror the discretion to establish a Maximum Allowable Cost list in order to: (i) enable the Offeror to generate cost-effective and marketing competitive prices, and (ii) decrease such prices as generic prices decrease in the market place. Accordingly, the Offeror is obligated to establish such prices, and thereafter adjust such prices, to provide Client with prices reflective of the Offeror’s acquisition and/or reimbursement costs. The Offeror represents that it incorporate only one proprietary Maximum Allowable Cost list used to reimburse all retail, 90-day at retail, mail and specialty pharmacies and to invoice Client. Should the Offeror in the future establish multiple Maximum Allowable Cost lists as alternative proprietary Maximum Allowable Cost lists for Participating Pharmacies, the Offeror shall provide to Client the most favorable Maximum Allowable Cost for each generic drug (and each brand drug that is dispensed as a generic) on any of its Maximum Allowable Cost lists. The PBM also represents that it currently reviews adjustments to its proprietary Maximum Allowable Cost list at least quarterly and that it will continue to do so, using Pass-Through Pricing as defined by these requirements as a basis for its adjustments. As brand drugs lose their patents, and generic substitutes for those brand drugs become available, and prices for each change as a result, the Offeror agrees to review at least quarterly all such drug prices for adjustment, using Pass-Through Pricing as defined by these requirements as a basis for its adjustments.

Answer: 1: Yes

Detail: We are offering aggressive generic drug pricing to State of Alaska, including an overall generic effective rate guarantee. We are willing to discuss with the State other approaches to maximize savings based on your goals and potential design changes. We can address alternatives and provide information on customers of similar size, pharmacy/geographic mix, and drug mix to support final decisions on design.

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.1.10 “Usual and Customary” (U&C) means the amount a participating pharmacy would charge to a cash-paying customer for same strength, quantity and dosage form of a covered drug, as of the date the prescription is filled.

Answer: 1: Yes

Detail: We agree with the following clarification:

“Usual and Customary” (U&C) means the amount a participating pharmacy would charge to a cash-paying customer for same strength, quantity and dosage form of a covered drug, as of the date the prescription is filled and as submitted to Aetna by the participating pharmacy.

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.2 Networks

3.2.2.1 Retail Networks

3.2.2.1.1 Retail Networks - General

3.2.2.1.1.1 Please list each retail pharmacy network you offer (i.e. broad retail network, narrow retail network, etc) and provide a brief description of each (e.g., number of pharmacies included, chains excluded).

Answer: We offer the following pharmacy networks to our self-funded customers:

APM National Retail Pharmacy Network

Our broadest retail pharmacy network provides members with access to approximately 67,000 pharmacies throughout all 50 states, the District of Columbia, Puerto Rico, Guam, Northern Mariana Islands and the U.S. Virgin Islands.

Extended Day Supply (EDS) Network

Through this network, members can fill prescriptions for 35 to 90 days at a participating retail pharmacy, providing deeper discounts for you. The network currently consists of over 57,000 retail pharmacies, which includes chain and independent pharmacies.

Aetna Rx Value Network

This network offers a narrow retail pharmacy network, consisting of more than 42,000 pharmacies. Members can fill a maintenance prescription with a days' supply of between 1 and 90 days' supply at any of our network pharmacies. We include drug store chains, large retail merchandisers, grocery chains and independent pharmacies in the network.

The network helps to improve savings for you while maintaining superior access and convenience for members. Working with a smaller number of retail pharmacies provides the opportunity to negotiate better rates with the contracted pharmacies and deliver increased savings to you. Potential customer savings of 0.5% to 1.5% of gross retail drug spend, depending on your specific utilization experience.

The benefit of this network is the convenient access for members and the cost savings you should achieve. If you choose to put this network in place, you will not be able to use any other Aetna network or mail order program.

Aetna Rx Preferred Network

This retail network includes CVS/pharmacy and Wal-Mart and provides access to approximately 11,700 retail pharmacies. Members can fill a 1-90 day supply of drugs at any of the in-network pharmacies. We exclude all other pharmacies from this network. In order to maximize the savings potential and offer your members a choice of pharmacy, certain requirements apply. This limited network offering can provide up to 2.5% to 3.5% savings on your gross retail pharmacy spend, depending on your specific experience.

The benefit of this network is the convenient access for members and the cost savings for customers. If you choose to put this network in place, you will not be able to use any other Aetna network or mail order program.

Aetna Rx Choice Network

This retail network provides access to our entire national network of pharmacies with financial incentives to use the Aetna Rx Preferred Network. Members receive the lowest out of pocket costs when they fill drugs through CVS/pharmacy and Wal-Mart. Members can choose to use other pharmacies within our large national network and incur higher out of pocket costs. Members can fill a 1-90 day supply of drugs at any of the pharmacies in the first tier and a 30-day supply of drugs at any of the pharmacies in the second tier. In order to maximize the savings potential of this retail network offering, certain requirements apply. This offering can provide up to 2% to 3% savings on your gross retail pharmacy spend, depending on your specific experience.

The benefit of this network is the convenient access for members and the cost savings for you. If you choose to put this network in place, you will not be able to use any other Aetna network or mail order program.

APM Customized Pharmacy Network

By analyzing your actual pharmacy claim data, we can develop a customized network option for the State of Alaska. This may include excluding certain chains.

Attachments:

3.2.2.1.1.2 Do you contract with and manage directly the retail pharmacy networks that you are proposing for the State?

Answer: 2: No

Detail: CVS Caremark provides the administration for Aetna's retail pharmacy network contracting and claim administration.

Options:

1. Yes
2. No

Attachments:

3.2.2.1.1.3 If you do not contract with and manage directly the retail pharmacy networks being proposed, provide information about the company that will be the subcontracted provider: Note: If you use the same company for all networks, please provide the information requested under the "Broad Retail Network" and insert "Same" in the cells for the other network options.

Subcontractor	Broad Retail Network	Retail-90 Network
Company name	CVS Caremark	CVS Caremark
Headquartered city	Woonsocket	Woonsocket
Headquartered state	RI	RI
Tenure of current relationship	2 years	2 years
Current contract term of relationship	12 years	12 years

Detail:

Attachments:

3.2.2.1.1.4 Does your organization track edits performed on retail prescriptions (e.g., change in dose, therapy)?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.2.1.1.5 Do you have contracts with retail pharmacies that allow you to deliver prescriptions filled by your mail-order pharmacy to their pharmacy for customer pick-up? If "yes," please provide list of pharmacies available to receive mail pharmacy deliveries.

Answer: 2: No

Detail: While we do not deliver prescriptions to retail pharmacies, we do offer solutions that allow members to obtain their maintenance medications at retail. We have described these network options below:

Extended Day Supply (EDS) Network

Through this network, members can fill prescriptions for 35 to 90 days at a participating retail pharmacy, providing deeper discounts for you. The network currently consists of over 57,000 retail pharmacies, which includes chain and independent pharmacies.

Aetna Rx Value Network

This network offers a narrow retail pharmacy network, consisting of more than 42,000 pharmacies. Members can fill a maintenance prescription with a days' supply of between 1 and 90 days' supply at any of our network pharmacies. We include drug store chains, large retail merchandisers, grocery chains and independent pharmacies in the network.

The network helps to improve savings for you while maintaining superior access and convenience for members. Working with a smaller number of retail pharmacies provides the opportunity to negotiate better rates with the contracted pharmacies and deliver increased savings to you. Potential customer savings of 0.5% to 1.5% of gross retail drug spend, depending on your specific utilization experience.

The benefit of this network is the convenient access for members and the cost savings you should achieve. If you choose to put this network in place, you will not be able to use any other Aetna network or mail order program.

Options:

1. Yes: [Text]
2. No

Attachments:

3.2.2.1.1.6 Will you notify the State when you delete pharmacies from your Retail network?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.2.1.1.7 Will you notify the State's members when you delete pharmacies from your Retail network? If so, please explain how and when members will be notified.

Answer: Yes. The network team will provide information on pharmacies closing and then run a report to determine which State of Alaska members are currently using that pharmacy. We would then send a letter letting the members know the pharmacy is closing and where the nearest pharmacy is located.

Attachments:

3.2.2.1.1.8 Should there be a decrease in the number or composition of one of your pharmacy network for which the State participates, will you agree to (1) provide an analysis of the impact of the change in the network - to help the State understand the impact to (a) participants, (b) the Guaranteed Ingredient Cost Discounts, and (c) Guaranteed Dispensing Fee; (2) allow the State to perform its own analysis; and (3) if the State disagrees with (a) the Offeror analysis, (b) the proposed change in the Guaranteed Ingredient Cost Discounts and Guaranteed Dispensing Fee, or (c) that the change to the network is unacceptable, the State may terminate the contract without financial consequence (e.g., no loss of rebates earned but not yet paid) upon sixty (60) days' notice.

Answer: 1: Yes

Detail: We will agree to provide an analysis of a change in the network if there's a more than 10% change in the composition of the network. If the State disagrees with our analysis and proposed

changes, the parties agree to work together in good faith on a resolution. If we're unable to come to agreement, the State can terminate the agreement early with reasonable notice but with our standard early termination penalties.

Options:

1. Yes
2. No

Attachments:

3.2.2.1.2 Broad National Retail Networks

3.2.2.1.2.1 Do you offer a retail network that provides access to all national and regional chains and the majority of independent pharmacies?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.2.1.2.2 If yes, please list each Broad Retail Network you offer and provide a brief description of each (e.g., number of pharmacies included, chains excluded). Please provide across your National Broad Retail Network and across the state of Alaska only.

Answer: The APM National Retail Pharmacy Network consists of over 67,000 retail pharmacies in all 50 states, the District of Columbia, Puerto Rico, Guam, Northern Mariana Islands and the U.S. Virgin Islands. All major national, regional and local retail pharmacy chains participate in the network. It includes 117 retail pharmacies in Alaska.

Attachments:

3.2.2.1.2.3 In the previous year, have you deleted pharmacies from your broad network?

Answer: 1: Yes

Detail: We terminated 69 retail pharmacies nationally in 2011. This accounted for 0.11 percent of all retail pharmacies participating in the APM National Retail Pharmacy Network.

Options:

1. Yes
2. No

Attachments:

3.2.2.1.2.4 In the previous year, if you deleted pharmacies from your broad network, please list these pharmacies and the reasons they were deleted. If reason is proprietary, please list reason as "confidential/proprietary"

Answer: We terminated 69 retail pharmacies nationally in 2011 due to audit findings and contract violations. However, the list of terminated pharmacies is confidential and proprietary.

Attachments:

3.2.2.1.2.5 Are you willing and able to customize your networks based on the State's specifications and needs?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.2.1.2.6 Provide a brief description of how members currently utilizing Broad Retail pharmacies that will move from being "in-network" to "out-of-network" would be transitioned over to your Broad Retail network.

Answer: All national retail pharmacy chains, most regional retail pharmacy chains and a large number of independent pharmacies currently participate in our retail networks. To ensure that members have easy access to a retail network pharmacy, we monitor network coverage and demographic data on a continuous basis. If the network team identifies an area where we might not have adequate pharmacy access, they will begin recruitment activities to pharmacies in the area.

The State of Alaska or their members may also request that we have an out-of-network retail pharmacy contacted and asked to join our network. Retail pharmacies that meet qualification standards, requirements included in the pharmacy contract, and who agree to the financial terms of the network, may be included.

Attachments:

3.2.2.1.3 Retail-90 Networks

3.2.2.1.3.1 Do you offer a retail network that provides better prices for dispensing 90-day supplies (i.e., Retail-90 Network)?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.2.1.3.2 If yes, please list each Retail-90 Network you offer and provide a brief description of each (e.g., number of pharmacies included, chains excluded). Please provide across your national network and across the state of Alaska only.

Answer: We offer our Extended Day Supply (EDS) network which provides up to a 90-day supply of maintenance drugs at retail pharmacies. The EDS network complements the national retail pharmacy network. This network provides deeper discounts and lowers the cost of dispensing fees for you (when a 90-day supply is dispensed, only one dispensing fee is paid, versus three dispensing fees that would

be paid on three 30-day supply prescription fills). Currently there are over 57,000 retail pharmacies that participate in this network. As of the date of this proposal, there are approximately 73 participating pharmacies in the EDS network in Alaska. Please note that this number may vary from time to time.

In addition, the EDS network option offers members the convenience of one trip to the pharmacy, a lower copayment (benefit plans designs may vary, you have the option of determining the copayment for the 90-day supply) and members can interact with their local pharmacist, when it is important to them.

The EDS pharmacy network discounted pricing is available for non-specialty claims equal to, or greater than a 35-day supply, when filled at a participating EDS pharmacy. Members may fill prescriptions for up to a 30-day supply at any APM retail pharmacy; however prescriptions for more than a 35-day supply must be filled at an EDS pharmacy, to receive the deeper discounts.

Attachments:

3.2.2.1.3.3 Does your company offer mail order pricing at select retail-90 pharmacies?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.2.1.3.4 If your company offers mail order pricing at select retail-90 pharmacies, please provide information about these networks/select pharmacies.

Answer: When a 90-day supply is dispensed, only one dispensing fee is paid, versus three dispensing fees that would be paid on three 30-day supply prescription fills. In addition, the EDS network option offers members the convenience of one trip to the pharmacy, a lower copayment (benefit plans designs may vary, you have the option of determining the copayment for the 90-day supply) and members can interact with their local pharmacist, when it is important to them.

Attachments:

3.2.2.1.3.5 In the previous year, have you deleted pharmacies from your Retail-90 network?

Answer: 2: No

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.2.1.3.6 In the current or previous year, if you deleted pharmacies from your Retail-90 network, please list these pharmacies and the reasons they were deleted. If reason is proprietary, please list reason as "confidential/proprietary"

Answer: We did not terminate any pharmacies from the EDS network in 2011.

Attachments:

3.2.2.1.3.7 Do you have the capability to customize your Retail-90 network based on the State's specifications and needs?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.2.1.3.8 Provide a brief description of how members currently utilizing Retail-90 pharmacies that will move from being "in-network" to "out-of-network" would be transitioned over to your Retail-90 network.

Answer: To ensure that members have easy access to a retail network pharmacy, we monitor network coverage and demographic data on a continuous basis. If the network team identifies an area where we might not have adequate pharmacy access, they will begin recruitment activities to pharmacies in the area.

The State of Alaska or members may also request that we have an out-of-network retail pharmacy contacted and asked to join our network. Retail pharmacies that meet qualification standards, requirements included in the pharmacy contract, and who agree to the financial terms of the network, may be included.

Attachments:

3.2.2.1.4 Price Source(s) for Retail Network

3.2.2.1.4.1 Specify the pricing source(s) used for each of your retail networks.

Answer: We use the Medi-Span® Prescription Pricing Guide (with supplements), as our pricing source for AWP discounts. Claims are adjudicated using Medi-Span drug prices as of the date of service. We receive and load AWP updates on a daily basis, Monday through Friday.

Attachments:

3.2.2.1.4.2 Specify the pricing source(s) used to determine pricing (e.g., Average Wholesale Price, or "AWP") guarantees with your clients.

Answer: Medi-Span is our primary pricing source.

Attachments:

3.2.2.1.4.3 How often do you update the pricing file used in contracts with your retail networks and with the State?

Answer: Claims are adjudicated using Medi-Span drug prices as of the date of service. We receive and load AWP updates on a daily basis, Monday through Friday.

Attachments:

3.2.2.1.4.4 Is your retail pharmacy network contracted at the new AWP (those available post-September 26, 2009)?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.2.1.4.5 If your retail pharmacy network is not contracted at the new AWP (those available post-September 26, 2009), when will this occur?

Answer: Because our answer to the previous question was yes, this question is not applicable.

Attachments:

3.2.2.2 Mail Order

3.2.2.2.1 Mail Order - General

3.2.2.2.1.1 Do you own and operate the mail order pharmacies that you are proposing for the State?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.2.2.1.2 If no, provide information about the company that will be used as a subcontracted for mail order providers.

Mail Pharmacies	Mail Pharmacy #1	Mail Pharmacy #2	Mail Pharmacy #3
Company name	N/A	N/A	N/A
Headquartered city	N/A	N/A	N/A
Headquartered state	N/A	N/A	N/A
Tenure of current relationship	N/A	N/A	N/A
Current contract term of relationship	N/A	N/A	N/A

Detail:

Attachments:

3.2.2.2.1.3 For each mail order facility currently in operation that you propose for primary and/or secondary mail order fulfillment for the State, please answer the following:

	Name of Mail Order Facility	Location: City, State	Year Opened	Number of Pharmacy Technicians/ Pharmacists	Max. Number of Prescriptions Processed per 24-hour Period (using last quarter data)	Current Operating Volume or Prescriptions per 24-hour Period (using last quarter data)	Dispensing Accuracy during the last 12-month period
Mail Order Facility #1	Aetna Rx Home Delivery	Plantation, FL (formerly Pompano Beach, FL)	This facility originally opened in 2003. We moved it to Plantation, FL in 2012.	141	78,500	24,691	99.99
Mail Order Facility #2	Aetna Rx Home Delivery	Kansas City, MO	2005	204	78,500	24,691	99.99
Mail Order Facility #3	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Mail Order Facility #4	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Mail Order Facility #5	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Others	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Detail:

Attachments:

3.2.2.2.1.4 Are all packages shipped from the mail pharmacy tracked from your pharmacies to the point of delivery?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.2.2.1.5 If yes, is the mail package tracking available regardless of whether a package is destined for a mailbox, P.O. Box, or mail slot?

Answer: 1: Yes

Detail: We utilize United States Postal Service (USPS) First-Class Mail as our primary shipping source for prescriptions. More than 85% of all deliveries are tracked to the final USPS location. When alternative carriers (UPS) are used, 100% of the packages are tracked. For all controlled substances, we use USPS with delivery confirmation, which provides a tracking process.

Options:

1. Yes
2. No
3. N/A

Attachments:

3.2.2.2.1.6 What percent of all inbound prescriptions and order forms are electronically imaged? If less than 100%, please explain why they are not all imaged.

Answer: 100%

Detail:

Attachments:

3.2.2.2.1.7 Does your organization track mail order errors reported by members?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.2.2.1.8 If your organization tracks mail pharmacy errors, is the tracking client-specific?

Answer: Yes.

Attachments:

3.2.2.2.1.9 Does your organization track edits performed on mail order prescriptions (e.g., change in dose, therapy)?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.2.2.1.10 If yes (your organization tracks edits to claims), is the tracking client-specific?

Answer: Yes.

Attachments:

3.2.2.2.1.11 Do you track the following types of errors?

Answer: 2: Patient Name,
3: Physician name,
4: Name of drug,
5: Dosage Strength of drug,
6: Quantity,
7: Directions,
10: Patient address

Detail:

Options:

1. Date of Rx fill
2. Patient Name
3. Physician name
4. Name of drug
5. Dosage Strength of drug
6. Quantity
7. Directions
8. Drug Interaction labels
9. Drug warning labels
10. Patient address
11. Other: [Text]

Attachments:

3.2.2.2.1.12 Please provide a description of how your firm reports the types of errors identified in the previous question.

Answer: We have a quality department at each of our mail order pharmacies. Any instance of an issue that may be perceived as an error is immediately reported to the quality department for investigation and review. They maintain records of any error reported as well as the investigation and final outcome. In addition, they proactively audit and review the operating systems daily to ensure that the process is working as designed.

The errors that we track include those that result from input (e.g., incorrect member name, drug, directions or strength), dispensing and shipping (i.e., damaged and lost prescriptions).

We have errors continually tracked and monitored by the mail order pharmacy and we have errors discussed during internal quality review meetings. We monitor quality internally on a daily basis - including our mail order facility error rate on prescriptions - and measure and report the results on a calendar-year basis for all of our customers.

Attachments:

3.2.2.2.1.13 Do you identify errors caught in-house versus reported by members separately?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.2.2.1.14 Are errors counted as errors only when a member reports them?

Answer: 2: No

Detail: We also count any errors that are discovered before a prescription leaves our facility.

Options:

1. Yes
2. No

Attachments:

3.2.2.2.1.15 Please provide a list of languages that are available through your Mail Order (for Rx labels and patient information), in addition to English.

Answer: We offer prescription labels with instructions in Spanish. However, all pharmacy related information listed on the prescription is in English.

Attachments:

3.2.2.2.1.16 Is there an additional cost to have additional languages available through your Mail order (for Rx labels and patient information), in addition to English? If there is an additional cost, please indicate the cost on the rate sheet

Answer: 2: No

Detail: Please note that the translation of communication material into other languages is not available at this time.

Options:

1. Yes (indicated on rate sheet)
2. No

Attachments:

3.2.2.2.1.17 Do you provide the following cost information to recipients on mail order prescriptions?

Answer: 1: Member Cost

Detail:

Options:

1. Member Cost
2. Employer Cost
3. Total Cost
4. YTD Out of Pocket ("OOP")
5. YTD payments
6. YTD OOP, as applicable to deductibles
7. YTD OOP, as applicable to annual OOP maximums
8. Other: [Text]

Attachments:

3.2.2.2.1.18 Can any of the cost information options provided above be “turned off” if requested by the State (e.g., State Cost)?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.2.2.1.19 Are there fees charged to the State if they implement a mandatory Mail Order program?

Answer: 2: No

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.2.2.1.20 Are there fees charged to the State if they implement a Retail penalty program (program that charges members more for refilling certain prescriptions at retail after a certain number of refills)?

Answer: 2: No

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.2.2.1.21 If you charge a fee for either a mandatory Mail Order or Retail penalty program, please provide the expected fee schedule.

Answer: N/A

Attachments:

3.2.2.2.1.22 What was your average annual turnaround time for dispensing mail order drugs without intervention?

Answer: As of October 2012, the average turnaround time for claims not requiring intervention (clean claims) was 0.60 business days.

Attachments:

3.2.2.2.2 Shipping and Handling

3.2.2.2.1 Do you offer expedited delivery of mail order prescriptions?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.2.2.2 If you offer expedited delivery of mail order prescriptions, please explain the conditions under which there will be an additional fee charged for this service.

Answer: We offer expedited delivery of mail order prescriptions in a variety of circumstances.

We consider temperature-sensitive items or high-dollar items (drugs over \$1,000) to be a special order. We ship these orders by UPS, FedEx or Express Mail for overnight delivery.

If members receive damaged prescriptions from Aetna Rx Home Delivery®, they should call Member Services. We then ask the member to send us the damaged package. Once received, we immediately process a replacement order. We ship replacement orders overnight at no cost. If a member needs the drug that day, we contact a local retail pharmacy for short-term supply pick up.

Members can also request overnight delivery or second day delivery for standard orders for an additional fee.

Attachments:

3.2.2.2.3 Do you fund emergency supplies of medication if/when the delivery from your mail-order pharmacy is delayed, creating the need for an emergency supply?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.2.2.4 How are members notified when a mail order prescription is delayed due to the following circumstances?

- a. A prescription requiring clarification from the physician or physician's agent (e.g., missing quantity, illegible drug name)?
- b. A clean prescription where the delay is due to the Offeror's operational, capacity or drug supply issues?
- c. A clean prescription where the delay is a result of the Offeror's therapeutic switch/ intervention?

Answer: In all of these circumstances, we call members to notify them of the delay. When appropriate (medication back order), we suggest and discuss alternative options with the member.

Attachments:

3.2.2.2.2.5 Provide a brief description of how existing mail order patients would be transitioned over to your mail order facility with minimized disruption.

Answer: We have seamlessly transitioned thousands of members from outside vendors to Aetna Rx Home Delivery®. We will work with your current vendor to transfer open refills. We use the standard format, known as the 1600 file, that large mail-order vendors developed to ensure consistent and accurate transitioning of data.

After consulting with you, we will work directly with your former vendor to smoothly transition open refills. Please note that prescriptions excluded from this process include specialty drugs that Aetna Rx Home Delivery does not fill, Class II through Class V controlled substances, expired prescriptions and prescriptions with no refills remaining.

To transition members to Aetna Rx Home Delivery, we can accept a file claim transfer from the previous vendor. We do not charge a fee to accept an open refill file transfer for members transitioning from a previous vendor.

Attachments:

3.2.2.2.2.6 Explain how prescriptions are shipped. Differentiating between specialty and standard prescriptions, describe your protocol for shipping temperature sensitive products, and your quality control processes.

Answer: We use U.S. Mail (Priority or First Class), UPS or FedEx shipping based on a combination of factors, including:

- Destination
- Special handling
- Drug type
- Order value
- Package weight
- Member preference

Members can also request overnight delivery or second day delivery for an additional fee. Each refrigerated and frozen item receives special handling. We have these items shipped overnight or second day delivery in a box with special protective wrapping, at no cost.

For tracking purposes, we have all Schedule II narcotics and all orders with a total value exceeding \$1,500 shipped for two- or three-day delivery. All Schedule II narcotics require an adult signature for delivery. Recurring incidents of lost or stolen prescriptions also may result in a signature requirement for subsequent deliveries.

We have all orders packaged to prevent tampering and to support confidentiality. We use plain white poly bags with tamper-evident seals. We also use plain address labeling to minimize the possibility that an unauthorized person will suspect that the package contains prescription products.

Attachments:

3.2.2.2.3 Member Payments

3.2.2.2.3.1 What is your organization's standard maximum delinquent amount in outstanding balances before a member is denied further mail pharmacy prescriptions?

Answer: Copayments are typically collected when members place their order. However, we do have the capability to set a \$100 maximum floor limit.

Attachments:

3.2.2.2.3.2 Will you allow the State to set the unpaid member balance floor and ceiling?

Answer: 1: Yes

Detail: We are open to discussing this in greater detail with the State of Alaska.

Options:

1. Yes
2. No

Attachments:

3.2.2.3 Specialty Pharmacy

3.2.2.3.1 Specialty Pharmacy - General

3.2.2.3.1.1 Does your organization own and operate one or more Specialty pharmacies?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.2.3.1.2 How many years has your organization offered Specialty Pharmacy services?

Answer: 7

Detail: We began providing specialty services in 2005 through our specialty pharmacy located in Orlando, FL. We have since developed innovative and integrated processes to help members enjoy a better quality of life while saving money.

Attachments:

3.2.2.3.1.3 If your organization does not own and operate one or more of the Specialty pharmacies you are proposing for the State, provide the information requested below.

Specialty Pharmacies	Specialty Pharmacy #1	Specialty Pharmacy #2	Specialty Pharmacy #3
Company name	N/A	N/A	N/A
Headquartered city	N/A	N/A	N/A
Headquartered state	N/A	N/A	N/A
Tenure of current relationship	N/A	N/A	N/A
Current contract term of relationship	N/A	N/A	N/A

Detail:

Attachments:

3.2.2.3.1.4 Provide the information requested below for the specialty pharmacy facility(s) for those proposed for the State

Specialty Facility	Name of Specialty Facility	Location: City, State	Year Opened	Number of Pharmacy Technicians/ Pharmacists	Max. Number of Prescriptions Processed per 24-hour period (using last quarter)	Current Operating Volume or Prescriptions per 24-hour period (using last quarter)	Dispensing Accuracy during the last 12-month period
Facility #1	Aetna Specialty Pharmacy	Orlando, FL	2005	20 pharmacy technicians 18 pharmacists	Not available*	Not available*	99.99
Facility #2	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Facility #3	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Facility #4	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Facility #5	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Detail: *We consider this information confidential and proprietary. However, as one of the largest specialty pharmacy providers, our service capacity in our network has not been an issue. We are pleased to discuss any specific customer concerns around capacity capabilities regarding your specific specialty population and therapy mix.

Attachments:

3.2.2.3.1.5 Which of the following price sources does your company use to determine the gross cost of medications which are dispensed at the specialty pharmacy?

Answer: 1: MediSpan

Detail:

Options:

1. MediSpan
2. Micromedex
3. Thomson HealthCare's Red Book
4. Other: [Text]

Attachments:

3.2.2.3.1.6 Which of the following can you accept and use to adjudicate specialty claims:

Answer: 1: Healthcare Common Procedure Coding ("HCPC"),

2: J Codes,

3: National Drug Code ("NDC") Codes

Detail:

Options:

1. Healthcare Common Procedure Coding (“HCPC”)
2. J Codes
3. National Drug Code (“NDC”) Codes
4. Other: [Text]

Attachments:

3.2.2.3.2 Definition of Specialty Drugs

3.2.2.3.2.1 What is your definition of Specialty/Biotech drugs?

Answer: We define specialty drugs as medications that include, but are not limited to, pharmaceutical products that are very expensive, typically have no less costly equivalents, are often biologicals, may or may not be infusible or injectable, require a greater amount of pharmaceutical oversight and clinical monitoring, and/or are addressed to serious conditions like cancer, rheumatoid arthritis and multiple sclerosis.

In addition, we also understand that these medications:

- Frequently cost over \$500 per prescription
- Sometimes have harsh side effects
- Are most commonly infused or injected
- Require special handling or temperature control
- Need therapy management including:
 - Side effect management
 - Patient adherence and compliance
 - Training and support for administration
 - Are subject to wastage
 - Should be dispensed as a 30 day supply to account for potential changes in therapy
 - Are more effectively managed in a high touch, low volume delivery mode

Attachments:

3.2.2.3.2.2 Which of the following are considered in determining if a medication is termed "specialty":

Answer: 6: Other: [We define specialty drugs as medications that include, but are not limited to, pharmaceutical products that are very expensive, typically have no less costly equivalents, are often biologicals, may or may not be infusible or injectable, require a greater amount of pharmaceutical oversight and clinical monitoring, and/or are addressed to serious conditions like cancer, rheumatoid arthritis and multiple sclerosis.

In addition, we also understand that these medications:

- Frequently cost over \$500 per prescription
- Sometimes have harsh side effects
- Are most commonly infused or injected
- Require special handling or temperature control
- Need therapy management including:
 - Side effect management
 - Patient adherence and compliance
 - Training and support for administration
 - Are subject to wastage

- Should be dispensed as a 30 day supply to account for potential changes in therapy
- Are more effectively managed in a high touch, low volume delivery mode]

Detail:

Options:

1. The unit cost of the medication
2. The 30-day cost of the medication
3. The production of the medication
4. The method of delivery of the medication - intravenously, orally, etc
5. Method of distribution of the medication - specialty, mail order, retail pharmacies, etc
6. Other: [Text]

Attachments:

3.2.2.3.2.3 Do you have a dedicated P&T (Pharmacy and Therapeutics) committee for your specialty drug program?

Answer: 2: No

Detail: Our Pharmacy and Therapeutics (P&T) committee determines all formulary decisions, including those for specialty drugs.

Options:

1. Yes
2. No

Attachments:

3.2.2.3.2.4 If you have a dedicated specialty P&T Committee for specialty, what is the composition of your specialty P&T Committee, and their credentials.

Answer: While not dedicated only to specialty drugs, our P&T committee includes 13 voting members. The majority of P&T committee members are practicing health care providers not employed by Aetna.

This includes at least six practicing physicians and pharmacists, not employed by Aetna, practicing in key medical areas and specialties:

- Geriatrician Physician Specialist
- Geriatric Clinical Pharmacist Specialist
- Physician, Specialty in Internal Medicine
- Physician, Specialty in Cardiology
- Physician, Specialty in Endocrinology
- Physician, Specialty in Family Practice

There are also five medical and pharmacy directors who Aetna employs:

- Clinical Policy Medical Director, Co-Chair
- Director of Formulary Development & Pharmacy Clinical Policies, Co-Chair
- Medical Director, Behavior Health
- Medical Director, Patient Management
- Clinical Pharmacy Director, Pharmacy Clinical Programs

We also include practicing physicians not employed by Aetna as required by select state regulations:

- Practicing Physician, NC
- Practicing Dentist, MI

Attachments:

3.2.2.3.2.5 List the Specialty drugs to which your organization does not have access (i.e., limited distribution products).

Answer: While members can receive most specialty drugs through Aetna Specialty Pharmacy®, the specialty drugs listed below are currently not available. If we receive an order for any of these drugs, we transfer the order to a participating pharmacy where they are available and inform the prescribing physician and member.

- ADAGEN
- ADCETRIS
- APLIGRAF
- ARCALYST
- CAPRELSA
- CARBAGLU
- CAYSTON
- CEPROTIN
- CHENODAL
- CINRYZE
- CYSTADINE
- CYSTAGON
- ELEYSO
- epoprostenol (Flolan Generic)
- epoprostenol (Sodium Diluent)
- ERWINAZE
- FERRIPROX
- FLOLAN
- FLOLAN (Sodium Diluent)
- ILARIS
- IMPLANON
- IRESSA
- JAKAFI
- KALBITOR
- KUVAN
- NPLATE
- OFORTA
- ONSOLIS
- ORFADIN
- PROLASTIN
- REMODULIN
- RETISERT
- SABRIL
- SAMSCA
- SUCRAID
- THYMOGLOBULIN

- TIKOSYN
- TYVASCO
- VELETRI
- VENTAVIS
- XALKORI
- XENAZINE
- XYREM
- ZACTIMA
- ZAVESCA
- ZEMAIRA

Attachments:

3.2.2.3.2.6 How does your organization obtain access to limited distribution products if you are not a “preferred vendor” for your clients?

Answer: If we receive an order for any limited distribution specialty drugs, we transfer the order to a participating pharmacy where they are available and inform the prescribing physician and member.

Attachments:

3.2.2.3.3 Distribution Alternatives and Operations

3.2.2.3.3.1 Which of the following distribution routes will your company support for member purchases of specialty medications?

Answer: 1: Your company's specialty pharmacy-ie

Detail: Specialty medications can also be dispensed from our retail network pharmacies. We can also coordinate delivery with physician's office or home health care facility.

Options:

1. Your company's specialty pharmacy-ie
2. Any willing pharmacy in the contracted retail pharmacy network
3. A subset of pharmacies in the contracted retail pharmacy network
4. A contracted medical provider of the Client (e.g., physician, hospital, outpatient clinic)

Attachments:

3.2.2.3.3.2 If you support a subset of pharmacies in the contracted retail pharmacy network as a distribution route as indicated in the previous question, please state the necessary criteria.

Answer: Because we do not support subsets, this question is not applicable.

Attachments:

3.2.2.3.3.3 Describe your organization's Specialty drug distribution procedures to patient homes versus physician offices.

Answer: The following is our specialty pharmacy distribution process:

- Initial Order Entry - Ensure orders contain necessary data and scan in to system
- Member Intake - Verify data and member special needs
- Clinical Assessment - Identify high-risk members

- Nurse Support - Offer coping advice to members and coordinate care
- Order Setup - Set up order components, verify data and provide ancillary supplies
- Insurance Verification - Verify benefits and initiate precertification
- Claim Review - Notify members of payments and pursue copay assistance programs
- Pharmacist Review - Review prescription and call physician or member with concerns
- Order Confirmation - Confirm delivery, shipping address and signature requirement
- Order Fulfillment - Fill the prescription, scan documents and include instructions
- Second Pharmacist Review - Verify the correct drug has been dispensed
- Packaging - Properly package following strict safety procedures
- Delivery - Send medication orders anywhere the member requests (members home, physicians, home healthcare facility)

The member is always called in advance regarding the expected shipment to determine a convenient delivery time and date. We use UPS and FedEx to provide reliable and consistent, high-quality services. A direct computer link with these couriers enables us to immediately determine the status of packages, which is a valuable tool for preventing or minimizing product loss resulting from prolonged exposure to temperatures outside of the required parameters.

In addition, we maintain open, ongoing communication with physicians and home health care nurses when coordinating delivery of medications and appropriate supplies. If the member requires home health care, we can arrange for a home health care nurse to administer therapy in the comfort of the member's home.

To assure timely medication delivery, our representatives speak directly with the member, physician's office or home health care nurse to verify the treatment time and location. We can have medications delivered to the member's home, their prescribing physician's office or to an ambulatory infusion center within 24 to 48 hours of order confirmation.

Attachments:

3.2.2.3.3.4 Is there any additional cost to the member or plan for expedited deliveries of prescriptions for specialty medications? If yes, explain.

Answer: 2: No

Detail:

Options:

1. Yes: [Text]
2. No

Attachments:

3.2.2.3.3.5 Will you allow the State to set the unpaid member balance floor and ceiling?

Answer: 1: Yes

Detail: We are willing to discuss this in greater detail with the State of Alaska.

Options:

1. Yes
2. No

Attachments:

3.2.2.3.3.6 What are your procedures to address out-of-stock drugs?

Answer: Although stock-outs are rare, we have a process in place to ensure uninterrupted member therapy. In the event of a stock out, we would contact members in advance regarding the expected ship date. This allows us time to have stock obtained before the scheduled ship date. If the member requires the out-of-stock drug immediately, we will work to find the product at a local pharmacy.

We have product quantities monitored daily, where an on hand par level is established based on previous three to four dispensing history. We have inventory levels based on computations of prior and anticipated utilization. We determine the inventory level for a particular drug or therapy based on the consistency of utilization and the fluctuation of delivery times. Generally, the inventory balance for a specialty product is in the range of two to five weeks.

Attachments:

3.2.2.3.3.7 What was your out-of-stock rate for each of the past 2 years?

Answer: Our out-of-stock rate was less than 1 percent in 2010 and 2011.

Attachments:

3.2.2.3.3.8 What procedures do you have in place to minimize drug wastage, including ensuring precise dosing of self-injectables?

Answer: We continuously evaluate and take every opportunity to keep our specialty drug costs low while providing quality member care. Several of our programs designed specifically to control specialty waste and ensure savings include:

- Precertification programs - Precertification requires that specialty drugs identified by our National Precertification List meet the requirements of Aetna's Clinical Policy Bulletins (CPBs) in order to dispense the medications or for claims to be paid. This program also defines appropriate dosing to prevent drug waste.
- Drug quantity management - Providing a 30-day drug supply instead of a 90-day supply prevents waste in members that require modifications in their therapy
- Critical Package Recovery - Our unique Aetna Specialty Pharmacy® Critical Package Recovery program assures all drug shipments arrive safely and quickly to the final destination and avoids waste. We use secure, online shipment tracking to monitor the whereabouts of every package throughout delivery.
- Ready-to-Inject (RTI) program - Medication vials are available only in set units. However, the member's dose may require slightly less or more than one vial's contents. Once members open a vial,

they cannot preserve leftover medication so it goes to waste. With the RTI program, vial contents are broken out into ready-to-inject individual syringes pre-filled with the exact quantity of medication needed for single-dose administration. The member gets the exact amount of product they need for each dose, which prevents waste. The added convenience can also increase compliance.

- Hemophilia Assay Management - Industry standard for factor product is that the dose dispensed is within 10% + or - of dose prescribed. Aetna Specialty Pharmacy assures that factor product is dispensed within +/- 7% of targeted dose for at least 95% of dispenses. This is accomplished by: (a) maintaining adequate inventory of medication; (b) ensuring specific assay vials are stocked at necessary levels to reduce over dispensation; (c) trend to ensure adequate medication is on hand for emergent situations.
- Vial Management - Infertility - Vial management avoids waste of medication and/or over-utilization. Initial and refill prescriptions are tracked to ensure that the amounts/quantities of vials dispensed are clinically appropriate. The current prescribed dose is verified with the ordering physician, as are the number of vials that the member has on hand, only the quantity needed for the current cycle would be dispensed.

Attachments:

3.2.2.3.3.9 Does your Specialty pharmacy titrate and pre-mix self-injectables so that syringes are ready for patient use upon delivery?

Answer: 1: Yes

Detail: With the Ready-to-Inject (RTI) program, vial contents are broken out into ready-to-inject individual syringes pre-filled with the exact quantity of medication necessary for single-dose administration. The member gets the exact amount of product they need for each dose, which helps prevent waste. This also helps to convenience members, which can have a positive impact on compliance.

Options:

1. Yes
2. No

Attachments:

3.2.2.3.3.10 Does your Specialty Pharmacy charge as a compound drug when they have to dilute or pre-mix a medication for patient use upon delivery?

Answer: 2: No

Detail: Not applicable, as Aetna Specialty Pharmacy is not a compound pharmacy. Members can fill compound prescriptions at a retail network pharmacy.

Options:

1. Yes
2. No

Attachments:

3.2.2.3.3.11 If yes to the question directly above, provide the pricing formula used by the specialty pharmacy for compounding medications.

Answer: Because our answer was no, this question is not applicable.

Attachments:

3.2.2.3.3.12 Provide a listing of the prior authorizations, step therapy and other clinical programs available for Specialty drugs dispensed at Retail and Specialty pharmacies. Label attachment “Specialty Drug Management Programs.”

Answer: Attached.

Attachments: [Question 3.2.2.3.3.12 Specialty Drug Management Programs.doc](#)

3.2.2.3.3.13 What was your average annual turnaround time for dispensing Specialty drugs without intervention?

Answer: Aetna Specialty Pharmacy's average turnaround time is 5 business days.

Attachments:

3.2.2.3.3.14 What was your average annual turnaround time for dispensing Specialty drugs with intervention?

Answer: Aetna Specialty Pharmacy's average turnaround time is 5 business days.

Attachments:

3.2.2.3.3.15 Will your organization split quantities to meet client benefit parameters if requested?

Answer: 1: Yes

Detail: We can split quantities to meet your benefit parameters. However, the member pays the full copay amount at the first refill, and we set a copay override of \$0 for the second refill. We would be happy to discuss this plan option with you in more detail in order to meet your needs.

Options:

1. Yes
2. No

Attachments:

3.2.2.4 Required Attachments

3.2.2.4.1 Pharmacy Benefit Management GeoAccess and Network Analysis

Please complete the Excel worksheets in Attachment J7 and provide the completed worksheets as an attachment to the RFP. Detailed instructions are provided in the worksheet.

Answer: 1: Attached

Detail:

Options:

1. Attached
2. Not Attached

Attachments: [Attachment J7 - Pharmacy Benefit Management Services GeoAccess and Network Analysis.xlsx](#)

3.2.3 Pricing

3.2.3.1 Pricing - General

3.2.3.1.1 Offeror must uphold contractual pricing for the life of the contract regardless of changes in the State's membership.

Answer: 1: Yes

Detail: Aetna has provided pricing under 2 scenarios: Total Population and Non Medicare Population. Depending on the scenario and enrollment on 7/1/2013 and 1/1/2014, the pricing in either scenario will apply for the life of the contract.

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.1.2 If any changes in pricing terms are required by your organization, the State may terminate the agreement without financial consequence (e.g., rebates earned but not yet paid).

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.1.3 The terms you present do NOT require the State to implement any plan designs or programs that are different from the plan designs and programs currently in place, or planned to be in place for implementation date. This includes participation in step therapy, prior authorization, therapeutic interchange (i.e., switch programs), if not currently in place or planned to be in place for implementation date.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.1.4 The terms you present are State-specific (not book-of-business averages).

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.1.5 Pricing, guarantees and reconciliations for all terms (discounts, dispensing fees, rebates etc.) do not differ for Consumer Driven Plans, High Deductible Health Plans, Health Savings Accounts (HSAs), Health Reimbursement Accounts (HRAs) or other such Plans should the State implement at some point in the future.

Answer: 2: No. Explanation: [The proposed financial arrangement is based on the current plan of benefits. Aetna would re-evaluate the financial arrangement for any plans contemplated being offered at a future date.]

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.1.6 Confirm that pricing is based on your open formulary, and does not assume use of a preferred drug step therapy or high performance formulary, unless currently in place, or planned to be in place for implementation date.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.1.7 Each financial component guarantee for discounts and dispensing fees at retail, mail order and specialty will be measured, reported, reconciled and guaranteed on an individual component basis. There will be no cross subsidization within a distribution channel or among distribution channels. Shortfalls in one component guarantee may not be offset by overages in another component guarantee. Rebate guarantees for retail, mail order and specialty can be reconciled in the aggregate.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.1.8 The same claims and methodologies used to calculate actual performance (e.g. guaranteed discount achieved) will be used when calculating the net shortfall/surplus tied to the performance guarantees.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.1.9 You will provide an annual reconciliation between the actual claims pricing terms (Average Whole Sale “AWP” discounts and dispensing fees) by network (retail, mail, specialty) that were applied and those that were guaranteed within 90 days from the close of the year and, if necessary, will credit any difference against future billings to the State under the program, or reimburse the State directly with a check, depending on the State’s preferred method of payment.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.1.10 You will provide aggregate semi-annual discount guarantees for generics dispensed at retail and through mail order.

Answer: 2: No. Explanation: [Aetna is providing an annual overall retail generic discount guarantee and an annual overall mail order generic discount guarantee.]

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.1.11 You will provide an annual reconciliation between the actual rebates received and those that were paid/guaranteed within 120 days from the close of the year and will credit, if necessary, any difference against future billings to the State under the program will be used when calculating the net shortfall/surplus tied to the performance guarantees.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.1.12 In the pass-thru pricing arrangement, compounds (i.e., claims for a prescription that requires the pharmacy to create the medication by combining two or more ingredients) will be priced at the exact rate you negotiated with the pharmacy.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.1.13 Multi-Source ("MS") Brands filled under a Dispense As Written ("DAW") 1(substitution allowed; dispensed as written by prescriber) or DAW 2 (substitution allowed; patient requested product dispensed) code when a "mandatory generic policy" is not in place (i.e., member only pays the applicable copay) will be included in the Brand AWP Discount Effective Rate Guarantee.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.1.14 At the State's option, Offeror must offer a competitive generic dispensing rate guarantee at both retail and mail order for each year of the contract. Generic Dispensing Rate (GDR) must be defined as the number of generic prescriptions dispensed divided by the total number of prescriptions dispensed (brand and generic) on an annual basis. (Generic Dispensing Rate = Generic Rx's / Total Rx's)

Answer: 2: No. Explanation: [$GDR = \text{Generic Rx's less DAW Rx's} / \text{Total Rx's less DAW Rx's}$]

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.1.15 Within ninety (90) days after the end of each Contract Year, Offeror shall pay to the State the full shortfall at Retail and/or Mail Order, should the actual GDR be less than the target guaranteed GDR. The shortfall will be calculated as the Average Plan Cost per Brand (multi and single source) Claim less the Average Plan Cost per Generic (multi and single source) Claims multiplied by the shortfall (Target/Guaranteed GDR minus Actual GDR)

Answer: 2: No. Explanation: [Within ninety (90) days after the end of each Contract Year, Offeror shall pay to the State the full shortfall at Retail and/or Mail Order, should the actual GDR be less than the target guaranteed GDR. The shortfall will be calculated as the Average Plan Cost per Brand (multi and single source) Claim less the Average Plan Cost per Generic (multi and single source) Claims multiplied by the shortfall (guaranteed generic dispensing rate for the contract year minus the actual generic dispensing rate for the contract year) multiplied by the actual claim volume in the contract year.]

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.1.16 The Offeror's financial proposal must be based on a full disclosure, fully transparent, 100 percent pass-through arrangement.

Answer: 2: No. Explanation: [Aetna is offering a Pass Through at Retail Financial Arrangement and a Guaranteed at Mail Order Financial Arrangement. Aetna is passing through 100% of customer rebates to State of Alaska.]

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.1.17 The only source of profit/revenue derived by the Offeror will be the contractually agreed upon per member (or per employee/retiree) per month administrative fee.

Answer: 2: No. Explanation: [Aetna is offering a Pass Through at Retail Financial Arrangement and a Guaranteed at Mail Order Financial Arrangement. Aetna is passing through 100% of customer rebates to State of Alaska.]

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.1.18 The Offeror will not earn revenues from any hidden source, including but not limited to rebates, discounts, credits, incentives, grants, chargebacks, reimbursements, health management fees paid by pharmaceutical manufacturers and other third parties to the Offeror, or other financial benefits of any sort. The Offeror will be required to pass-through to the State all such financial benefits.

Answer: 1: Yes

Detail: We will pass on all rebates we receive based on the utilization for the State of Alaska employees and their dependents.

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.1.19 The Offeror will pass-through to the State all network pricing and manufacturer rebate and fee improvements made over the contract term immediately or as soon as practically possible such that the State will receive the benefit of the improved pricing when the PBM itself does.

Answer: 1: Yes

Detail: Applies to Pass Through at Retail and Rebates Only; Does not apply to Mail Order which is based on Guaranteed pricing.

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.2 Maximum Allowable Cost (MAC)

3.2.3.2.1 The Offeror must apply a lowest-net-cost, single MAC price list across all channels (retail, mail order, 90-day at retail, specialty pharmacy).

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.2.2 The MAC list at Retail-90 will include the same medications or more and will use the same prices or lower prices as the most aggressive retail pharmacy MAC list.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.2.3 The MAC list used at Retail-90 pharmacies will include price points that compete with low-cost generic programs available from retails (e.g., WalMart's \$10 per 90).

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.2.4 The MAC list you use for the State at mail pharmacies will include the same medications or more and will use the same prices or lower prices as the most aggressive retail pharmacy MAC list.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.2.5 The MAC list used at mail pharmacies will include price points that compete with low-cost generic programs available from retails (e.g., Wal-Mart's \$10 per 90).

Answer: 2: No. Explanation: [The low-cost generic programs at certain retail pharmacies are promotional programs that are not truly tied to drug cost. In aggregate, our MAC at mail list and discounts generate greater value through the mail channel compared to retail.

We strive to align pricing between retail and mail; such that in aggregate the State of Alaska and its members achieve a greater overall value by using mail order.]

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.2.6 The MAC list at specialty pharmacies will include the same medications or more and will use the same prices or lower prices as the most aggressive retail pharmacy MAC list.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.2.7 You agree that the MAC lists used to price claims will be updated no less frequently than 4 times throughout each contract year term of the contract to remain competitive; however, you will proactively communicate, identify and explain, to the client any deletions and any unit price increases over 10% per month.

Answer: 1: Yes

Detail:

Options:

1. Yes

2. No. Explanation: [Text]

Attachments:

3.2.3.2.8 The Offeror MAC list must cover at least 95 percent of generic drugs dispensed through retail, 90-day retail and mail.

Answer: 2: No. Explanation: [Over 94 percent of all qualified A-rated generics in the market place are on the APM MAC list. Products that do not meet our MAC criteria may be excluded from the MAC list. Our criteria include, but are not limited to, generics that are not A-rated drugs, generics with low claim volume, or single-source generic drugs.]

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.2.9 The Offeror will not earn any MAC and/or generic spread revenue, passing through to the State the actual contracted rate and dispensing fee or usual and customary price for every paid claim.

Answer: 2: No. Explanation: [Mail Order is offered on a Guaranteed Financial Arrangement.]

Detail: Agree for Retail; Do Not Agree for Mail Order as noted above.

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.2.10 If the Offeror in the future establish multiple Maximum Allowable Cost lists as alternative proprietary Maximum Allowable Cost lists for Participating Pharmacies, the Offeror shall provide to State the most favorable Maximum Allowable Cost for each generic drug (SS and MS) on any of its Maximum Allowable Cost lists.

Answer: 2: No. Explanation: [We are offering aggressive generic drug pricing to State of Alaska, including an overall generic effective rate guarantee. We are willing to discuss with the State other approaches to maximize savings based on your goals and potential design changes. We can address alternatives and provide information on customers of similar size, pharmacy/geographic mix, and drug mix to support final decisions on design.]

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.3 Average Wholesale Price (AWP)

3.2.3.3.1 All references and inputs of AWP are based on current AWP (Post-AWP Rollback, September 26, 2009), and AWP discounts are applied directly to this AWP, with no further adjustment

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.3.2 The AWP used to price the claim must be from only one nationally recognized source (e.g., MediSpan).

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.3.3 The AWP used to price retail pharmacy claims will be the actual National Drug Code (NDC)-11 submitted by the pharmacy as the one the pharmacy used to fill the prescription.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.3.4 The AWP used to price mail pharmacy claims will be the actual NDC-11 submitted by the pharmacy as the one the pharmacy used to fill the prescription.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.3.5 The AWP used to price specialty pharmacy claims will be the actual NDC-11 submitted by the pharmacy as the one the pharmacy used to fill the prescription.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.3.6 All inputs for AWP will apply to the AWP applicable on the date that the claim is processed.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.3.7 The AWP's used in the guaranteed AWP discount calculation will be the same AWP used to price the claim. See the requirements associated with the AWP's used to price the claims.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.3.8 You will not charge a higher AWP price per unit for any repackaged products assigned a different NDC number than the original manufacturer/labeler AWP price per unit for the same product (drug name, form and strength).

Answer: 2: No. Explanation: [Not applicable, as we do not repackage any prescription drugs, nor do we use a repackager during the mail order dispensing process.]

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.3.9 The AWP that will be used to calculate the AWP discount for MS-Brands dispensed as the "house generic" (DAW 5 code submitted by the pharmacy) will be no higher than the average AWP of the three least expensive generic products available in the marketplace.

Answer: 2: No. Explanation: [The claim system uses the AWP as published by Medi-Span of the NDC dispensed as submitted by the pharmacy.]

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.3.10 In the event there are changes in the marketplace to the baseline measure used for the ingredient costs of drugs (e.g. AWP), the terms will be adjusted accordingly to provide an equivalent price.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.3.11 In the event there are changes in the marketplace to the baseline measure used for the ingredient costs of drugs (e.g. AWP), you will provide as much advanced notice as possible to the State and sufficient details to support any changes being propose.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.3.12 In the event there are changes in the marketplace to the baseline measure used for the ingredient costs of drugs (e.g. AWP) and you propose changes to the State's pricing terms in order to account for the changes, changes will be agreed upon before any changes are made. If changes are not agreeable either party has the right to terminate the agreement without financial consequences (e.g., loss of rebates earned but not yet paid).

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.4 Drug Classification

3.2.3.4.1 You may not manipulate or change a product's brand or generic status retroactively for purposes of achieving pricing guarantees

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.4.2 Generics, for purposes of pricing term offers and guarantees in this RFP, will be defined as all products that are not SS-Brands or MS-Brands.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.4.3 You will maintain a list of single-source generics and will provide the list upon the State's request. Additionally, you will provide effective dates and term dates for drugs that have dropped from or been added to the list.

Answer: 1: Yes

Detail: Please note that the effective and term date is determined by Medi-Span.

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.5 Retail Pricing

3.2.3.5.1 All retail claims must be adjudicated at the lowest of: (a) the contracted discount plus dispensing fee; (b) MAC plus dispensing fee; or (c) the usual and customary (U&C) price (including the pharmacy's sales price, if any).

Answer: 1: Yes

Detail: We follow a "lesser of" approach to pricing at a participating retail pharmacy. What this means is that when members visit a retail network pharmacy, they will pay the lowest cost possible. You and your members will always pay the lowest amount of the following four options:

1. Discounted ingredient costs + dispensing fee
2. MAC + dispensing fee

3. The pharmacy's usual and customary (U&C) price
4. Member copay/coinsurance

All pharmacies that participate in the APM retail pharmacy networks have agreed to submit U&C pricing for prescriptions and accept reimbursement based on this “lesser of” logic. We code the “lesser of” logic into the claim system along with the contractually negotiated reimbursement rates. All pharmacies are required to use this system.

When a retail network pharmacy submits a claim, we capture the U&C pricing in the system. We then have claims audited on a regular basis to ensure that pharmacies adhere to U&C requirements. What this means for you is that we will make sure you and your members pay the lowest cost possible when filling a prescription at a retail network pharmacy.

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.5.2 All retail claims will be adjudicated according to the “lowest of” logic such that members always pay the lowest of the applicable copayment, the contracted price and/or the pharmacy’s U&C amount (including the pharmacy's sale price, if any). Offerors will not be allowed to adjudicate based on “zero balance logic” or on a minimum copayment amount (except as allowed by the plan) and retail pharmacies will not be allowed to collect a minimum payment.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.5.3 U&C priced claims will NOT be assessed a separate dispensing fee.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.5.4 Maximum Average Dispensing Fee guarantees will exclude all U&C claims submitted and billed by retail pharmacies including reversed/denied claims.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.5.5 Effective (Average Annual) rates for Brands will include all claims for multi and single source brands.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.5.6 Effective (Average Annual) rates for Brands will include all specialty brand claims dispensed at retail.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.5.7 Effective (Average Annual) rates for Brands will include the impact of U&C claims; the ingredient cost must be equal to the submitted U&C price for discount guarantee reconciliation purposes.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.5.8 Effective (Average Semi-Annual) rates for Generics will include all claims for ALL generics, including multi and single source generic drugs, MAC'd and Non-MAC'd generics, limited supply generics, patent litigated generics.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.5.9 Effective (Average Semi-Annual) rates for Generics will include all specialty generics claims dispensed at retail.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.5.10 Effective (Average Semi-Annual) rates for Generics will include the impact of U&C claims; the ingredient cost must be equal to the submitted U&C price for discount guarantee reconciliation purposes.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.5.11 In addition to including single source generics in the overall generic effective rate, you will also offer a standalone single source generic guarantee that must be greater than the Brand effective rate.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.6 Mail Order

3.2.3.6.1 All mail order claims must be adjudicated at the lowest of: (a) the contracted discount plus dispensing fee; or (b) MAC plus dispensing fee. Offerors are not allowed to assess a "minimum charge" at mail order.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.6.2 All mail order claims will be adjudicated according to the “lowest of” logic such that members always pay the lowest of the applicable copayment or the discounted price. Offerors will not be allowed to adjudicate based on a minimum copayment amount through mail order.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.6.3 Effective (Average Annual) rates for Brands will include all claims for multi and single source brands.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.6.4 Effective (Average Semi-Annual) rates for Generics will include all claims for ALL generics, including multi and single source generic drugs, MAC'd and Non-MAC'd generics, limited supply generics, patent litigated generics.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.6.5 In addition to including single source generics in the overall generic effective rate, you will also offer a standalone single source generic guarantee below that must be greater than the Brand effective rate.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.6.6 You will NOT pass along the cost of increases in postage rates to the State during the term of the agreement.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.6.7 The dispensing fee per claim listed for mail, if any, is not an average but the maximum amount that will apply per claim.

Answer: 1: Yes

Detail: Please note that we do not charge a dispensing fee at mail order.

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.6.8 Offeror agrees that the State will not be responsible for any member contributions (e.g., deductible, coinsurance, copays) owed to the Offeror. Collecting such fees will be the sole responsibility of the Offeror.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.6.9 The Offeror must agree to offer consistent pricing for all standard mail order prescriptions regardless of the days' supply (i.e., Offeror will not apply retail pricing to any mail order claims).

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.6.10 The State will not be assessed any fees for mail order claims where member pays 100% the cost of the prescription, exclusive of administrative fees, if applicable.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.6.11 The Offeror will not earn any spread revenue in mail, passing through to the State the full value of the agreed upon pricing and any upside performance.

Answer: 2: No. Explanation: [Aetna is offering a Guaranteed Financial Arrangement at Mail Order.]

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.7 Specialty Pharmacy Pricing

3.2.3.7.1 All specialty pharmacy claims must be adjudicated at the lowest of: (a) the contracted discount plus dispensing fee; or (b) MAC plus dispensing fee. Offerors may not assess a "minimum charge" through specialty pharmacy.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.7.2 All specialty pharmacy claims will be adjudicated according to the "lowest of" logic such that members always pay the lowest of the applicable copayment or the discounted price. Offerors will not be allowed to adjudicate based on a minimum copayment amount through specialty pharmacy

Answer: 1: Yes

Detail:

Options:

1. Yes

2. No. Explanation: [Text]

Attachments:

3.2.3.7.3 In addition to providing your specialty drug list, which applies varying ingredient cost (AWP) discount and dispensing fees by drug for the State, in the appropriate section “Specialty Drug Price List,” you will offer a minimum annual average AWP discount guarantee for all specialty claims processed at specialty pharmacy, as requested in the pricing offer section.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.7.4 You will price all claims processed by the specialty pharmacy for medications that are not on your specialty drug list at the mail-order pharmacy rates.

Answer: 2: No. Explanation: [Please refer the Aetna Specialty Pharmacy Pricing Supplement provided in the RFP response.]

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.7.5 If Offeror classifies a drug as specialty, but the drug is designated by the FDA as generic, vendor must price drug at the generic guaranteed rates.

Answer: 1: Yes

Detail: Specialty Drugs dispensed at a retail pharmacy receive the retail discounts. Please refer to the Aetna Specialty Pharmacy Pricing Supplement for the discounts by drug for specialty drugs dispensed at Aetna Specialty Pharmacy.

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.7.6 You will NOT pass along the cost of increases in postage rates to the State during the term of the agreement.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.7.7 You agree your pricing will not be contingent upon an exclusive retail lockout arrangement, unless currently in place or planned to be in place prior to implementation date.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.7.8 The dispensing fee per claim listed for specialty pharmacy, if any, is not an average but the maximum amount that will apply per claim.

Answer: 1: Yes

Detail: Under Aetna Specialty Pharmacy, there is no dispensing fee for injectable specialty drugs. There is a \$1.75 dispensing fee for oral specialty drugs. Specialty drugs dispensed at retail are included under the retail pricing.

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.7.9 Offeror agrees that the State will not be responsible for any member contributions (e.g., deductible, coinsurance, copays) owed to the Offeror through the specialty pharmacy. Collecting such fees will be the sole responsibility of the Offeror.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.7.10 Specialty Pharmacy pricing, including guaranteed discounts, dispensing fees and rebate guarantees, apply to all specialty pharmacy claims, regardless of supply days.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.7.11 You will allow the State to limit specialty pharmacy claims to a 30-day supply (including those dispensed by your specialty pharmacy), with no modification to the pricing terms you are proposing for specialty medications in this RFP.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.7.12 The State will not be assessed any fees for specialty pharmacy claims where member pays 100% the cost of the prescription, exclusive of administrative fees, if applicable.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.7.13 Please provide the criteria you use to determine whether a medication is/will be considered to be a "specialty drug" during the term of the contract.

Answer: We define specialty drugs as medications that include, but are not limited to, pharmaceutical products that are very expensive, typically have no less costly equivalents, are often biologicals, may or may not be infusible or injectable, require a greater amount of pharmaceutical oversight and clinical monitoring, and/or are addressed to serious conditions like cancer, rheumatoid arthritis and multiple sclerosis.

In addition, we also understand that these medications:

- Frequently cost over \$500 per prescription
- Sometimes have harsh side effects
- Are most commonly infused or injected
- Require special handling or temperature control
- Need therapy management including:
 - Side effect management
 - Patient adherence and compliance
 - Training and support for administration
 - Are subject to wastage

- Should be dispensed as a 30 day supply to account for potential changes in therapy
- Are more effectively managed in a high touch, low volume delivery model

Attachments:

3.2.3.7.14 Medications will only be added to your "specialty drug list" that meet the specific criteria you provided directly above, as the definition/criteria used to determine whether a medication is considered to be a specialty drug.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.7.15 The State will be provided at least 90 days notice in advance of new medications being added to your "specialty drug list" whenever feasible; the State reserves right to exclude the medication from coverage if the medication is in a category that is currently excluded (e.g., growth hormones).

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.7.16 You will maintain and submit to the State on a mutually agreed upon frequency your list of specialty drugs (that include effective and term dates, as appropriate).

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.7.17 You will provide guaranteed minimum AWP discount pricing and dispensing fees per Rx for newly approved Specialty drugs similar to those already available to treat the same condition.

Answer: 2: No. Explanation: [Aetna reserves the right to exclude from the guarantee new-to-market specialty drugs and specialty drugs subject to supply limitations or disruptions.]

Detail:

Options:

1. Yes

2. No. Explanation: [Text]

Attachments:

3.2.3.7.18 The Offeror will not earn any spread revenue in specialty pharmacy, passing through to the State the full value of the agreed upon pricing and any upside performance.

Answer: 2: No. Explanation: [Aetna is offering a Guaranteed Financial Arrangement for Aetna Specialty Pharmacy.]

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.8 Rebates

3.2.3.8.1 Offeror agrees to pay the State a guaranteed rebate payment/credit equal to the greater of the specified % pass-through of actual Total Rebates or Per Claim Rebate Guarantees.

Answer: 1: Yes

Detail: Minimum Rebate Guarantee is on a Per Brand Script basis.

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.8.2 All rebates must be received by the State no less than quarterly and paid within 30 days of the end of each quarter.

Answer: 2: No. Explanation: [We will provide collected rebates to you on a quarterly basis. At the end of each quarter, we will begin collecting rebates from drug manufacturers based on the utilization of your membership. It typically takes 90 to 120 days to collect the funds from the manufacturers, and distribute them back to you.]

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.8.3 The State will receive the first rebate check/credit within 60 days from the end of the first quarter of the agreement.

Answer: 2: No. Explanation: [We will provide collected rebates to you on a quarterly basis. At the end of each quarter, we will begin collecting rebates from drug manufacturers based on the

utilization of your membership. It typically takes 90 to 120 days to collect the funds from the manufacturers, and distribute them back to you.]

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.8.4 You will pay the State the greater of the amount received or the minimum amount guaranteed per claim, regardless of the actual rebates that have been received for rebates during the quarter.

Answer: 2: No. Explanation: [Rebates will be distributed on a quarterly basis based on the minimum guarantees. Rebate allocations will be made approximately 45 days from the end of such allocation period. Aetna will reconcile the rebate guarantee on an annual basis.]

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.8.5 The State's share of any Total Rebates received by the Offeror from manufacturers after the annual reconciliation will be applied to the next contract year's annual reconciliation or sent to the State as a check, at the State's preferred method of payment.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.8.6 The State's share of any Total Rebates received by the Offeror from manufacturers after the annual reconciliation and after the Termination of the Contract, shall be paid to the State.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.8.7 Minimum rebate guarantees will apply to all prescriptions dispensed under the State's Plan; including covered prescriptions where the member paid the full cost of the drug and the State paid zero. Amounts may vary based on delivery channel and plan design type.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.8.8 Rebate Guarantees must be provided without minimum or average days' supply requirements.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.8.9 Rebate guarantees will not be reduced based on patent expirations, OTC introductions of branded drugs, actions by drug manufacturers, brand products moving off-patent to generic status, recalls or withdrawals of branded products or unexpected generic introductions for the term of the proposed contract or for changes made by Offeror to your standard formulary.

Answer: 2: No. Explanation: [Aetna reserves the right to re-evaluate its financial offer for the following: actions by drug manufacturers or wholesalers that have a material adverse impact on rebates, product recalls or withdrawals, unexpected or "at risk" generic introductions, or any legal action or Law that materially affects or could materially affect the manner in which Aetna administers the rebate program.]

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.8.10 The State's rebate share, which you propose in your pricing offer , includes rebates received for specialty drugs and you have provided your rebate guarantees for specialty drugs dispensed at retail and through the specialty pharmacy, as requested in the pricing offer.

Answer: 1: Yes

Detail:

Options:

1. Yes

2. No. Explanation: [Text]

Attachments:

3.2.3.8.11 The Offeror cannot employ any therapeutic switching/interchange program(s) or rebate maximization strategies, without the full consent and disclosure of all therapeutic class considerations, cost differential, overall financial impact and member impact to the State.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.3.8.12 Rebate reporting must be at the 11-digit National Drug Code level (NDC11).

Answer: 2: No. Explanation: [We do not include drug or manufacturer-level rebate information in rebate reports due to our manufacturer agreements. On a limited basis, we can share this information in the case of a customer rebate audit.

While our manufacturer rebate contracts are considered proprietary, we would allow the State of Alaska or a mutually agreed upon third-party auditor to conduct this type of audit. We will make every effort to provide you with information sufficient to confirm the payments to you are accurate.

The audit will target a review representing approximately 15 percent of the State of Alaska's rebate dollars, which cover the most highly utilized drugs. When permitted by our rebate agreements, we will disclose the financial exhibits of the contract, including the manufacturer name, drug name and rebate percentage for the drugs agreed upon between Aetna and the pharmaceutical manufacturer.

We will work with you to select the drugs to be audited based on rebate dollars, and to target the fewest unique contracts required for audit so that the selected drugs represent approximately 15 percent of rebate dollars or no more than 5 contracts, whichever is lower. In addition to the contracts, we will provide access to documents governing the calculation, invoicing, remittance, accounting and allocation of rebates received for the identified drugs. APM will provide a report identifying those drugs to you for review prior to the audit.

We believe this process will provide the State of Alaska with information sufficient to satisfy the transparency requirements of the contract.]

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.4 Eligibility & Enrollment

3.2.4.1 Can you accommodate an account code structure in the eligibility file that will allow the State to identify trends in rebates and claim activity information broken down by different organizational units?

Answer: Yes. We will work with the State to set up an account code structure that will allow the State to identify trends for each organizational unit. We will work with the State to establish the structure that optimizes reporting for all of the Aetna administered programs.

Attachments:

3.2.4.2 Explain whether or not your proposal includes on-line access by the State to view eligibility files. If yes, describe this arrangement, and whether or not this access includes the ability for the State to update member data on an ad hoc basis.

Answer: Yes. We have systems in place to allow the State to view on-line eligibility and make updates as appropriate. We will also provide the State with Aetna resources in Alaska and on the Account Team who can make eligibility updates on an ad hoc basis or review the State's eligibility system.

Attachments:

3.2.4.3 How will eligibility data be transferred from the State to the Offeror?

Answer: We can accept eligibility data in all of the following formats:

- Internet-based Eligibility Transfer Solutions - The State can use a UNIX server or web-based transfer solutions to transmit eligibility files to us during open enrollment and as updates are needed. SecureTransport, which uses customer software, is our preferred method of receiving eligibility through the internet.

- Electronic Transport Method - The State can submit enrollment through any number of electronic transport methods including secure Internet FTP, VAN or mainframe-to-mainframe connections, using ConnectDirect and EDI ANSI X12 formats. If the EDI ANSI format is used, the only connectivity options available are SecureTransport or VAN.

- e.Listing - An e.Listing is an Excel spreadsheet populated with eligibility data. The spreadsheet is scanned into our systems and mirrors an electronic file, eliminating manual intervention. The e.Listing functionality increases the timeliness of eligibility updates so that members can access care quickly.

- Enrollment Forms - The State can submit paper enrollment forms that will be input manually.

Attachments:

3.2.4.4 Please confirm your ability to accommodate the electronic transfer of eligibility from the State's system.

Answer: Confirmed. We can accept the State's 834 eligibility layout.

Attachments:

3.2.4.5 How often is eligibility electronically updated? Confirm that you will accept a daily eligibility file.

Answer: We can accept a daily file, but we recommend transaction only or full-inforce files twice per week. This would ensure that we have the most accurate and up-to-date file submissions possible. We find this process beneficial in minimizing disruption in eligibility files for customers. Once we upload the eligibility file to our mainframe system, the State's eligibility consultant reviews an edit of the file

online. If there are no other data quality concerns, we update the system. If there are any errors or issues, the eligibility consultant will work with the State to resolve these prior to updating the system.

While we recommend twice weekly files to allow this eligibility verification process to take place, we can accept daily files for an additional charge.

Updated information appears in our eligibility system immediately and in the claim system within approximately 24 hours. If the State grants access, our Health Concierges and Alaska Team can review any questions on eligibility in the State's eligibility system. We can have standard processes to address any emergency eligibility issues in that manner to ensure no issues with coverage.

Attachments:

3.2.4.6 How often is eligibility electronically updated by any subcontractors or joint venturers?

Answer: We will establish automated eligibility extracts once per week to VSP. We can also discuss any other subcontractors that the State may require Aetna to interface with for eligibility.

Attachments:

3.2.4.7 Please confirm you can receive and send FTP files or have other secure methods of transmission.

Answer: Confirmed. We offer the following secure methods of transmission:

- Internet-based Eligibility Transfer Solutions - The State can submit eligibility using our web-based transfer solution called SecureTransport.
- Electronic Transport Method - The State can submit enrollment through SecureTransport using an electronic transport method. We support transfers in:
 - Explicit SSL (FTPs)
 - SSH (sFTP)
 - AS2 protocols
 - EDI ANSI X12 formats
 - Connect Direct with secure+ encryption.

Attachments:

3.2.4.8 Can you accept eligibility via paper, as well as by electronic feed?

Answer: Yes.

Attachments:

3.2.4.9 Do you allow online access to the client's staff for real-time eligibility updates?

Answer: Yes. We have systems in place to allow the State to view on-line eligibility and make updates as appropriate. We will also provide the State with Aetna resources in Alaska and on the Account Team who can make eligibility updates on an ad hoc basis or review the State's eligibility system.

Attachments:

3.2.4.10 Indicate how dependent eligibility information is stored. Is it part of the member record, or a separate record?

Answer: We store dependent eligibility information as a separate record but attached to the employee ID.

Attachments:

3.2.4.11 What is the standard turnaround time for an eligibility file upload?

Answer: 1: Within 24 hours

Detail:

Options:

1. Within 24 hours
2. By Next Business Day
3. Within 5 Business Days
4. Other: [Text]

Attachments:

3.2.4.12 Are you able to administer 90 day retroactive enrollment adjustments?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No
3. Other: [Text]

Attachments:

3.2.4.13 Are you able to make exceptions to the 90 day retroactive enrollment to allow for longer periods than 90 days?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No
3. Other: [Text]

Attachments:

3.2.4.14 Clearly state your company's timelines and deadlines for Open Enrollment (system updates due to plan changes or file formats, new divisions, manual work arounds, dates for the last pre-OE updates, OE file updates, etc.).

Answer: We will work closely with you to develop an Open Enrollment schedule based on the State's enrolled employees, chosen products, programs and services. Our Account Team will assist in identifying tasks, needed resources and schedule key milestone dates that work best for the State and

their members.

Key milestones dates include:

- Kick-off Strategy Call - 4/1/13
- Begin Implementation - 4/8/13
- Implementation meeting - 4/8/13
- Confirm eligibility 6/14/13
- Confirm ID cards mailed - 6/21/13
- Effective date - 7/1/13

Please refer to the attached Implementation Schedule for all of our implementation dates.

Attachments: [State of Alaska Implementation.doc](#)

3.2.5 Customer/Member Service

3.2.5.1 Customer/Member Service - General

3.2.5.1.1 Will you provide the State with unit(s) dedicated to customer service? Please describe each function supported by these customer service unit(s).

Answer: There will be four on-site sales support consultants (SSCs) for the State. Two will be on-site in Juneau and the other two will be in Anchorage. The SSC will interface directly with State employees and their dependents regarding health benefits offered through the State's benefit program, including pharmacy.

The health concierge can answer many pharmacy-related questions. For complex pharmacy-related issues, the health concierge will warm transfer your members to our APM Member Services center. These pharmacy CSRs are empowered to function as member advocates by engaging members and educating them on how to maximize their prescription benefit. We provide the CSR teams and supervisors with customer-specific training, which enables CSRs to:

Inform Members

- Provide members with detailed prescription benefit and plan information
- Provide pricing estimates on drug cost
- Verify a mail claim's status at any point in the dispensing process
- Verify order information
- Provide eligibility status

Educate Members

- Teach members how to submit a claim
- Instruct members on how to use the mail order pharmacy and turnaround times for processing orders

Serve Members

- Research claim inquiries regarding how a claim paid
- Maintain account information
- Create, view and resolve requests online, which allows for improved tracking of member requests
- View communications that have been sent to members
- Order ID cards and forms
- Find a retail pharmacy location that is convenient for the member

Attachments:

3.2.5.1.2 Where will the dedicated offices(s) be located and will those offices be dedicated to customer service, claims processing or both?

Answer: Two SCCs will be on-site in Juneau and the other two will be in Anchorage. The pharmacy customer service center is located in San Antonio, TX.

Over 99 percent of pharmacy claims are processed immediately at the point of care. When members fill prescriptions at non-network pharmacies, they will pay the full cost at the pharmacy and submit a paper claim form to our Direct Member Reimbursement (DMR) unit. The DMR unit is located in Minnesota.

Attachments:

3.2.5.1.3 List how many customer service representatives will be dedicated to the State's plans.

Answer: In addition to the 4 SCCs and the health concierge, there are 560 CSRs who answer APM member calls.

Attachments:

3.2.5.1.4 Describe your training program for customer service employees.

Answer: Every pharmacy CSR completes a 15 to 18 week training program. CSRs learn how to handle calls from all contact sources by using the call tracking system application. The program includes benefit determination, claim review, eligibility information and system navigation as well as communication, documentation and soft skill training.

This program may incorporate training approaches that introduce additional interactive application-based learning opportunities. Along with classroom lecture and computer-assisted instruction, we use learn-by-discovery methods, including review of previously recorded calls and mock-up call scenarios.

We review all content weekly. We build changes that occur because of policy, system or product releases into the new hire curriculum within five working days. The content consists of systems training, health care, policy and a proven customer service skills training.

Additional Training Program for Concierge Level

In addition to the 12-14 week core customer service training that all CSRs receive, our Concierge staff receive an additional 3 weeks of training. The additional Concierge level training has a special emphasis on soft skills and consultative skills, problem-solving, and listening for and acting upon triggers to assist in making the right connections for a member at the right time.

Attachments:

3.2.5.1.5 Explain any incentive programs you employ to retain competent customer service employees.

Answer: We conduct regular performance reviews for CSRs and pay increases are determined annually. CSRs are recognized and rewarded for their effectiveness in attaining positive individual and team outcomes.

The results from the scorecard elements listed above factor significantly in the annual performance merit review.

In addition to their base salary, eligible CSRs participate in an incentive program that permits them to earn additional monies on a quarterly basis.

The customer service incentive program is an individual incentive program designed to retain and motivate CSRs, and to encourage a higher level of performance by providing meaningful financial

rewards to those who excel in specific quality, productivity and teamwork goals.

Final individual bonus eligibility and actual bonus amounts are subject to plan maximums and managers' discretion.

Attachments:

3.2.5.1.6 What is the average years of experience for your customer service staff?

Answer: We hire representatives who have a minimum of 3 to 5 years experience in health care, social services, education, and/or related fields, with a heavy emphasis on customer service.

Attachments:

3.2.5.1.7 What is the average length of employment for your customer service staff?

Answer: The average tenure of our CSRs team is 4.5 years.

Attachments:

3.2.5.1.8 How many dedicated toll-free phone lines will be made available to answer member and provider inquiries?

Answer: The State will have one dedicated 800 number with prompting for members and providers.

Attachments:

3.2.5.1.9 How many dedicated toll free phone lines for the hearing impaired will be made available to answer member and provider inquiries?

Answer: The teletypewriter (TTY) feature enables our CSRs to communicate with hearing impaired members through written communication. In addition, we can use e-mail to communicate with these members. Members with hearing impairments do not access a separate CSR team or telephone line.

Attachments:

3.2.5.1.10 During what hours/days of week will toll free phone lines be staffed?

Answer: APM Member Services standard hours of operation are:

Monday - Friday: 7 a.m. to 11 p.m. ET

Saturday: 7 a.m. to 9 p.m. ET

Sunday: 8 a.m. to 6 p.m. ET

However, members will be able to reach CSRs 24 hours a day, 7 days a week.

Attachments:

3.2.5.1.11 Provide an explanation of how you define “after-hours.” How are calls “after-hours” of operation handled?

Answer: Members will be able to reach pharmacy CSRs 24 hours a day, 7 days a week.

Attachments:

3.2.5.1.12 Is there a voice mail system or capability for callers to leave messages after normal business hours? During after-hours?

Answer: We provide members with an Interactive Voice Response (IVR) system. This is available 24 hours a day, 7 days a week.

Attachments:

3.2.5.1.13 Do members reach a live representative or an interactive voice response unit (IVR) when calling customer service?

Answer: When members call customer service, they are first greeted by the IVR system. Members are able to request to speak to a live CSR at any time during the call and can be shifted over to a representative simply saying so or pressing "0." This transfers the call and all information already gathered to someone who is trained to help.

Attachments:

3.2.5.1.14 Are all calls logged into your tracking system?

Answer: Yes.

Attachments:

3.2.5.1.15 If no, what percentage of calls are logged into your tracking system?

Answer: We record and track 100 percent of all APM Member Service call center calls.

Attachments:

3.2.5.1.16 Please check all items below which pertain to calls handled by the customer service representatives:

Answer: 1: All calls are recorded,
2: Customer service representatives document all calls,
5: Calls are documented in summarization

Detail:

Options:

1. All calls are recorded
2. Customer service representatives document all calls
3. Customer service representatives can make adjustments to claims during a call
4. Calls are documented verbatim
5. Calls are documented in summarization

Attachments:

3.2.5.1.17 What other methods of contacting customer service representatives, besides telephone, are available for members to use?

Answer: Members can e-mail or send written inquiries to APM Member Services. The local representative in Juneau and Anchorage will have access to the same systems and information as the Concierge team and will be able to assist members who visit those locations. Concierge Service model also allows members to contact Aetna via web chat, through a feature on Aetna Navigator.

Attachments:

3.2.5.1.18 Do customer service representatives handle both member calls and provider calls?

Answer: We staff two separate teams to handle member and provider calls.

Attachments:

3.2.5.1.19 Can customer service representatives access claims status on-line in real-time?

Answer: Yes.

Attachments:

3.2.5.1.20 Identify the typical work and training experience required of your customer service and claims processing supervisors and/or managers.

Answer: We hire representatives who have a minimum of 3 to 5 years experience in health care, social services, education, and/or related fields, with a heavy emphasis on customer service. This type of prior job experience fits in with how a representative's job relates to our vision and strategy. Our minimum education requirement for CSRs is a high school Diploma or GED equivalent.

We require paper claim processors to have a high school diploma or general education degree. A minimum of one year of data entry or related experience and/or training is desired. Computer and ten key experience is required. Individuals must be detail oriented and have the ability to work independently in a demanding and fast-paced environment. Please note that paper claim processors do not answer member calls.

When a new CSR is in training, they experience an increased number of service observes. During service observes the CSR in training sits with an experienced CSR to observe and listen while they take incoming member calls. As the newer CSR progresses, these service observes are lengthened to include "talk/type" sessions.

We do not consider the training completed until a CSR in training shows, for a minimum of two weeks, that they can complete all assigned duties with a quality level that meets or exceeds our designated standards.

Health Concierge

Health concierges receive a much broader training that provides a thorough understanding of all products, services and clinical programs. We include information about the State's culture, preferences and benefit offerings, even if offered through another carrier, in our training curriculum. This includes instructions for transferring calls to other vendor partners so that service is as seamless as possible for the member. This training, along with our best-in-class customer service technology, enables the health concierges to deliver a consultative, simplified service experience for the members, and full integration with the clinical teams.

Attachments:

3.2.5.1.21 What is the current ratio of customer service representatives to supervisors and managers.

Answer: 1:15 ratio of supervisor and senior lead representative to representatives

Attachments:

3.2.5.1.22 What is the ratio of customer service representatives to covered lives in your organization's programs?

Answer: The ratio of pharmacy CSRs to members is 11,310:1. Ratio for concierge to members is about 1:5,500, as typically the membership in the Concierge team would average 120,000 members, depending on the membership of the clients in the team, the number of clients could range from about five to ten clients in serviced in the concierge team. For the State of Alaska it would comprise over 65% of the membership in the team. There would be about 16 Concierge in the team that would have State of Alaska as a "primary" assignment within the team, others in the team may serve as a backup.

Attachments:

3.2.5.1.23 Describe when and how a caller's recurring or unresolved issue is elevated to a supervisor/manager for resolution. Explain how you measure the success of this process over time.

Answer: If a CSR cannot resolve the issue, they will speak to their supervisor, and if need be, transfer the call so the supervisor can talk directly to the member. All CSRs receive in-depth training prior to answering member calls. In addition they have online access to our system which includes access to plan design information, member profiles, utilization history, order status, eligibility status, claim status and pharmacy locations.

For inquiries that require follow-up and for those that cannot be resolved at the time of the call, CSRs use an online workflow management tool. The tool tracks the status of the activity, resolution, volume and overall turnaround time. In addition, they use a separate workflow process for any escalated issues. We identify an escalated issue as a situation where the member is out of medication or has a limited days' supply on hand. We special attention in these cases and make every effort to resolve the issue within 24 hours of the request. We will also provide updates to the member so they are aware of what we are doing to ensure that they do not experience a disruption in therapy.

We document and track all escalated complaints. A weekly trend report is reviewed and monitored with the Senior Management Member Experience Team. Trends are identified, root cause analyses are conducted, and process improvements are recommended.

We provide monthly reports on trends by business unit and compare trends to those of previous months and years. Each business unit maintains indicators of its top five complaints, which fluctuate based on the implementation of new plan designs, the release of new generic products, and the incorporation of new programs.

Attachments:

3.2.5.1.24 Provide the turnover rate of your call center representatives for the past three calendar years.

Answer: Annual turnover rates for pharmacy-specific CSRs are as follows:

- 2010: 18.4 percent
- 2011: 5.0 percent
- 2012: 5.0 percent

This percentage excludes team members who terminated within the first 90 days of employment.

Attachments:

3.2.5.1.25 Using current calendar year data, please provide the following information for each customer service office that will have responsibility for this account:

- Answer Speed
- Wait Time
- Abandonment Rate
- ID Card Issuance (timeliness)

Answer: In 2012, our APM Member Services team achieved the following results:

Answer Speed: 22 seconds

Wait Time: 88.9% of calls answered within 30 seconds

Abandonment Rate: 1.7%

ID Card Issuance(book of business: 7-10 business days.

The Concierge standard results that will have responsibility for the State are:

Average Speed of Answer (ASA): 30 seconds
 Abandonment Rate: 2.5%
 Telephone Service Factor: 80% in 30 seconds

Attachments:

3.2.5.1.26 Please indicate whether customer service representatives have on-line access to the following information and/or the ability to edit or update data by providing a Yes or No response below.

	On-Line access	Ability to edit or update data
Member Eligibility	1: Yes	1: Yes
Date of Initial call	1: Yes	2: No
Date Inquiry Closed	1: Yes	2: No
Representative who handled the call	1: Yes	2: No
Call Status	1: Yes	2: No
If and where issue was referred for handling	1: Yes	1: Yes
Reason for call	1: Yes	1: Yes
What was communicated to member	1: Yes	1: Yes
Claims History-Status	1: Yes	1: Yes
Benefit Descriptions	1: Yes	1: Yes
Status of Questions-Complaints	1: Yes	1: Yes
Status of Pre-certification Requests	1: Yes	1: Yes
Mail-order delivery status	1: Yes	1: Yes
Specialty pharmacy delivery status	1: Yes	1: Yes
Referral Status	1: Yes	1: Yes
Price a prescription	1: Yes	1: Yes
Cost-savings opportunities (e.g., using generic alternatives to brands)	1: Yes	1: Yes
Disease Specific Education Information	1: Yes	1: Yes
ID Card Orders	1: Yes	1: Yes
Specify Other Features	1: Yes	1: Yes

Detail: CSRs have access to all retail, mail and specialty claims data and use the same online system as our network pharmacies. The following information is also available to CSRs online:

- Notes from the pharmacist recorded at time of fill
- Covered drugs
- Pharmacy location(s) access by zip code
- Explanation of benefit
- Literature fulfillment information, including the status of any literature being mailed to a member
- Web registration status
- Targeted member communications
- Accumulator balances

Additionally, our CSR have access to a member-specific comment history screen. The narrative information entered becomes a permanent part of the member's record. All CSRs are able to access the screen for future service inquiries.

Our CSRs also have access to an online reference manual, where Invesco plan-related information is

kept current and stored. This electronic manual allows the CSRs to see sample communications provided to members, information regarding new initiatives, procedures specific to the Invesco program and other reference information.

Attachments:

3.2.5.1.27 When ordering a prescription refill, can the member reach a customer service representative without redialing into a new number?

Answer: Yes.

Attachments:

3.2.5.1.28 Describe your process for written inquiries.

Answer: Written correspondence from members is date-stamped and routed to a research team for resolution. A notation of each inquiry is made in our system for tracking and management purposes. Every written inquiry is assured a response within 10 business days; however, a simple inquiry can often be handled by phone within 2 business days from our receipt of the inquiry. We can provide reports to the State to quantify and detail inquiry responses.

Attachments:

3.2.5.1.29 Do you send a letter of acknowledgment for written inquiries prior to the issue resolution?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.5.1.30 In the past calendar year, what was your average turnaround time for responding to written inquiries? (days)

Answer: Every written inquiry is assured a response within 10 business days; however, a simple inquiry can often be handled by phone within 2 business days from our receipt of the inquiry.

Attachments:

3.2.5.1.31 Describe other dedicated or customized customer services you are prepared to offer the State.

Answer: We are offering our Aetna Concierge customer service to the State.

This provides highly-skilled benefits experts to serve as single-points-of-contact to simplify and streamline the member experience. Using a consultative approach to address member needs, Aetna Concierges:

- Answer questions about all of a member's Aetna benefits, as well as any non-Aetna employer-sponsored benefits that may be available
- Transfer the member's call to a different area when necessary and remain on the line to make sure the connection is made
- Help the member learn about our online tools and health information resources, and provide guided support, as necessary
- Let members know when another one of our programs is trying to reach them, such as disease

management, and offer to connect them

- Listen holistically to fully understand the member's needs, including triggers for clinical engagement opportunities, unasked questions and implicit needs the member may have, and teachable moments that afford our Concierges the opportunity to educate and empower them
- Focus on opportunities to make the right connection at the right time, ensuring members are linked to relevant resources when they need them most

All our Concierges use a 360-degree member dashboard to quickly and effectively access information about:

- The member's plan
- Programs in which the member is enrolled or available to join
- Disability and absence management information (if available)
- Available incentive programs

As an example, your employee receives a doctor bill that was much higher than expected. With Aetna Concierge, the employee can call the number on the back of the ID card and talk to a service professional who will not only explain how the plan works, but can even call the doctor to work out any problems.

Additionally, all Aetna Concierges use the Aetna Social Learning Tool. This tool is customized for the State and regularly updated to reflect specific information on all benefit and clinical programs that are available to your employees. Aetna Concierges use this tool to deliver personalized service that is tailored to meet the unique needs of your employee population based on the products, programs, and services that are available to them at Aetna and through any employer-sponsored third-party vendors.

Attachments:

3.2.5.2 Pharmacist Availability

3.2.5.2.1 How many pharmacists are available to answer member questions?

Answer: There are 65 pharmacists dedicated to our pharmacy call center.

Attachments:

3.2.5.2.2 How many pharmacists are available to answer member question 24 hours per day, 7 days per week, 365 days per year?

Answer: There are 65 pharmacists dedicated to our pharmacy call center. Members can reach a pharmacist 24 hours a day, 7 days a week, 365 days a year.

Attachments:

3.2.5.2.3 If pharmacists are not available 24 hours per day, 7 days per week, 365 days per year, to answer member questions, what are the hours of operation for the pharmacy customer service unit?

Answer: Pharmacists are available 24 hours a day, 7 days a week, 365 days a year.

Attachments:

3.2.5.2.4 Do you have a separate pharmacy customer service unit dedicated to answering questions specific to Specialty Medications and the Specialty Pharmacy?

Answer: Yes. We staff a specially trained team of specialty CSRs located in Orlando, FL.

Attachments:

3.2.5.2.5 If you have a separate pharmacy customer service unit dedicated to answering questions specific to Specialty Medications and the Specialty Pharmacy, how many pharmacist customer service representatives are dedicated to answering questions specific to Specialty Medications and the Specialty Pharmacy?

Answer: We staff 102 CSRs dedicated to specialty pharmacy Member Services.

Attachments:

3.2.5.2.6 Do you have pharmacists dedicated to answering physician calls versus member calls?

Answer: 2: No

Detail: The same pharmacists answer both members and physicians calls.

Options:

1. Yes
2. No

Attachments:

3.2.5.2.7 How many pharmacists are dedicated to handling calls from physicians?

Answer: There are 65 pharmacists dedicated to our pharmacy call center who handles both member and physician calls. There are also 18 pharmacists dedicated at Aetna Specialty Pharmacy member services who handle both member and physician calls.

Attachments:

3.2.5.2.8 What percentage of pharmacy customer service calls is recorded?

Answer: 100%

Attachments:

3.2.5.3 Specialty Drugs

3.2.5.3.1 How many customer service representatives are dedicated to answering questions specific to Specialty Medications / Pharmacy?

Answer: We staff 102 CSRs dedicated to specialty pharmacy Member Services.

Attachments:

3.2.5.3.2 What percentage of all your customer service representatives are dedicated to answering questions specific to Specialty Medications / Pharmacy?

Answer: We staff a separate team of 102 specially trained CSRs to answer questions specific to specialty drugs. This CSR team is 100% dedicated to answer specialty drug questions.

Attachments:

3.2.5.3.3 What is the composition of staffing in your Specialty organization? Include the clinical support available for patients through your Specialty organization, including the number of nurses and pharmacists on staff at the proposed pharmacy(-ies).

Answer: Aetna Specialty Pharmacy® currently employs the following full-time staff:

Senior Executives - 1
Administration - 1
Sales - 22

Marketing - 5
Finance - 6
IT - 6
Legal Regulatory/Government Affairs - 1
Account Management - 4
Physicians - 8
Nurses - 46
Customer Service Representatives - 102
Pharmacists - 18
Pharmacy Technicians - 20
Reimbursement Specialists - 52
Data Analysts - 7
Researchers - 4
Total Employees - 268

Attachments:

3.2.5.3.4 What percentage of calls, answered by the dedicated specialty customer service unit, is recorded?

Answer: We record 100 percent of specialty CSR member phone calls. We record these calls for quality and training purposes only.

Attachments:

3.2.5.3.5 What are the minimum hiring standards and training for your CSRs regarding Specialty drug patient issues?

Answer: Our CSR hiring criteria requires all new hires to have at least a high school diploma and customer service experience. Where allowed by law, we impose a mandatory pre-employment drug screening. We provide CSRs with an initial two-week training that covers:

- Organizational structure
- Standard operating procedures
- Policies and procedures
- Product offering training
- Product knowledge training
- Disease state knowledge training
- Manufacturer program offering/training
- Current legislation-federal, state and regional
- Aetna Specialty Pharmacy team culture training

We then have CSRs undergo periodic mandatory training that includes:

- Quarterly customer service training
- Product knowledge training on every new drug and/or protocol
- Internet technology/new application training as new features are unveiled
- New contract training as new agreements are implemented

We engage in multi-faceted quality assurance testing. This not only ensures that we are treating all members politely and helpfully, but also that we are keeping high overall member satisfaction. CSRs participate in a minimum of eight individual quality assurance checks each month.

Side-by-Side Monitoring

Two of these checks involve a side-by-side monitoring session in which a supervisor or quality analyst sits at the CSR's station and listens to a live phone conversation. We evaluate performance based on the CSR successfully:

- Initiating a friendly greeting when beginning the call
- Securing the call by verifying the member's name, date of birth, phone number and account information
- Exhibiting empathy and careful listening skills
- Demonstrating knowledge by providing helpful and accurate answers to questions
- Closing the call with a friendly comment

Silent Monitoring

We employ these same criteria for four additional monthly quality assurance checks known as silent monitoring. During silent monitoring, the CSR is unaware that their supervisor is listening. These monitoring sessions result in CSRs receiving constructive feedback from their supervisor.

We further monitor each CSR's customer service proficiency through a monthly scorecard that grades:

- Adherence
- Speed of answering calls
- Number of lives touched
- Correctly fulfilling customer requests
- Overall quality

Attachments:

3.2.5.3.6 What are your minimum hiring standards for a Non-Clinical Specialty-Specific Customer Service Representatives?

Answer: Our CSR hiring criteria requires all new hires to have at least a high school diploma and customer service experience. Where allowed by law, we impose a mandatory pre-employment drug screening.

Attachments:

3.2.5.3.7 What are your minimum hiring standards for a Non-Clinical Specialty-Specific Customer Service Representatives?

Answer: Our CSR hiring criteria requires all new hires to have at least a high school diploma and customer service experience. Where allowed by law, we impose a mandatory pre-employment drug screening.

Attachments:

3.2.5.3.8 If your Specialty Service Center conducts outbound calls to patients, please describe the nature of these calls.

Answer: Under the headers below, we have described some of the outbound telephone calls we make to members who fill specialty drugs through Aetna Specialty Pharmacy.

Member Intake

When we receive orders, we call members to verify information including gender, height, weight, age, therapy, dosage, allergies and shipping address. We also find out if members have any special needs, such as help understanding their therapy. We enter all of this information into the member's electronic medical record (EMR).

Helping with Payments

We help members stay on top of their payments for any out-of-pocket costs. If an outstanding balance persists, we contact them and re-confirm their payment method. When appropriate and available, we help members pursue copay assistance programs. These include pursuing programs that are based on need as well as non-needs based programs, such as manufacturer copay assistance.

Confirming Orders

We call members, as well as their prescribing physicians, to confirm delivery. We also confirm the shipping address and whether or not a signature release is required. We also review with the member any copay or coinsurance amount due and obtain a payment method.

Active Refill

Through our active refill service, we proactively contact members seven days before their refill is due. During active refill, we monitor compliance and confirm delivery. We verify the member is still taking their medication, confirm their dosage and ask if they are experiencing any unmanageable side effects. At time of refill, we offer the member the opportunity to speak with a nurse or pharmacist to address any therapy-related questions or concerns.

Specialty Health Care Management

When we identify that a member needs enhanced clinical support, one of our nurses conducts an assessment call. During the assessment call, the nurse will:

- Confirm treatment is appropriate
- Verify the member is able and motivated to succeed
- Understand the member's risk for non-compliance
- Review the member's medical history (including co-morbidities)
- Provide clinical support resources to resolve identified knowledge gaps

The nurse coordinates with the physician's office and provides additional education and support, as needed, to implement an effective care management strategy. The nurse establishes a call schedule with the member to begin the coaching relationship. We tailor the frequency of these calls to how much support the member needs.

Our nurses briefly assess members during each call to determine how their therapies are progressing. This is significant because members taking specialty drugs often experience varying side effects that may take weeks or months to take effect. If the member's condition steadily improves, we know that the original care plan is working. If we see the member's condition stays the same or worsens, we may adjust the call frequency and care plan.

Attachments:

3.2.5.3.9 If your Specialty Service Center conducts outbound calls to physicians and/or case managers, please describe the nature of these calls.

Answer: We proactively reach out to physicians to encourage referrals to Aetna Specialty Pharmacy. We also reach out to physicians at multiple points during the dispensing process, as appropriate:

Proactively Reaching Out To Physicians

We encourage providers to refer members to Aetna Specialty Pharmacy® for specialty drugs and personalized support services. We send communications and call providers to inform them of our high-touch services and the benefits of ordering through Aetna Specialty Pharmacy. We also offer

customized physician welcome packets that explain:

- The advantages of using Aetna Specialty Pharmacy
- The available support services
- How to access support

We also maintain provider directed online resources. Through our website, providers can access helpful information about our services and print medication request forms. Not only can providers use our online tools to learn how to order specialty drugs, but they can also learn how to access follow-up support and tailored clinical monitoring.

Reaching Out During Dispensing

If during the dispensing process we find that an order is missing necessary information, we reach out to the prescribing physician to get an acceptable prescription order. If at any time members report side effects or trouble staying on track with their therapy, we offer the member coping advice and then contact the prescribing physician to discuss:

- The member's concerns
- The suggested intervention
- Whether the member might benefit from a change in their medication, dose or therapy schedule

During the pharmacist review phase of dispensing, the pharmacist reviews the prescription image and contacts the prescribing physician if there are any concerns. During this conversation, the pharmacist and physician discuss the member's prescription and determine if any intervention is necessary.

Attachments:

3.2.5.3.10 Are your patient management programs supported by pharmaceutical manufacturer revenue in any way?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.5.3.11 If your patient management programs are supported by pharmaceutical manufacturer revenue in any way, please describe.

Answer: We leverage manufacturer resources to ensure members receive the best possible care. We work with them to receive education on specialty drugs, proper administration and utilization through a variety of business and clinical stratified sessions. Manufacturers may provide continuing educational unit (CEU) classes as well as general product and disease state training for our specialty staff.

We also provide manufacturer educational materials for our members, physicians, caregivers and staff to educate them on specialty therapies. Some manufacturers request we send product materials to members with specialty drug shipments. Depending on the size of the materials, we may send the

materials with the shipment at no cost to the manufacturer (i.e., Business Reply Card). In other instances, we may require a contract and a fee-for-service agreement.

Attachments:

3.2.5.3.12 Provide a brief description of how existing specialty drug patients would be transitioned over to your Specialty Pharmacy seamlessly, including those patients whose medication is not considered a specialty drug by client current vendor and those taking medications with limited distribution rights.

Answer: For members whose prescriptions are transitioning to Aetna Specialty Pharmacy®, we work with the outside vendor to obtain necessary information. We smoothly transition all members without disrupting therapy, including those where a health care professional administers the specialty drug in the provider's office. Our transitioning process involves:

- **Data Transition File** - We send a data transition Microsoft® Excel spreadsheet to the outside provider, providing a template to enter required member data.
- **Multiple Conference Calls** - We share multiple conference calls before the actual transfer. We identify high-touch members, agree on a transition date and prioritize members with fill-dates closest to the go-live date.
- **Discuss High-Touch Members** - We hold a conference call with clinicians from transferring pharmacies to discuss high-touch members (e.g., required supplies and time of day they prefer to receive deliveries).
- **Contact Prescribing Physicians** - Our pharmacists may contact prescribing physicians to obtain a new member prescription to facilitate a swift transition.
- **Contact Members** - We send each transitioning member a notification letter and welcome packet. These materials include service start date, instructions with the first shipment, a description of our services, FAQs and tips for success. We begin making member notification phone calls one week after members receive their welcome packet. Our nurses directly contact all high-touch members.
- **Verify Prescription Receipt** - We perform a review to confirm receipt of all transitioning members' prescriptions.

Limited Distribution

While members can receive most specialty drugs through Aetna Specialty Pharmacy®, there are certain specialty drugs with limited distribution. If we receive an order for any of these drugs, we transfer the order to a participating pharmacy where they are available and inform the prescribing physician and member.

Attachments:

3.2.5.3.13 Please respond to the following questions noting whether each method is available to 1) contact a mail order/specialty pharmacist, 2) submit inquiries to the customer service team and 3) interface with the applicable nurse line.

	Via email	Via live phone conversation	Via phone messaging	Via fax
Contact a mail order/specialty pharmacist:	1: Yes	1: Yes	1: Yes	1: Yes
Submit inquiries to customer service team:	1: Yes	1: Yes	1: Yes	2: No

	Via email	Via live phone conversation	Via phone messaging	Via fax
Interface with applicable nurse line:	1: Yes	1: Yes	1: Yes	2: No

Detail:

Attachments:

3.2.5.3.14 Attach an example of your proposed member satisfaction survey tool and label it “Member Satisfaction Survey”

Answer: 1: Provided

Detail:

Options:

1. Provided
2. Not Provided

Attachments: [Question 3.2.5.3.14 Member Satisfaction Survey.pdf](#)

3.2.5.3.15 Detail your member satisfaction survey methodology, including: member selection, details on minimum number of respondents to achieve statistical significance, mode of communication (telephonic or mail) and calculations used to determine the final satisfaction score.

Answer: We measure overall member satisfaction using our telephone-based Aetna Performance Tracking Member Satisfaction Survey. The survey is conducted continually throughout the year using a random sample of 6,400 members. Survey topics include member satisfaction with claim processing, member services and the health plan in general. The survey focuses on the following target areas:

- > Overall satisfaction with the health plan
- > Satisfaction with the plan coverage and benefits
- > Satisfaction with Aetna's network
- > Satisfaction with the information provided by Aetna
- > Satisfaction with our claims process
- > Satisfaction with the enrollment process
- > Satisfaction with member services

DSS Research, an independent market research and consulting firm based in Fort Worth, TX, administers our Aetna Performance Tracking Member Satisfaction tool. Survey results are distributed internally within the health plan, quarterly at the national level, and annually at the regional and service center levels. Customers will be provided with a topline summary of the survey results upon request.

Overall satisfaction was 90 percent among APM members in 2011.

Attachments:

3.2.5.3.16 Indicate your willingness to include in the selection of respondents for the survey, those members that have utilized mail order services, specialty services and live member call center services. Describe how your methodology will accommodate this request.

Answer: In addition to our Aetna Performance Tracking Member Satisfaction Survey, we also conduct satisfaction surveys for our mail order and specialty pharmacy providers. Surveys are provided to a random sample of members for each facility as described below:

Aetna Rx Home Delivery conducts quarterly member satisfaction surveys. The mail service member surveys are intended to be a tool that is used internally to evaluate our processes, gauge members' perceptions of our services and generate ideas for new and improved services and features.

Aetna Rx Home Delivery's most recent telephonic member survey results indicated that 92 percent of members using Aetna Rx Home Delivery are completely or very satisfied with their service.

Member satisfaction is also of utmost importance at Aetna Specialty Pharmacy and is recorded in the member's electronic medical record (EMR) during any interaction that takes place between the member and our clinical staff. Member satisfaction is also recorded by the refill technician or nurse case manager during the active refill process. If at any time a member expresses dissatisfaction, the Aetna Specialty Pharmacy representative speaking with the member will record the issue in the member's EMR then, if necessary, transfer the member to the Quality Assurance department to review and amend any service failure.

Aetna Specialty Pharmacy also proactively measures member satisfaction each business quarter through telephonic surveys performed by an outside firm. They evaluate processes, gauge members' perceptions of services and generate ideas for new and improved services and features.

Aetna Specialty Pharmacy's member survey data reflects that approximately 96 percent of members are satisfied with their overall Aetna Specialty Pharmacy experience.

Attachments:

3.2.5.3.17 Indicate your willingness to modify the existing survey tool to meet the needs and requests of the State.

Answer: Yes. We are willing to modify the existing survey tool to meet the State of Alaska's unique needs. We would look to discuss the specific modifications in greater detail.

Attachments:

3.2.5.3.18 Indicate any costs for a second and/or subsequent survey in a given year if requested by the State on the rate sheet.

Answer: We can have surveys conducted annually or semiannually at the State's request. When a second survey is administered, the cost is \$10,100 per survey (\$20,200 in total).

Attachments:

3.2.5.3.19 Please provide Calendar Year 2011 (CY2011) book-of-business (BOB) member satisfaction results.

Answer: Overall satisfaction was 90 percent among APM members in 2011.

Attachments:

3.2.6 Claims Processing

3.2.6.1 Offeror must provide an Administrative Manual for the pharmacy program that provides the information necessary for the State or its designee to operate the plan. The manual must be in a mutually agreed upon format and the necessary information within the manual. The manual must be provided at completion of the implementation and must be updated on an ongoing basis by the Account Management team. This manual must be provided as part of the base administrative fees with no additional cost to the State.

Answer: We will provide the State of Alaska with all necessary information for operating the pharmacy program. However, we would like the opportunity to discuss your request in greater detail to better understand your requirements.

Attachments:

3.2.6.2 Describe how you will provide a dedicated system of claims administration.

Answer: Our new, more robust claim platform is called RxClaim. We have spent the past year testing all scenarios to ensure that the new claim system is processing claims accurately. This system provides advanced programming abilities that we have not had in the past. RxClaim gives us more flexibility in our plan designs, benefit set-ups and clinical programs so that we can offer additional solutions that meet your pharmacy needs.

Pharmacies in the APM National Retail Pharmacy Network are required to have online access to the claim system. Member eligibility flows from the mainframe to the claim system, where it becomes available for online processing within 24 to 48 hours.

Once a claim is processed, it is automatically edited against a single member profile. The system provides the dispensing pharmacists with eligibility and plan coverage, including copayment or coinsurance amounts, usually within three seconds. Prospective and concurrent drug utilization review (DUR) are also performed on each claim to help the pharmacist identify potential problems.

In the event of any issue, pharmacists are instructed to call our toll-free Pharmacy Help Desk, where customer service representatives (CSRs) are available 24 hours a day, 7 days a week, 365 days a year.

Attachments:

3.2.6.3 Does your claim system have a common database for edits, pricing, production of EOBs and reporting?

Answer: Yes.

Attachments:

3.2.6.4 Explain your capability to accept electronic claims directly from providers and claim clearinghouses on behalf of members.

Answer: Pharmacies in the APM National Retail Pharmacy Network are required to have online access to the claim system. Claims are automatically and electronically adjudicated at the point of care.

Attachments:

3.2.6.5 What are the hours/days of operation for the claims processing unit?

Answer: Over 99 percent of claims are processed automatically and immediately at the point of care. When members fill prescriptions at non-network pharmacies, they pay the full cost at the point of care and send in a paper claim to the Direct Member Reimbursement (DMR) unit. The hours of operation for this unit are 8:00 a.m. to 4:30 p.m. CT.

Attachments:

3.2.6.6 How many claims processors will be dedicated to the State's plans?

Answer: We have 47 staff members who process paper claims in our DMR unit.

Attachments:

3.2.6.7 What are the average years of experience for your claim processing staff?

Answer: Claim processors have an average of five years of experience. Claim processing department supervisors have an average of nine years of experience.

Attachments:

3.2.6.8 What is the average length of employment for claim processing staff?

Answer: The average tenure of claim processors is five years.

Attachments:

3.2.6.9 Describe your training program for claims processing staff?

Answer: The program for the training and development of claim processors begins with the selection process. We select candidates based on a minimum education level of a high school diploma or GED and prefers candidates with experience in data entry or claims processing.

Once selected, all candidates complete an intensive New Hire Training program designed and administered by our paper claim department trainer. The trainer provides policy and procedural information in a classroom environment and oversees the adjudication of claims. The Quality Audit Department considers the first 90 days of claim processing as the training period for new processors. Trainees are audited for 90 days at 50% of processed claims. Once training is completed, the processor is subject to the standard ongoing performance audit at 4% of claims. The trainer also serves as a subject matter expert and is available to the processors each business day. Please note that if the supervisor deems it appropriate to continue a 50% audit after the processor's 90-day training period, the audit team will continue as directed by his/her supervisor.

Once training is completed, the processor is subject to ongoing performance management standards and monthly one-on-one feedback sessions with the supervisor.

The claims department trainer is available to conduct up-training and works in conjunction with the supervisor and the processor for performance improvement to build the processor's skill level. The training department also works closely with the quality and claims processing staff to develop departmental procedures.

Based on performance over the course of time, processors are eligible for a departmental in-line promotion.

Attachments:

3.2.6.10 Explain any incentive programs you employ to retain competent claim processing staff?

Answer: We have paper claims department wage levels periodically reviewed for equity in the marketplace based on similar skill requirements. The three levels of Processor I, Processor II and Processor III, as well as Clerk, Trainer/Subject Matter Expert, Specialists, Analysts, Advisor, Manager, and Supervisor positions, reflect specific job responsibilities, complexity, and skill levels, providing distinct opportunities for career development.

Each Processor level and clerical position has defined skill requirements, responsibilities with corresponding productivity, and quality standards. Clear and specific goals, standards, and measurements form the basis of development and recognition programs in the paper claims department. Merit wage adjustments are considered annually based on overall employee performance.

Attachments:

3.2.6.11 What is the average productivity of the claims approvers on a per approver per day basis?

Answer: DMR claim processors process approximately 19 claims per day. The entire DMR unit processes approximately 900 claims per day. It is important to note that paper claims account for less than 1 percent of all pharmacy claims we receive.

Attachments:

3.2.6.12 How does the claim office handle periods of significantly increased workload?

Answer: Should claim activity exceed forecast, we will reposition staff to support teams needing coverage. We continually monitor volume and staffing.

Attachments:

3.2.6.13 How does the claim office's performance for the past two years compare with the claim turnaround time goal?

Answer: 7: Other. Indicate: [Our turnaround time goal is to process 90 percent of paper claims in 14 days. Through the third quarter of 2012, we processed 98.09 percent of paper claims in 14 days. In 2011, we processed 93.66 percent of paper claims in 14 days.]

Detail:

Options:

1. Up by 5--10%
2. Up by 11--15%
3. Up by 16--20%
4. Down by 5--10%
5. Down by 11--15%
6. Down by 16--20%
7. Other. Indicate: [Text]

Attachments:

3.2.6.14 In the claim processing office that will have payment responsibility for this account, what are your standard targets and average statistics for the following?

	Standard Target	Average Statistics
Claims processing turnaround time	90% in 14 days	98.09% in 2012
Answer speed	Not applicable because DMR claim processors do not answer member calls.	Not applicable because DMR claim processors do not answer member calls.
Wait time	Not applicable because of DMR claim processors do not answer member calls.	Not applicable because of DMR claim processors do not answer member calls.
Abandonment rate	Not applicable because DMR claim processors do not answer member calls.	Not applicable because DMR claim processors do not answer member calls.
Payment accuracy	97%	99.23% in 2012
Financial accuracy	97%	99.62% in 2012
Member Satisfaction	Not applicable because DMR claim processors do not answer member calls.	Not applicable because DMR claim processors do not answer member calls.

	Standard Target	Average Statistics
First Call Resolution	Not applicable because DMR claim processors do not answer member calls.	Not applicable because DMR claim processors do not answer member calls.

Detail:

Attachments:

3.2.6.15 What clinical staff is available as a resource to the claims processors?

Answer: Should the DMR team have any questions regarding the paper claims submitted, they can work with their management team, as well as our Clinical Management team, including our Prior Authorization Unit.

Attachments:

3.2.6.16 Did you develop the claims system internally? If you did not develop your system internally, which firm developed it and when?

Answer: CVS Caremark developed the RxClaim system. We have supported real-time point-of-service (POS) transaction processing since the late 1980s, linking plans to pharmacies at the time that a prescription is dispensed, and introduced its state-of-the-art, automated mail service system in 1996.

Attachments:

3.2.6.17 Are all claims processed on a single claims system?

Answer: We are currently processing claims on two separate claims platforms. Our primary claims system has been Aetna Pharmacy Management Claims Adjudication System (APMCAS), which we are in the process of phasing out. We began implementing customers on our new claims platform, RxClaim in 2012. We anticipate that by early 2015, all customers will have pharmacy claims adjudicated on RxClaim.

Attachments:

3.2.6.18 How are changes to the claims system implemented?

Answer: The functionality and flexibility within our suite of systems accommodate virtually any plan designs without changes to the system software. In the event that software enhancements are needed, our IS staff can implement them.

To minimize the need for customer-specific software changes, our account teams collaborate with customers before, during and after implementation to ensure that plan design terms and expectations are clearly defined, tested and approved by the State of Alaska before becoming effective. As such, the State of Alaska will be included in every step of transitioning its members to us, including pre- and post-implementation testing for quality assurance.

Attachments:

3.2.6.19 When was the last update to your claim processing system, and what changes were implemented?

Answer: There are six major software releases per year. Changes with impacts to key systems such as adjudication, which require additional levels of testing and integration work, are implemented in these major releases after the completion of regression testing, risk analysis and implementation planning with on-site staff support from release management, application development and operation teams. Minor releases, those without online impacts or cross-application dependencies, are implemented at least monthly, after extensive testing and planning.

Attachments:

3.2.6.20 Are system changes planned in the next two years? If there are system changes planned, please indicate the nature of the changes.

Answer: No major system changes, beyond the regular enhancements described above, are planned for the RxClaims system.

Attachments:

3.2.6.21 Does your claims system have the capability to process network and non-network claims on the same system?

Answer: Yes. Network claims process automatically and immediately at the point of care. When members fill prescriptions at non-network pharmacies, they submit paper claims to the DMR unit. This unit then processes the claim on the same claim platform.

Attachments:

3.2.6.22 Please provide a claims workflow diagram from date of receipt of a claim through release of payment and reporting to plan sponsor.

Answer: We have included the requested information in our Samples and Brochures section of this proposal.

Attachments: [Quesiton 3.1.3.2 - Paper Claims Flow Chart.doc](#)

3.2.6.23 Confirm that you are able to pay claims in accordance with provider contracts held by the State and not your network.

Answer: Confirmed. We can pay claims in accordance with the laws of the State of Alaska.

Attachments:

3.2.6.24 For what period of time are claims records maintained after records are purged from the system?

Answer: Claim history is archived on tape for at least seven years, unless there are any laws that require a longer timeframe for the retention or maintenance of hard copies. We comply with all legal requirements for the storage of claim information. We maintain detailed claim history online for a minimum of 36 months, then archive the history to tape. We maintain summary claim history online indefinitely. Claims paid by our DMR unit are integrated with data for claims that are processed online at the point of care. The integrated data are maintained online for 36 months and then archived.

Attachments:

3.2.6.25 Does your claims system automatically match claims with predetermination information, both for in- and out-of-network?

Answer: Yes. The claim system automatically edits the claim against a single member profile. This occurs immediately for network pharmacies. This occurs retroactively for DMR paper claims.

Attachments:

3.2.6.26 Confirm that you are able to pay claims in accordance with provider contracts held by the State and not your network.

Answer: We can pay claims in accordance with the laws of the State of Alaska. Out-of-network pharmacies cannot be reimbursed for prescriptions by us because there is no contractual arrangement upon which to base such reimbursement.

For out-of-network claims, members typically pay cash at the point of service and submit paper claims for reimbursement. These claims are then reimbursed according to your specific plan parameters.

Attachments:

3.2.6.27 For what period of time are claims records maintained after records are purged from the system?

Answer: Claim history is archived on tape for at least seven years, unless there are any laws that require a longer timeframe for the retention or maintenance of hard copies. We comply with all legal requirements for the storage of claim information. We maintain detailed claim history online for a minimum of 36 months, then archive the history to tape. We maintain summary claim history online indefinitely. Claims paid by our DMR unit are integrated with data for claims that are processed online at the point of care. The integrated data are maintained online for 36 months and then archived.

Attachments:

3.2.6.28 What percentage of claims are auto-adjudicated for contracted Alaska providers? For non-contracted?

Answer: When your members fill drugs at network pharmacies in Alaska, 100 percent will be automatically adjudicated at the point of care. When members fill drugs at non-network pharmacies, they will pay the full cost at the pharmacy and then submit a paper claim form for reimbursement.

Attachments:

3.2.6.29 Describe your organization's success in increasing auto adjudication rates for Alaska providers.

Answer: As long as a pharmacy participates in our network, 100% of their submitted claims are automatically adjudicated.

Attachments:

3.2.6.30 Is customer/member services housed with the claims paying unit?

Answer: The Member Services team is separate from the DMR unit.

Attachments:

3.2.6.31 What was your percentage of turnover for claims examiners in 2011 and 2010 at the claim office(s) that would be assigned to this account.

Answer: Our DMR unit experienced a turnover rate of less than 10 percent in 2011 and 2010.

Attachments:

3.2.6.32 Which of the following descriptions would best characterize your claim adjudication process?

Answer: 1: System-based adjudication with claims specialist oversight

Detail:

Options:

1. System-based adjudication with claims specialist oversight
2. Claim specialist adjudication with system-based claim tracking
3. Primarily claim specialist adjudication and tracking
4. Other: [Text]

Attachments:

3.2.6.33 What security measures are in place to ensure that reimbursements are issued to the proper party?

Answer: 3: Other: [Every customer receives a unique client code, which is attached to its Funder ID, preventing one group's experience from being charged to another. During adjudication, each claim is subject to a series of system edits to help ensure billing integrity.]

Detail:

Options:

1. Assignment signature required
2. Network provider automatically assigned
3. Other: [Text]

Attachments:

3.2.6.34 Will you accept liability for claim processor negligence? Fraud?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.6.35 Can you use an identifier other than the SSN?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.6.36 If an identifier other than SSN is used, is there an additional charge? If so, please indicate on the rate sheet.

Answer: 2: No

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.6.37 Explain whether you offer direct deposit of participant benefit reimbursement.

Answer: No. Paper claims are reimbursed by check.

Attachments:

3.2.7 Coordination of Benefits

3.2.7.1 Describe your current COB administrative procedures to ensure all claims are paid consistently in the correct order of benefit determination.

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

- During enrollment, many of our customers collect information about other coverage and share it with us.
- During the precertification process, our nurses ask about other coverage.
- Due to the cooperative nature of our relationship with network providers, hospitals and physicians routinely obtain other coverage information and submit it with the claim.
- In addition to the normal “other coverage” questions on our claim form, we ask if any other family members are employed and specific details.
- We send mailers to members with more than one dependent and members who turn 65.
- Registered plan members can provide us with updated COB information at any time using the Requests and Changes feature of Aetna Navigator, our secure member website.
- We exchange data with CMS (Medicare) regarding member eligibility and enrollment information. We exchange data on a quarterly basis. We update our verification files based on this information.

All claims submitted are screened for COB, even those where the member's current eligibility file does not indicate other coverage.

Identifying COB claims is a combination of system-automated processes and claim processor judgment. When other coverage is possible, the claim is pended online, and we send an EOB to the member requesting specific details. If the member does not respond within 45 days of sending the original mailer, we send a follow-up mailer to the member requesting the additional information. If we still do not obtain a response we would pay, pend, or deny the claim based on state regulation.

When other coverage information is obtained, we update the online family eligibility record to indicate primary/secondary/tertiary status. The system automatically presents a COB edit during claim processing when the eligibility file indicates that other coverage is primary. The notice includes details about the other coverage, which family members the other plan covers, the carrier, type of coverage and date of the last update.

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

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

Attachments:

3.2.7.2 Define the process, including who in your organization is responsible, for follow-up on possible COB opportunities.

Answer: Our COB approach is to determine the order of benefits for coordination prior to payment. We investigate any other primary benefits before issuing benefits.

Our claim processors handle claims with COB. We train them in both COB identification and investigation. We also identifying COB claims through our system-automated processes.

COB PROCESS

When other coverage is possible, we pend the claim online. We send an EOB to the member requesting specific details. If the member does not respond within 45 days of sending the original mailer, we send a follow-up mailer requesting the additional information. If we still do not obtain a response we pay, pend or deny the claim based on state regulation. If the information we receive does not seem plausible, we contact the provider or member to inquire about other coverage.

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

- Details about the other coverage
- Family members the other plan covers
- Carrier
- Type of coverage (e.g., medical only, medical-dental, etc.)
- Date of the last update

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

Attachments:

3.2.7.3 Explain the edits used in your system to identify potential COB cases on a continual basis.

Answer: All claims submitted are screened for COB, even those where the member's current eligibility file does not indicate other coverage. The system supports COB administration in several ways:

- The system has an online edit to warn the processor when accessing any family member's record for claims processing.
- The system notice or COB database includes details about the other coverage, such as:
 - Family members covered
 - Carrier
 - Date last updated
 - Pertinent facts about the other coverage such as effective date
- Depending on your plan or state legislation, the system automatically picks the type of COB administered.
- The system calculates the COB benefits and updates the member's claim records with some processor intervention. (Exception: Manual processing is required if you choose to offer the COB carve-out method.)

- Electronic and paper claims have a field to indicate with a yes or no whether the claim is a result of a work-related condition or injury. Our claims system will present an edit if the answer to this question is yes. In addition, there are diagnosis codes that the claims system will edit to determine if work related. For claims with these diagnosis codes, the system logic will present the processor with an edit indicating “claim may be accident/workmen's comp related”. On a prepayment basis, processors will review these claims which have an indication of potential occupational injuries or conditions. We deny claims identified as work-related. In addition, we add an online notice in the claims system to flag future related claims. If we suspect a work-related injury due to the diagnosis and time of occurrence, we pend the claim and request additional information from the employee, you and/or the provider.

Attachments:

3.2.7.4 Describe how you would fulfill the annual validation to identify other health insurance coverage requirement.

Answer: We have an annual validation process (AVP) in addition to a variety of ongoing ways to identify when members have other coverage. Our COB administration starts with the collection and maintenance of accurate information about other coverage. We exchange data with CMS (Medicare) regarding member eligibility and enrollment information. We exchange data on a quarterly basis. We update our verification files based on this information.

In addition, we have a variety of methods for gathering COB information on an annual and ongoing basis, including:

- During enrollment, the State may wish to collect information about other coverage and share it with us.
- During the precertification process, our nurses ask about other coverage.
- Due to the cooperative nature of our relationship with network providers, hospitals and physicians routinely obtain other coverage information and submit it with the claim.
- In addition to the normal “other coverage” questions on our claim form, we ask if any other family members are employed and specific details.
- We send mailers to members with more than one dependent and members who turn 65.
- Registered plan members can provide us with updated COB information at any time using the Requests and Changes feature of Aetna Navigator, our secure member website, at www.aetnanavigator.com.
- COB screening: We screen all claims for COB, even those where the member's current eligibility file does not indicate other coverage.

Attachments:

3.2.7.5 Confirm that you will coordinate COB information electronically with other vendors such as the medical provider, dental network, and health management provider, for their use in coordinating benefits.

Answer: Confirmed. We are a one stop shop for medical, pharmacy, dental and health management services.

Attachments:

3.2.7.6 Confirm whether you are able to handle internal coordination when a claimant is covered under more than one State benefit plan such as being covered as the member and also as a dependent.

Answer: Confirmed. We add a special handling indicator and notice on the member's file to indicate internal COB applies. We have detailed workflows for the processors on handling of these claims.

Attachments:

3.2.7.7 Describe how you will obtain coordination of benefits information to determine when case management might not be appropriate, such as when the plan is secondary to Medicare or other plans.

Answer: From a claim perspective, we follow the primary plan determination of medical necessity for length of stay. The information is obtained from the primary plan's explanation of benefits.

Our case managers obtain coordination of benefits information through the screening process. Screening identifies members who are appropriate for the program through a review of the member's current eligibility status and benefit plan, including a review of COB information. We close the case when the case manager verifies other insurance is primary and our plan is not at financial risk, and there is no obligation with the State to perform case management for the member.

Attachments:

3.2.7.8 Describe your use of computer edit checks or triggers to initiate COB.

Answer: Our claims system includes edits that identify when a member is eligible for other coverage, such as age limit edits for Medicare, to trigger COB. In addition, our claim system edits consider the following as potential indicators of other coverage to initiate COB:

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

Attachments:

3.2.7.9 Is COB history stored online?

Answer: Yes. Our eligibility file provides a field that allows documentation of a member's other coverage including:

- Name of the other carrier
- Policy number
- Effective date of the other coverage
- Order of benefit determination.

Attachments:

3.2.7.10 Medicare COB:

- Explain whether or not you have an electronic system currently in place to allow Medicare Part B claims filed with the Medicare carrier to automatically coordinate (crossover) with the retiree plans so that retirees are not required to submit secondary Part B claims to this plan.
- Describe your Medicare COB program; note whether you accept information from all Medicare Part B carriers or list those carriers with whom you have contracts.

Answer: Yes. We have a Medicare Direct option. Effective February 2012, we accept both Parts A and B Medicare Direct claims. Under Medicare Direct, the Medicare intermediary submits claims directly to Aetna electronically. The claims show the original submitted expense as well as the Medicare write-off, Medicare payment and member responsibility. The electronic claim submission populates the claim to the member's file. Many of the Medicare Direct claims auto-adjudicate.

Attachments:

3.2.8 Clinical Programs

3.2.8.1 Clinical Programs - General

3.2.8.1.1 Does your organization contract with any other organization for clinical program administration or management?

Answer: 2: No

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.8.1.2 If your organization contracts with another organization clinical program administration or management, please provide the information that is requested in the table below

Clinical Program Subcontracts	Subcontract#1	Subcontract#2
Company name	N/A	N/A
Headquartered city	N/A	N/A
Headquartered state	N/A	N/A
Tenure of current relationship	N/A	N/A
Current contract term of relationship	N/A	N/A

Detail:

Attachments:

3.2.8.2 Drug Utilization Review (DUR) Programs

3.2.8.2.1 Please attach an Exhibit that describes your methodology for calculating DUR Savings. Label the exhibit "DUR savings." If different methodologies are used for Prospective compared to Concurrent and Retrospective DURs, please describe each separately.

Answer: 1: Attached

Detail:

Options:

1. Attached
2. Not Attached

Attachments: [Question 3.2.8.2.1 DUR Savings.doc](#)

3.2.8.2.2 If a DUR edit is overridden, is it counted in the savings presented in the DUR Savings Reports?

Answer: 2: No

Detail: The DUR savings is not counted in the savings report if the DUR edit is overridden.

Options:

1. Yes
2. No

Attachments:

3.2.8.2.3 Is there a charge for hard edits used for DUR programs?

Answer: 2: No

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.8.2.4 Please attach an exhibit that lists the therapeutic classes/medications for which you offer Prospective DUR ("PDUR") programs (e.g., medications subjected to prior authorizations). Please differentiate between different types of PDUR programs (prior authorization, step therapy). Label the exhibit "Prospective DUR programs."

Answer: 1: Attached

Detail:

Options:

1. Attached
2. Not Attached

Attachments: [Question 3.2.8.2.4 Prospective DUR Programs.xlsx](#)

3.2.8.2.5 Does your company automatically notify participants about savings opportunities?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.8.2.6 If yes, provide the information requested below about the means by which notifications are provided and the charges assessed:

	Available (yes/no)	Charge (\$ per notice)
Internet	1: Yes	No additional cost.
Email	1: Yes	No additional cost.
Letter	1: Yes	Standard communications are no additional cost.

Detail:

Attachments:

3.2.8.2.7 Does your company currently have the ability to run all pharmacy claims of a given client against a RDUR program to identify potential safety issues (e.g., drug-drug interactions) for which physicians would be alerted?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.8.2.8 Does your company currently have the ability to run medical claims against a pharmacy RDUR program to identify potential safety issues (e.g., drug-medical condition interactions) for which physicians would be alerted?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.8.2.9 Can you receive and use data from the medical vendor to identify and outreach to members obtaining specialty medications through a provider?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.8.2.10 Does your company currently have the ability to run claims against a RDUR program to identify gaps or omissions in care (e.g., no ARB for a patient with Diabetes) for which physicians would be alerted?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.8.2.11 Does your company currently have the ability to run claims against a RDUR program to identify patient adherence issues for which patients and/or physicians would be alerted?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.8.2.12 Provide an exhibit that includes information about programs you offer or patient / physician touch points that help address potential patient adherence issues. Label attachment “Adherence Programs.”

Answer: 1: Attached

Detail:

Options:

1. Attached
2. Not Attached

Attachments: [Question 3.2.8.2.12 Adherence Programs.doc](#)

3.2.8.2.13 Are savings reported for DUR programs auditable to the individual claims transactions?

Answer: 1: Yes

Detail: We can provide for our fee based optional clinical programs where we offer a ROI guarantee.

Options:

1. Yes
2. No

Attachments:

3.2.8.2.14 For fee-based programs, do you guarantee a minimum Return-On-Investment (“ROI”)?

Answer: 1: Yes

Detail: We can provide an ROI guarantee for Rx Check and Save A Copay should State of Alaska decide to purchase either of these optional programs.

Options:

1. Yes
2. No

Attachments:

3.2.8.2.15 Do you have predictive modeling capabilities specific to pharmacy claims only?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.8.2.16 Do you have the ability to receive medical claims information in addition to the pharmacy claims for the purposes of predictive modeling?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.8.3 Formulary

3.2.8.3.1 Provide a listing of drugs your PBM does not normally cover. Describe your process for modifying this list to meet the State's open formulary provisions.

Answer: Our open formulary includes the vast majority of drugs. However, we typically exclude the following drug categories :

- Anorexiant
- Anti-obesity drugs
- Blood/blood plasma
- Drugs for cosmetic use
- Experimental/investigational drugs (except as required by law)
- Immunization agents
- Lifestyle drugs
- Nutritional/dietary supplements or supplies
- Over-the-counter (OTC) drugs and prescriptions with OTC equivalents
- Smoking-cessation products

We can offer a flexible approach to meet the State of Alaska's needs. We provide a consultative approach to any exception request, making recommendations that we can support administratively and clinically. This approach will ensure the best financial and clinical outcome for you, your employees and their dependents.

Attachments:

3.2.8.3.2 Does your organization contract with any other organization for formulary development and/or administration?

Answer: 2: No

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.8.3.3 If your organization contracts with another organization for formulary development and/or administration, please provide the information that is requested in the table below

Formulary Subcontracts	Subcontract#1	Subcontract#2
Company name	N/A	N/A
Headquartered city	N/A	N/A
Headquartered state	N/A	N/A
Tenure of current relationship	N/A	N/A
Current contract term of relationship	N/A	N/A

Detail:**Attachments:**

3.2.8.3.4 Describe the different formularies you offer.

Answer: Depending on your needs, you may choose among the tier copayment plan designs for in-network benefits:

- A closed formulary single-tier plan - Members pay a single copayment for each covered generic or brand prescription. Drugs on the Formulary Exclusion List are not covered unless a medical exception is obtained.
- A closed formulary two-tier plan - Members pay a lower copayment for each covered generic drug prescription and a higher copayment for each covered brand prescription. Drugs on the Formulary Exclusion List are not covered unless a medical exception is obtained.
- An open formulary single-tier plan - Members pay a single copayment for each covered generic or brand prescription.
- An open formulary two-tier plan - Members pay a lower copayment per prescription for covered generic drugs and a higher copayment for covered brand drugs.
- An open formulary three-tier plan - Members pay a lower copayment for each covered generic drug on our formulary, a middle copayment for each covered brand drug on our formulary, or the highest copayment for each covered generic or brand drug not listed on our formulary.
- An optional fourth and fifth tier plan for Aetna Specialty CareRx drugs - Members pay copayments ranging from 10 percent to 50 percent with a 10 percent spread between tiers as follows:
 - Fourth Tier - Copayment covers all preferred and nonpreferred Aetna Specialty CareRx drugs.
 - Fourth/Fifth Tier - Copayment for Aetna Specialty CareRx drugs on the formulary (fourth tier) and Aetna Specialty CareRx drugs not on the formulary (fifth tier).

Additional Aetna Specialty CareRx copayment options include flat dollar ranging from \$10 to \$100 and minimum/maximums per script ranging from \$10 to \$200.

Attachments:

3.2.8.3.5 How often are your formularies reviewed?

Answer: We annually conduct a formal review of our entire formulary. Our Pharmacy and Therapeutics (P&T) committee meets monthly to clinically review drugs newly approved by the FDA in the context of each drug's therapeutic class. The committee also meets to evaluate new drug indications and new clinical information on existing formulary drugs to ensure they continue to meet our safety criteria, effectiveness and current use in therapy. As brands go off patent and new generics become available, we may move the brand to a non-preferred drug status at a higher copay, or remove it from the formulary.

The formulary is subject to change as new drugs come to market and new clinical information becomes available. The most current version is available online at www.aetn navigator.com.

Attachments:

3.2.8.3.6 Describe the committee(s)/team(s) involved in developing and managing your formularies?

Answer: Our Pharmacy and Therapeutics (P&T) committee includes 13 voting members, with the majority being practicing health care providers not employed by Aetna.

This includes at least six practicing physicians and pharmacists, not employed by Aetna, practicing in key medical areas and specialties:

- Geriatrician Physician Specialist
- Geriatric Clinical Pharmacist Specialist
- Physician, Specialty in Internal Medicine
- Physician, Specialty in Cardiology
- Physician, Specialty in Endocrinology
- Physician, Specialty in Family Practice

There are also five medical and pharmacy directors who Aetna employs:

- Clinical Policy Medical Director, Co-Chair
- Director of Formulary Development & Pharmacy Clinical Policies, Co-Chair
- Medical Director, Behavior Health
- Medical Director, Patient Management
- Clinical Pharmacy Director, Pharmacy Clinical Programs

We also include practicing physicians not employed by Aetna as required by select state regulations:

- Practicing Physician, NC
- Practicing Dentist, MI

Attachments:

3.2.8.3.7 Do you communicate formulary changes to clients at least 60 days prior to the change?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.8.3.8 Do you communicate formulary deletions to members impacted by the change?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.8.3.9 How many days in advance do you provide to members when a drug is removed from the formulary?

Answer: 30

Detail: We strive to provide members with as much notification time as possible, and at least 30 days notice before a drug is officially removed from the formulary. However, there are circumstances such as when a drug is recalled from the market and pulled immediately that we cannot provide such timely notification. For these situations, we mail letters within 30-calendar days from the FDA announcement of Class II, Class III or voluntary drug withdrawals from the market. We expedite prompt notification for all FDA Class I recalls.

In addition, it's important to note that all communications encourage members to access our website at www.aetnanavigator.com for the most up-to-date formulary, as well as current precertification, quantity limits and step therapy information.

Attachments:

3.2.8.3.10 Describe the Pharmacy & Therapeutics ("P & T") Committee's formulary drug review and decision-making process. Please include criteria for evaluating an existing drug's formulary status and criteria for adding a drug to your formulary.

Answer: All formulary decisions are based on our P&T committee's extensive review of drugs approved by the FDA. Other persons outside or within our organization who have specialized or unique knowledge, skills and judgment may be invited to contribute or participate in the formulary review process as appropriate or required.

We conduct a review of our formulary on an annual basis. We review therapeutic classes:

- When a new product is added to a class of drugs
- When there is new clinical information about the therapeutic class to evaluate
- As deemed necessary

As brands lose their patent and generics become available, we may move the brand to the non-preferred brand tier, or we may remove it from the formulary entirely.

Our P&T committee conducts an extensive clinical therapeutic class review to determine the safety and effectiveness of each drug. The P&T committee uses clinical information from literature and

database searches from a number of sources including:

- Clinical Pharmacology, a Gold Standard product
- American Hospital Formulary Service Drug Information (AHFS-DI)
- MicroMedex's DRUGDEX®
- Medline
- Other databases, including relevant findings of Federal government agencies (e.g., National Institutes of Health, guidelines developed by federal government agencies, Agency for Healthcare Research and Quality, Centers for Disease Control and Prevention)
- Medical professional associations (e.g., American Medical Association, American Academy of Pediatrics, American College of Cardiology), national commissions (e.g., Institute of Medicine, Expert Panel on Detection, Evaluation and Treatment of High Blood Cholesterol in Adults)
- Peer-reviewed journals (e.g., Journal of the American Medical Association, New England Journal of Medicine, Annals of Internal Medicine, Drugs, Annals of Pharmacotherapy)

An Academy of Managed Care Pharmacy (AMCP) Format for Formulary Submission dossier, if available, will also be utilized with new drugs to the market, and other currently available drugs.

Utilization data for drugs within the class will also be included in the review. Cost and manufacturer rebates are among the factors we consider for drugs that are clinically and therapeutically similar to other available products. We conduct additional reviews of such drugs before deciding whether to include these drugs on the formulary.

Regardless of cost factors, we include products that demonstrate important therapeutic advances on the formulary. Precertification may apply to such products. We exclude products that demonstrate significant disadvantages in safety or effectiveness in comparison to other similar products from the formulary or we cover them at the higher copayment level.

Attachments:

3.2.8.3.11 If your organization utilizes comparative effectiveness data in the formulary review process, please explain.

Answer: Our P&T committee conducts an extensive clinical therapeutic class review to determine each drug's safety and effectiveness. The P&T committee uses clinical information from literature and database searches from a number of sources. Regardless of cost factors, we include products that demonstrate important therapeutic advances on the formulary. Precertification may apply to such products. We exclude products that demonstrate significant disadvantages in safety or effectiveness in comparison to other similar products from the formulary or we cover them at the higher copayment level.

Attachments:

3.2.8.3.12 Are multi-source brand drugs moved to the non-preferred tier when a generic becomes available?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.8.3.13 Are new medications automatically placed on the non-preferred tier of the formulary until they are reviewed by the P & T Committee? If no, explain.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.8.3.14 Does at least one of the 3-tier formularies you offer have at least one medication from every therapy class (e.g., COX-2 Inhibitors) represented on either tier-1 or tier-2 of the formulary? If no, explain.

Answer: 2: No: [We have at least one preferred product (either tier 1 or tier 2) for treatment of any disease state. This is not necessarily the same as all therapy classes. Often, drugs in several different therapy classes may effectively treat a disease state. We may not always have a preferred drug in each drug therapy class, however, we do have a preferred drug for each disease state condition.

Although we recommend that customers implement the formulary without exception, we can offer a flexible approach to meet your needs. We provide a consultative approach to any exception request, making recommendations that we can support administratively and clinically. This approach will ensure the best financial and clinical outcome for you, your employees and their dependents.

]

Detail:

Options:

1. Yes
2. No: [Text]

Attachments:

3.2.8.3.15 Do you agree to not require the client exclude coverage any specific medication(s) within a therapy class for which coverage is currently provided during the term of the agreement without financial consequence (i.e., a change in the rebate guarantees proposed)? If no, explain.

Answer: 1: Yes

Detail: All drugs that are not contractually excluded are covered in open formulary plans. However, members may pay a higher copayment for certain drugs. These drugs may also be subject to

precertification or step therapy requirements. We will work with the State of Alaska to create a formulary that meets your unique needs.

Options:

1. Yes
2. No: [Text]

Attachments:

3.2.8.3.16 Do you agree to not make changes to the contracted pricing terms during the term of the agreement based on the State's decision to not follow coverage recommendations your organization makes (e.g., require specific medication(s) within a therapy class be subjected to step therapy or prior authorization)? If no, explain.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No: [Text]

Attachments:

3.2.8.3.17 Are specialty drugs found in more than one tier? If yes, in which tiers are specialty drugs found?

Answer: 1: Yes

Detail: Specialty drugs are found on all APM formulary tiers:

Tier 1 - Preferred Generics
Tier 2 - Preferred Brands
Tier 3 - Non-Preferred Brands

Options:

1. Yes
2. No

Attachments:

3.2.8.3.18 Will you customize a formulary based on the State's request should they wish to implement one?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.8.3.19 If a customized formulary is implemented, will member materials (including web-based information) be customized to reflect the client's specific formulary?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.8.3.20 Does your organization currently offer a suggested list of preventive medications that should be covered at 100% to comply with Patient Protection and Affordable Care Act ("PPACA")? If so, please provide the list and label it "PPACA Medications."

Answer: 1: Yes. List is provided

Detail: However, please note the following drug categories are contractually excluded from our pharmacy benefits on a standard basis:

- Anorexiant
- Anti-obesity drugs
- Blood/blood plasma
- Drugs for cosmetic use
- Experimental/investigational drugs (except as required by law)
- Immunization agents
- Lifestyle drugs
- Nutritional/dietary supplements or supplies
- Smoking-cessation products
- Over-the-counter (OTC) drugs and prescriptions with OTC equivalents

Our standard pharmacy benefit plan does not provide coverage or discounts for OTC and non-federal legend drugs. Exceptions include: OTC diabetic supplies in plans where diabetic supplies are covered. Unless specifically indicated by a member's plan documents, any non-prescription (OTC product) drug that does not, by federal or state law, require a prescription order is not covered.

Over-the-counter FDA approved female contraceptives are covered 100% under the women's preventive health coverage under the Federal Affordable Care Act (ACA). OTC drugs will not be covered unless you have a prescription and that prescription is presented at an in network pharmacy and processed through our pharmacy claim system. This benefit is optional for grandfathered and exempt plans.

Options:

1. Yes. List is provided
2. Yes. List is Not provided - Explain: [Text]
3. No

Attachments: [Question 3.2.8.3.20_HSA Preventive Drugs List.pdf](#)

3.2.8.3.21 Please confirm that all generics are included in the proposed formulary; if not, detail all generics that are not included.

Answer: Our formulary includes 137,927 generic drugs counted by NDC. We consider all generics formulary, except for drugs on our Formulary Exclusion List. The formulary is subject to change. Coverage is not limited to drugs included on the formulary.

We contractually exclude the following drug categories from our pharmacy benefit on a standard basis:

- Anorexiant
- Anti-obesity drugs
- Blood/blood plasma
- Drugs for cosmetic use
- Experimental/investigational drugs (except as required by law)
- Immunization agents
- Lifestyle drugs
- Nutritional/dietary supplements or supplies
- OTC drugs and prescriptions with OTC equivalents
- Smoking-cessation products

Attachments:

3.2.9 Medicare Part D

3.2.9.1 Medicare Part D Administration

3.2.9.1.1 What percent of your 2011 self-funded, commercial book-of-business do you support with Medicare Part D administrative services?

Answer: Aetna has been administering Part D, which includes offering Medicare Prescription Drug Plans and providing Retiree Drug Subsidy (RDS) reporting/administration services, since the inception of Part D in 2006.

We currently have 36,668 fully-insured Group Medicare members enrolled in our Medicare Prescription Drug Plans (PDPs). Having the experience of managing a large number of members will allow us to excel at administering our self-funded Medicare Part D Prescription Drug Plan, which is a new offering for 2013. We currently have three customers offering self-funded Medicare Part D Prescription Drug Plans. As the change in tax implications to RDS do not take effect until 2013, it is our understanding that more customers will look to self-funded PDP once they experience the financial impact of the Health Care Reform change.

Attachments:

3.2.9.1.2 Of these clients, what percent have filed for the CMS Retiree Drug Subsidy (RDS)?

Answer: We have approximately 95 plan sponsors who have engaged Aetna to assist them with their RDS reporting.

Attachments:

3.2.9.1.3 Complete the following table with the list of services that are included in your standard or core Medicare Part D administration fee.

Core service	Included in standard fee (yes/no)	If no, additional fee(s)
A. Medicare RDS application assistance	No	Please refer to the attachment.

Core service	Included in standard fee (yes/no)	If no, additional fee(s)
B. Medicare eligibility maintenance	Yes	Not applicable.
C. Upload of monthly eligibility data and reconciliation of weekly/monthly response files from CMS	Yes	Not applicable.
D. Separate data tracking and drug cost reporting	Yes	Not applicable.
E. Financial and plan design modeling relative to Medicare Part D standard plan to determine actuarial equivalence	No	Please refer to the attachment.
F. Submission and reconciliation of retiree drug costs, including quarterly or annual rebate adjustments	Yes	Not applicable.
G. Analytic support for valuing subsidy payments versus alternative coverage options	No	Please refer to the attachment.
H. Standard quarterly reporting to the State	Yes	Not applicable.
I. Custom or ad hoc reporting requests	Yes	Not applicable.
J. Quarterly updates on Medicare program changes, legislative issues, employer responses and recommendations for the State	No	Please refer to the attachment.
K. Prior Authorization reviews (Part D drug coverage determination)	No	Please refer to the attachment.
L. Prior Authorization reviews (Part B versus Part D covered drugs)	No	Please refer to the attachment.
M. Annual Letters of Creditable Coverage	No	Please refer to the attachment.
N. Retention of claim records and supporting documentation for a minimum of six (6) years	Yes	Not applicable.
O. Other (please specify)	No	Not applicable.

Detail:

Attachments: [Question 3.2.9.1.3 - RDS Costs.doc](#)

3.2.9.1.4 Confirm your willingness to submit Retiree List updates and drug cost reports directly to CMS via the RDS website on behalf of the State.

Answer: 1: Yes

Detail: Aetna Pharmacy Management can submit the reports on your behalf. If you choose to have APM submit to CMS on your behalf, there will be an annual charge of \$500 to submit eligibility reports and a separate \$500 annual charge to submit cost reports.

Additional charges may apply for changes to account structure after initial set-up or other nonstandard customization.

Options:

1. Yes
2. No

Attachments:

3.2.9.1.5 Describe any differences in formularies between your commercial plans and your Medicare Part D plans.

Answer: Aetna offers both standard and enhanced prescription drug plan (PDP) designs for our standalone Prescription Drug Plans (PDP) and our integrated Medicare Advantage-Prescription Drug (MA-PD) plans. Medicare PDPs differ from commercial pharmacy plans as they are regulated by the Centers for Medicare and Medicaid Services (CMS) and have minimum plan requirements.

Per CMS requirements Part D formularies must include coverage for all drugs within the 6 protected classes as defined by CMS. These classes include: immunosuppressant (for prophylaxis of organ transplant rejection), antidepressant, antipsychotic, anticonvulsant, antiretroviral, and antineoplastic classes.

We offer three types of standard formularies for our group PDPs. All formularies comply with CMS.

- Our Base Closed formulary covers a subset of Part D drugs prescribed for a medically-accepted indication for which a member meets medical necessity and follows plan rules. When new drugs come to market and are classified as “Part D”, they are considered for inclusion in the formulary. Non-preferred copayment levels may apply to some drugs on the formulary.
- Our Managed Standard formulary also covers a subset of Part D drugs prescribed for a medically accepted indication for which a member meets medical necessity and follows plan rules, but the list is broader than the base closed formulary described above. When new drugs come to market and are classified as “Part D”, they are considered for inclusion in the formulary. Non-preferred copayment levels may apply to some drugs on the formulary.
- Our Open formulary covers any Part D drug prescribed for a medically accepted indication for which a member meets medical necessity and follows plan rules. When new drugs come to market and are classified as “Part D” they are generally given immediate formulary status. Non-preferred copayment levels may apply to some drugs on the formulary.

The Base Closed and Managed Standard formularies provide cost-savings to the member and (Customer Name) by offering at least one drug in each therapeutic drug class. By offering the less expensive drug, this will result in lower cost-shares for retirees and lower premiums for (Customer Name).

Through our extensive Medicare retail pharmacy network of over 65,000 network pharmacies, we make quality pharmaceutical services easily accessible to beneficiaries at an affordable cost. Our Medicare pharmacy network includes major chain and independent retail pharmacies, long term care pharmacy providers, Indian Health Service (IHS), Tribal and Urban (I/T/U) pharmacies and home infusion pharmacy providers to meet the more specialized needs of our members.

Current information about Aetna Medicare network pharmacies is available on our website at www.aetnamedicare.com.

In addition, we provide mail order medications through Aetna's preferred mail order drug program, Aetna Rx Home Delivery*. Members may receive up to a 90-day supply via mail order and use of a preferred mail order provider ensures a lower cost share to the patient. Medicare members also have access to specialty medications via mail.

Aetna also operates its own specialty pharmacy for ordering drugs that local retail pharmacies often do not stock because of their expense and/or special handling requirements. Aetna Specialty Pharmacy* can also assist beneficiaries with personal instructions on using their specialty medication(s). We offer educational materials and a telephone support line staffed with clinical nurses and pharmacists. These

professionals are specially trained to provide beneficiaries with the information they need most to maintain their highest quality of health.

*Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a subsidiary of Aetna Inc., which is a licensed pharmacy that operates through mail-order. Aetna Specialty Pharmacy refers to Aetna Specialty Pharmacy, LLC, which is a subsidiary of Aetna Inc. Aetna Specialty Pharmacy is a licensed pharmacy that operates through specialty pharmacy prescription fulfillment. The charges that Aetna negotiates with Aetna Rx Home Delivery and Aetna Specialty Pharmacy may be higher than the cost those pharmacies pay for the drugs and the costs of their specialty pharmacy services. For these purposes, Aetna Specialty Pharmacy's and Aetna Rx Home Delivery's cost of purchasing drugs takes into account discounts, credits and other amounts that those pharmacies may receive from wholesalers, manufacturers, suppliers and distributors.

Attachments:

3.2.9.1.6 Do you permit client review of all communications to retirees prior to release?

Answer: 1: Yes

Detail: Our Medicare Prescription Drug Plans include a comprehensive, turnkey communications strategy during the Open Enrollment period and beyond, through our no-cost, member-centric solution. Some of these communications are mandated by CMS, where we are required to send to members without plan sponsor approval. However, we can send copies of these communications upon request. Any custom communications would have the opportunity to be reviewed by the State in advance.

Options:

1. Yes
2. No

Attachments:

3.2.9.1.7 Describe how you handle retroactive claim adjustments when a member reaches the Medicare Part-D True Out-of-Pocket ("TrOOP") limit.

Answer: We have adopted a pay as submitted approach and then review claims on a quarterly basis. Retroactive adjustments are handled based on each member's Part D accumulators at that point in time. If this review determines that an adjustment is needed, then that would occur on a quarterly basis.

Attachments:

3.2.9.1.8 Describe how you honor repayment demands or requests for reimbursement that are made within the time period mandated by Medicare for recovery of improper payments.

Answer: We process all requests within the Medicare mandated timeframes through a claim adjustment/reprocessing and recoupment letter to members.

Attachments:

3.2.9.1.9 Describe the training you provide to client's staff and other health vendors who could take calls from Medicare retired members.

Answer: We will support a "train the trainer" approach to educate the State's staff and other health vendors on servicing calls from Medicare retirees. The State staff and vendors would receive the same

training as our customer service representatives who service our Medicare Prescription Drug Plan population. They would participate in age-sensitivity training specific to the retiree population. Through this training, participants are exposed and sensitized to the distinctive characteristics of an aging population in order to be well equipped to provide the retiree with the focus, sensitivity and attention needed.

To help provide members with a valuable service experience, we have developed Centers of Excellence for our customer service centers. Our customer service representatives are trained on specific topics, including eligibility and enrollment, benefit coverage claims (separate for Medicare Advantage and Prescription Drug Plan) and billing invoices.

Attachments:

3.2.9.1.10 Describe your clinical programs over and above the minimum CMS requirements.

Answer: In accordance with the Centers for Medicare & Medicaid Services (CMS) guidelines, Aetna Pharmacy Management (APM) will offer programs specifically designed to help manage care of the Medicare Prescription Drug Plan population.

Drug Utilization Review

We offer prospective, concurrent and retrospective drug utilization review (DUR) programs to help promote appropriate prescribing, dispensing and medication use in accordance with FDA guidelines, manufacturer labeling and peer-reviewed literature. Programs include the following:

Precertification

Precertification encourages the appropriate and cost-effective use of medications by allowing coverage only when certain conditions are met. The precertification program is based upon current medical findings, FDA-approved manufacturer labeling information, and cost considerations. In addition we also include:

- **Quantity Limits** - Quantity limits are part of our precertification program and promote appropriate medication use and enhance member safety. Quantity limits are based on generally accepted pharmaceutical guidelines, efficient dosing regimens and dosing recommendations.
- **Age Limits** - These limits are applied to drugs that are generally believed to commonly cause side effects in elderly people (age 65 and older). The medications were identified according to criteria set by physicians and pharmacologists and is referred to as the Beer's list.

Step Therapy

Aetna uses step therapy as a way of maintaining the cost of drugs while ensuring access to quality services for members. We define step therapy as one or more prerequisite medications must be tried before the step therapy medication can be covered. Step therapy is optional.

Aetna Rx Check

Aetna Rx Check is a collection of clinical programs that use a rapid, retrospective DUR approach. Prescription drug claims are systematically analyzed within 24 hours of adjudication for possible physician outreach based on program algorithms. The specific outreach programs are designed to promote quality, cost-effective care in accordance with accepted guidelines through mailings or telephone calls to physicians and members.

Below is a brief description of the Aetna Rx Check programs applicable to Medicare prescription drug plans:

1. Therapeutic Duplication - Prescriptions filled for two medications in the same therapeutic class.
2. Drug Interaction - Prescriptions filled for any of approximately 60 medication combinations that have been identified as having a clinically significant interaction when used together.
3. High Utilization - Multiple prescriptions filled for medications that potentially may be misused.

Quality Assurance

We also have point-of-sale drug-to-drug and drug-to-age interaction edits, where we require the pharmacist to document the intervention and outcomes for promotion of patient safety.

Medication Therapy Management Programs

All Medication Therapy Management Programs (MTMP) programs are designed to promote the appropriate management of medication therapy for members with multiple chronic diseases and are administered by Aetna. These programs are not outsourced and will be available to qualifying members. The overall goal of all of our programs is to encourage optimal medication therapy to improve outcomes and reduce drug mishaps. The MTMP program is reviewed annually by Aetna and must be approved by the Centers for Medicare and Medicaid Services (CMS).

We have programs that target members with the following chronic disease states:

- Asthma
- Chronic Obstructive Pulmonary Disease
- Diabetes
- Heart failure
- Hypertension
- Rheumatoid arthritis

MTMP activities may involve:

- Outreach to member, including an annual comprehensive medication review (CMR) and an individualized written summary of CMR
- Offer of a person-to-person (CMR) to member
- Outreach to prescribing physician
- Outreach to dispensing pharmacist/pharmacy
- Consultation with clinicians (pharmacists and physicians specializing in geriatrics) regarding a member's current drug therapy regimen and treatment protocol
- Quarterly targeted medication review (TMR) for eligible members

*Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a subsidiary of Aetna Inc., which is a licensed pharmacy that operates through mail-order prescription fulfillment. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the costs the pharmacy incurs for drug products, supplies, packing, shipping and other pharmacy services.

Attachments:

3.2.9.1.11 Do you provide an insured rate and/or shared risk rate for Medicare D group plans?

Answer: 2: No

Detail: We are quoting a self-funded standalone Part D Employer Group Waiver Plan.

Options:

1. Yes
2. No

Attachments:

3.2.9.1.12 Will you allow the State to offer a customized formulary for its EGWP?

Answer: 1: Yes

Detail: Yes, we have the ability to offer a customized formulary for our Part D EGWP, within CMS guidelines. We can work with the State to provide a formulary that meets your needs.

Options:

1. Yes
2. No

Attachments:

3.2.9.1.13 Describe how non-Part D drugs are handled.

Answer: Under Aetna's standard Medicare Prescription Drug Plans (PDP), certain classes of drugs that are not considered Medicare Part D are excluded from coverage.

However, Aetna does offer a non-Part D drug rider that is offered as an enhancement to the PDP plan for an additional cost. This rider adds coverage to certain categories of non-Part D drugs:

- Agents when used for weight loss (precertification is required)
- Prescription vitamins and mineral products
- Erectile dysfunction (with quantity limits)

Non-Part D drugs covered under the rider can be accessed at the applicable plan copay. Copayments and associated costs for these prescription drugs will not apply toward the deductible, initial coverage limit or True Out-of-Pocket (TrOOP) limit.

In addition, if the State is considering a custom formulary, we can consider coverage of additional classes as needed to meet the State's needs.

Attachments:

3.2.9.1.14 Will you allow the State to elect to cover non-Part D drugs?

Answer: 1: Yes

Detail: Yes. Aetna offers a Non-Part D Drug Rider, which covers certain classes of drugs that are excluded from Part D coverage. The rider is offered in addition to the Part D plan for an additional cost. This rider adds coverage for three categories of non-Part D drugs:

- Agents when used for weight loss (precertification required)
- Prescription vitamins and mineral products

- Erectile dysfunction (quantity limits apply)

Non-Part D drugs covered under the rider can be accessed at the applicable plan copay. Copayments and associated costs for these prescription drugs will not apply toward the deductible, initial coverage limit or the True Out-of-Pocket (TrOOP) limit.

Options:

1. Yes
2. No

Attachments:

3.2.9.1.15 Will you allow the State to elect to cover non-formulary drugs via a prior authorization exceptions process or in the wrap plan?

Answer: 2: No

Detail: Non-formulary drugs on our closed formularies can only be covered if approved via a prior authorization process. A determination is made based upon clinical information provided by the prescriber.

In addition, our managed standard closed and open formularies cover many drugs not on our base closed formulary, with utilization management edits to help support appropriate utilization.

Options:

1. Yes
2. No

Attachments:

3.2.9.1.16 Will you allow the State to offer a customized network for its EGWP?

Answer: 2: No

Detail: Aetna's Medicare Prescription Drug Plans offer many flexible plan design offerings. These plans access one primary Medicare network which is very comprehensive, including over 65,000 pharmacies nationwide. The program and network offerings are reviewed and approved by CMS. The Medicare network is currently not able to be customized, we can consider a preferred network/preferred pharmacy approach to meet the needs of the State.

Options:

1. Yes
2. No

Attachments:

3.2.9.1.17 Describe the specialty program available for the EGWP.

Answer: Through Aetna Specialty Pharmacy®, we offer the following clinical and financial benefits to you, your employees and their dependents:

Member Confidence

We properly handle drugs requiring special storage and handling. Pharmacists perform multiple

quality checks before releasing each order to ensure dosage, quantity and timing accuracy. We have drugs delivered in refrigerated, insulated packaging, as indicated by manufacturer requirements.

Therapy Appropriateness Verification

We coordinate with the prescribing physician to verify the member's therapy, and ensure that members always have needed supplies. We also maintain ongoing communication with physicians to report on each member's status between office visits.

Free, Timely Delivery

Members enjoy free, confidential drug delivery within 48 hours of order confirmation. The member can choose to have drugs delivered to the home, physician's office or any other location.

Compliance Monitoring

We closely monitor member compliance throughout therapy. The clinical process addresses side effects and helps prevent inappropriate therapy termination.

Refill Reminders

We initiate retroactive refill reminder calls seven days before the member's next scheduled refill. During these calls, we conduct compliance monitoring and schedule delivery.

24/7 Support

Nurses and pharmacists provide 24/7 telephonic support.

Self-Injection Training

We provide member and caregiver training on how to administer self-injectable medications.

Standard Supplies

We include free standard supplies with self-injectable medications, such as needles, syringes, alcohol swabs, adhesive bandages and Sharps containers for needle waste.

Educational Materials

We provide members with complimentary educational materials, including a welcome packet and supplementary educational materials from the manufacturer.

Financial Support

We establish viable payment plans for members who struggle paying. We provide information on assistance available through manufacturer-sponsored programs and social service organizations consistent with plan benefit requirements. We will even keep the member and prescribing physician informed of coverage and coinsurance application.

Deep Discounts

By purchasing in high volume, we obtain deep discounts and pass these savings directly to you.

Attachments:

3.2.9.1.18 Will you allow the State to offer a customized specialty program for its EGWP?

Answer: 1: Yes

Detail: We will work with the State to discuss the customization required in greater detail.

Options:

1. Yes

2. No

Attachments:

3.2.9.1.19 Are you able to manage a commercial wrap-around plan using one identification card?

Answer: 1: Yes

Detail: Aetna's current approach is to offer an enhanced Part D Employer Group Waiver Plan that integrates basic Part D coverage with supplemental benefits offered through the plan sponsor. This approach achieves the same financial savings from the 50 percent manufacturer brand discount (the Coverage Gap Discount Program), as a secondary commercial wrap plan. Aetna can provide the same level of cost savings for plan sponsors with an enhanced Part D EGWP. Our enhanced EGWP approach utilizes one identification card.

Options:

1. Yes
2. No

Attachments:

3.2.9.1.20 In response to recent CMS regulations, are you able to administer an enhanced EGWP in lieu of a standard part D plan and commercial wrap?

Answer: 1: Yes

Detail: In response to the recent CMS guidance, Aetna's Medicare Part D EGWP will be structured to include base benefits and enhanced benefits. As the manufacturer discount is applied prior to the enhanced benefits, the plan sponsor is able to optimize the manufacturer discount first, then the enhanced benefit is applied so that the member's cost sharing remains consistent. This design optimizes brand drugs eligible for manufacturer discounts and minimizes member confusion. The Aetna Medicare Part D Employer Group Waiver Plan product is administered as a single Part D plan with enhanced benefits, providing consistent member cost sharing. We can customize the Part D EGWP to meet the State's needs, while ensuring compliance to CMS requirements. Customization options include flexibility in plan design and cost sharing. We also offer riders that can be included to cover many non-Part D drugs.

Options:

1. Yes
2. No

Attachments:

3.2.9.2 Retail Network

3.2.9.2.1 Is the retail network for your Medicare business different in participating pharmacy composition than your commercial business?

Answer: 2: No

Detail: Our Medicare pharmacy network includes all major chains. Through our extensive Medicare retail pharmacy network of over 65,000 participating pharmacies, we make quality pharmaceutical services easily accessible to beneficiaries at an affordable cost.

Medicare pharmacy networks are required to include certain types of pharmacies. Our Medicare

pharmacy network includes major chain and independent retail pharmacies, 1,826 long term care pharmacy providers, 81 Indian Health Service (IHS), Tribal and Urban (I/T/U) pharmacies and 517 home infusion pharmacy providers to meet the more specialized needs of our members.

Current information about Aetna Medicare network pharmacies is available on our website at www.aetnamedicare.com.

In addition, we provide mail order medications through two preferred mail order providers and one non-preferred mail order provider. Use of a preferred mail order provider ensures a lower cost share to the patient. Medicare members also have access to specialty medications via mail. Through Aetna's mail order drug program, members may receive up to a 90-day supply via our preferred vendor, Aetna Rx Home Delivery.

We also own and operate a specialty pharmacy for ordering drugs that local retail pharmacies often do not stock because of their expense and/or special handling requirements. Aetna Specialty Pharmacy can also assist beneficiaries with personal instructions on using their specialty medication(s). We offer educational materials and a telephone support line staffed with clinical nurses and pharmacists. These professionals are specially trained to provide beneficiaries with the information they need most to maintain the highest quality of health.

Options:

1. Yes
2. No

Attachments:

3.2.9.2.2 If the retail network for your Medicare business is different in participating pharmacy composition than your commercial business, please note any major composition differences.

Answer: There are no material composition differences between our commercial and Medicare retail pharmacy networks. Medicare pharmacy networks are required to include certain types of pharmacies, including certain types of Indian Health Services, Tribal and Urban, and home infusion pharmacies in their networks.

Attachments:

3.2.9.2.3 How many CMS-compliant retail pharmacy networks do you offer?

Answer: 1

Detail: Aetna offers one national Medicare pharmacy network, providing access to over 65,000 pharmacies nationwide, and including major chains and independent retail pharmacies.

Attachments:

3.2.9.2.4 Are you willing to customize the retail network to meet the State's needs?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.9.2.5 Are you able to administer Low Income Subsidy pass back on behalf of the State's retirees?

Answer: 1: Yes

Detail: Aetna's self-funded Part D EWGP will reimburse the State for the Low Income Subsidy (LIS) received by the Centers for Medicare and Medicaid Services (CMS) for the State's LIS retirees. The applicable Low Income Subsidy payments will be allocated to the State's account and used to fund claims; concurrently, the names of Low Income Subsidy members and their specific subsidy amounts will be identified on the bill and the claim detail reports sent to the State. It will be the State's responsibility to reduce any retiree-paid premium by the amount of the applicable Low Income Subsidy for each of the LIS retirees.

Options:

1. Yes
2. No

Attachments:

3.2.9.2.6 Are you able to administer a Medicare B vs. D program at point of sale?

Answer: 2: No

Detail: At point of sale, Aetna identifies true Part B-eligible drugs versus situational drugs (drugs that can either be B or D depending on treatment). True Part D and situational drugs are covered under the Medicare PDP. However, situational drugs require precertification to determine if the Part B or D coverage is appropriate for the member. Drugs determined to be Part B are not covered under the Medicare PDP and will need to be resubmitted by the member for coverage under the medical plan

Options:

1. Yes
2. No

Attachments:

3.2.9.2.7 Is there a fee for this service?

Answer: For the process described in 3.2.9.2.6 above, there is not a fee for this service.

Attachments:

3.2.9.2.8 Do you have the capabilities to bill Medicare B claims to the Medical Provider if requested? At POS? At Mail Order? Please list any associated fees.

Answer: Aetna currently does not have the capability to automatically resubmit Part B claims to the medical carrier at point of sale or at mail order.

Attachments:

3.2.9.3 Formulary

3.2.9.3.1 How many CMS-compliant Part-D formularies do you offer?

Answer: 3

Detail: We currently offer three CMS-compliant Part-D formularies specific to our standard Employer Group Waiver Plans: the Medicare Part D Base Closed formulary, the Medicare Part D Managed

Standard formulary, or the Medicare Part D Open formulary. We also administer one additional custom group formulary.

Attachments:

3.2.9.3.2 Describe the differences between the CMS-compliant Part-D formularies you offer.

Answer: For 2013, Aetna will have three formulary variations available for group Part D business:

- Aetna Medicare Group Open Formulary: includes coverage for all Part D drugs.
- Aetna Medicare Group Managed Standard Formulary: includes all Part D drugs except multi-source brand drugs and some new drug entities (including new generics).
- Aetna Medicare Group Base Closed Formulary: includes a subset of the drugs available under the “Standard” formulary, and therefore has fewer drugs available in each therapeutic class or category. This formulary is equivalent to what will be available for our individual Part D business in 2013.

We also offer a non-Part D Drug Rider, called an Enhanced Drug Benefit, which can be purchased at additional cost. The rider offers additional coverage of some prescription drugs not normally covered in a Medicare prescription drug plan, including the following: agents when used for weight loss, prescription vitamin and mineral products (except prenatal vitamins and fluoride preparations), and erectile dysfunction drugs when prescribed for the treatment of sexual or erectile dysfunction. The amount a member pays for a prescription for these drugs does not count towards qualifying for catastrophic coverage. In addition, if the member receives extra help from Medicare to pay for their prescriptions, then the extra help will not pay for these drugs.

Attachments:

3.2.9.3.3 Does your organization contract with any other organization for formulary development and/or administration?

Answer: 1: Yes

Detail: Aetna contracts with CVSC to process pharmacy claims that includes point of service administration of formulary.

Options:

1. Yes
2. No

Attachments:

3.2.9.3.4 If your organization contracts with any other organization for formulary development and/or administration please list 1) the organization and describe its role, 2) Fees that your organization pays for formulary development/administration, including formulary administration fees, and 3) The percent of rebates that are retained by the contracting organization.

Answer: The Aetna formulary is developed and administered internally through our Pharmaceutical & Therapeutic (P&T) Committee. Formulary management is critical to the success of our Medicare Part D programs and is included in our offering to the State of Alaska at no additional charge. We are passing on 100 percent of the rebates associated with the utilization of the State of Alaska membership.

CVS Caremark contracts, manages and audits our participating retail pharmacy network; provides member services for our retail and mail benefits; provides dispensing services for Aetna Rx Home Delivery and Aetna Specialty Pharmacy; and is responsible for inventory management. We began contracting with CVS Caremark in 2011.

Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a subsidiary of Aetna Inc., which

is a licensed pharmacy that operates through mail-order prescription fulfillment. Aetna Specialty Pharmacy refers to Aetna Specialty Pharmacy, LLC, a subsidiary of Aetna Inc., which is a licensed pharmacy that operates through specialty pharmacy prescription fulfillment. The charges that Aetna negotiates with Aetna Rx Home Delivery and Aetna Specialty Pharmacy may be higher than the costs those pharmacies incur for drug products, supplies, packing, shipping, and other pharmacy services. Beginning in 2014, CVS Caremark will manage the pharmacy claim adjudication system we use to pay claims.

Attachments:

3.2.9.3.5 How often are your CMS compliant Part D formularies reviewed?

Answer: Aetna uses a Pharmacy and Therapeutic (P&T) committee to develop our Medicare Preferred Drug List. The committee will continue to meet to review it and make additions or deletions as needed and will continue to follow the Centers for Medicare & Medicaid Services (CMS) regulations.

The P&T committee meets monthly, with ad-hoc meetings as necessary. Our goal is to ensure the maintenance of a current Preferred Drug List that provides beneficiaries with current and useful drug choices. When a new drug or device, if applicable, is identified as having received Food and Drug Administration (FDA) approval, this and other drugs or devices in its therapeutic class are generally scheduled for review by the P&T committee. The P&T committee will review the entire contents of all Preferred Drug Lists annually. The P&T committee also reviews and approves drug medical exception criteria, precertification criteria, step therapy criteria and Pharmacy Clinical Policy Bulletins (CPBs). In addition, it reviews and supplies comments and recommendations on pharmacy clinical programs.

Attachments:

3.2.9.3.6 What is the frequency of formulary changes allowed under your Medicare Part D plan?

Answer: Our formulary is updated annually. However, certain changes may occur throughout the year. When a change occurs mid-year, it will not impact members who are currently taking the drug, unless it has been determined the drug is no longer safe. In addition, on our closed formularies, when a brand drug has a generic equivalent, the brand drug will be removed from coverage and we will only cover the generic.

Attachments:

3.2.9.3.7 Describe the committee(s)/team(s) involved in developing and managing your formularies?

Answer: Aetna Medicare utilizes a number of committees and teams to develop and maintain its formularies.

For formulary development, Aetna Medicare's Formulary and Utilization Management team facilitates a number of workgroups to evaluate existing and creation of new formulary coverage designations. Using a therapeutic class approach, clinical literature, evidence based standards of practice, and pharmacoeconomic informatics are evaluated for clinical appropriateness of drug coverage and utilization management application. Additionally a Criteria Council consisting of internal Medical Directors and pharmacists evaluates utilization management coverage criteria and clinical policy bulletins to ensure clinical appropriateness and application. Our P&T committee oversees all of Aetna Medicare's practices and policies regarding formulary development.

Attachments:

3.2.9.3.8 Do you have a separate P&T Committee (from your commercial committee) that makes decisions or recommendations for the Part D formularies and coverage rules you offer?

Answer: No. The P&T Committee is the same committee for both commercial and Part D.

Attachments:

3.2.9.3.9 What is the composition of your P&T Committee, and their credentials?

Answer: Our Pharmacy and Therapeutics (P&T) committee includes 13 voting members, with the majority being practicing health care providers not employed by Aetna.

At least seven (7) practicing physicians and pharmacists, who are independent and free of conflict with Aetna and pharmaceutical manufacturers, at least one of whom shall practice in each of the following key medical areas and specialties:

- Physician expert in the care of the elderly or disabled (Board-certified)
- Clinical Pharmacist expert in the care of the elderly or disabled (Board-certified)
- Physician Specialty in Internal Medicine
- Physician Specialty in Cardiology
- Physician Specialty in Adult Endocrinology
- Physician Specialty in Pediatric Endocrinology
- Physician Specialty in Family Practice
- Additional Specialty as designated

There are also six medical and pharmacy directors who Aetna employs:

- Clinical Policy Medical Director, Co-Chair
- Head, Pharmacy Clinical Operations, Co-Chair
- Medical Director, Behavior Health
- Medical Director, Patient Management
- Medical Director, Medicare, Specialty - Rheumatology
- Clinical Pharmacy Director, Pharmacy Clinical Program Development

We also include practicing physicians not employed by Aetna as required by select state regulations:

- Practicing Physician, NC
- Practicing Dentist, MI

Aetna also maintains a Consultant Board of Practicing Medical Specialists that may be consulted on an ad hoc basis during the evaluation and development of the formulary. Physician Specialists may be invited by the Co-Chairs to the Committee meetings as necessary.

Attachments:

3.2.9.3.10 Describe the P & T Committee's formulary drug review and decision-making process.

Answer: The P&T Committee reviews and approve Aetna's practices and policies regarding formulary development and UM for clinical appropriateness. Clinical decisions regarding formulary development and UM is based on scientific evidence and standards of practice, including, but not limited to peer-reviewed medical literature, well-established clinical practice guidelines, and pharmacoeconomic studies. The P&T Committee considers whether a drug represents an important therapeutic advance, is therapeutically similar to other available products, or has significant disadvantages in safety or efficacy when compared to other similar products in the same therapeutic class.

Formulary development activities examined by the P&T Committee include formulary development / revision decisions and drug reviews. UM practices examined by the P&T Committee include prior authorizations, step therapies, quantity limitations, generic substitutions, and other drug utilization activities that affect access.

Attachments:

3.2.9.3.11 What lead time do you provide to members when a drug is removed from the formulary?

Answer: Aetna Medicare typically refrains from making negative changes during the plan year, however should a need arise to remove a drug from the formulary, pending CMS approval of the negative change, members are notified no less than 60 days in advance per CMS guidelines.

Attachments:

3.2.9.3.12 What are the criteria for evaluating an existing drug's formulary status?

Answer: Our Formulary is governed by CMS regulation and Pharmaceutical & Therapeutics (P&T) committee to ensure broad coverage of clinically appropriate choices is available to address the unique needs of Medicare beneficiaries.

For existing drug formulary evaluation, we start with clinical assessment including drug efficacy and safety comparing to alternatives in the same therapeutic category. Pertinent information including drug monograph and additional clinical literature is evaluated by our national P&T committee. Once the clinical assessment is completed, drugs that are deemed superior will be added to the formulary while inferior drugs are typically excluded from the formulary or managed through utilization management programs. For drugs that are neutral to other formulary alternatives, financial modeling is conducted to assess opportunity for improving affordability of care.

Attachments:

3.2.9.3.13 What are the criteria for adding a drug to your formulary?

Answer: Aetna Medicare formularies are designed to offer ample drug selection while simultaneously balancing access with affordability of care. Drugs included on the formulary are based on CMS regulation, safety and efficacy assessment by Aetna's National P&T committee, and financial evaluation to promote cost effectiveness of care. Formularies are set once a year; new drugs are evaluated and considered for formulary addition throughout the year as they become available. We follow the same evaluation process as used to determine coverage of existing formulary drugs while ensuring that we continue to meet CMS regulation.

For closed formularies, drugs that do not offer additional clinical benefit comparing to formulary drugs or pose clinical risk are typically designated to restrictive coverage positions. Drugs that pose clinical and/or financial advantage are typically considered for formulary addition. For formularies with open benefit designs, coverage of newly approved drugs that do not pose clinical or safety risk are covered.

Attachments:

3.2.9.3.14 What are the criteria for deleting single-source brand drugs from your Part-D formulary?

Answer: The Formulary changes are limited throughout the year in order to minimize disruption while continuing to improve affordability of care with broad clinically appropriate choices. A number of factors could influence whether a given formulary drug is to be deleted. Deletion of a single-source drug is considered when there are drug safety issues, market withdrawal or alternative drugs with

equal or better clinical efficacy and safety profiles that present better options to beneficiaries from either clinical or affordability of care perspective.

Attachments:

3.2.9.3.15 Do you allow clients the option to delay single-source brand deletions from the Part-D formulary until the next plan year?

Answer: 2: No

Detail: No, however, our open formulary covers all part D eligible drugs, should a client have a need to keep coverage on a single source brand that's not covered under our closed formulary, our open formulary option can help support that need for those groups that qualify for a custom plan set up.

If the drug deletion was driven by drug safety issue or market withdrawals, the formulary change will follow FDA guidelines and protocols for formulary changes defined by CMS. Our philosophy is to minimize any negative formulary changes during the plan benefit year.

Options:

1. Yes
2. No

Attachments:

3.2.9.3.16 How do you communicate formulary changes to your clients and their members?

Answer: Aetna ensures that members and providers are notified timely of drug coverage, prior authorization and step therapy program information prior to the start of each plan year.

If Aetna makes a negative formulary change, members are notified at least 60 days prior to the date that the formulary changes will go into effect. If a member who does not receive such notice presents with a prescription for a drug affected by a negative formulary change, Aetna provides the member with notice of the formulary change along with a 60-day supply of the Part D drug under the same terms as previously allowed.

If, during a contract year, Aetna makes a non-maintenance negative formulary change (e.g., removes Part D drugs from its formulary, moves covered Part D drugs to a less preferred tier status, or adds utilization management (UM) requirements to a formulary drug that was not previously subject to UM), members currently taking the affected drug will be exempt from the formulary change for the remainder of the contract year.

In addition to member notification, Aetna provides its formulary change policy and web address for viewing negative formulary changes to providers, pharmacies and SPAPs annually.

Safety concern-based changes to Aetna's formulary do not need to meet the advance notice requirements described above. However, Aetna provides retrospective notice of any such formulary changes to affected members, CMS, and other entities described above as soon as possible to ensure that the affected members are aware of the safety concerns associated with their drugs.

Other entities will be identified and notified of the formulary change policy on an annual basis via mail. Negative formulary changes will be posted to the Aetna Medicare website more than 60 days prior to the effective date of change.

Attachments:

3.2.9.3.17 What percentage of your formulary consists of multi-source brand drugs?

Answer: We offer formulary choices ranging from a closed formulary design where no multisource brands are covered to open formulary where multi-source part D drugs are covered. Our intent is to provide a variety of choices to meet unique needs of our clients.

Attachments:

3.2.9.3.18 What percentage of your formulary are extended release versions of medications?

Answer: we do not have any method of pulling this from our drug databases.

Attachments:

3.2.10 Quality Control

3.2.10.1 The State reserves right to exercise a market check in the third or fourth quarter prior to the second contract year, and each subsequent contract year the Agreement is in effect, to assess and verify the competitiveness of the pricing term set forth in the agreement in comparison to that available in the marketplace at that time. The State will designate a third party independent consultant of its choosing that will compare the aggregate value of the upcoming plan year pricing terms to what they may receive under a competitive procurement; should the comparison yield a 1% or greater savings for the State on either a gross claims cost basis (i.e. including the impact of administrative fees and rebate guarantees, but prior to the application of member cost share) or case mix change opportunity, you agree to renegotiate in good faith, the pricing terms for the upcoming year of the contract agreement. If parties are unable to reach agreement, either party may terminate agreement without penalty upon 60 days' notice to the other party. Pricing terms evaluated shall include base administrative fees, discount and dispensing fee guarantees, and rebate guarantees. Benchmarks chosen in the analysis shall be groups with similar plan design, membership and utilization patterns as the State, to the extent possible.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.10.2 Offeror agrees to comply with the State's request for a third-party to perform an Implementation Audit of the pharmacy plan set-up prior to and after the effective date of the Agreement. No charge will be assessed by the Offeror in conjunction with these services.

Answer: 1: Yes

Detail: We have provided the State of Alaska with an Implementation Allowance, which can be used to offset any audit fees.

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.10.3 Offeror agrees to cooperate with any independent auditor retained by the State for the purpose of reviewing the administration, adjudication and/or utilization management performance of the vendor for the State's pharmacy plan. No charge will be assessed by the vendor in conjunction with these services. Offeror agrees to comply with the State's request for a third-party to perform an Implementation Audit of the pharmacy plan set-up prior to or after the effective date of the Agreement.

Answer: 1: Yes

Detail: We have provided the State of Alaska with an Implementation Allowance, which can be used to offset any audit fees.

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

3.2.10.4 Please explain in detail how you will evaluate and report to the State your performance under the Contract. Specifically, identify and describe, by function, how each aspect of the work set forth in Section 1.04 of the RFP instructions relative to the Pharmacy Benefit Management component will be evaluated for effectiveness and efficiency. For each function, please provide the following evaluative information:

- A detailed description of each performance standard you will utilize to evaluate each functional component for effectiveness and efficiency.
- The benchmark measurement for each identified performance standard for each functional component.
- The frequency of reporting to the State your evaluation of each identified performance standard for each functional component based on the standards and benchmarks you utilized to determine effectiveness and efficiency.
- Which standards you are willing to subject to penalty for failure to meet.
- Whether the evaluation of each standard will be conducted by your organization or will be conducted by an independent external organization.

Answer: Aetna has provided a financial guarantee document showing the guaranteed discounts, dispensing fees and rebates. Aetna has also provided sample reconciliation exhibits that outline how the actual components are reconciled against the guaranteed components. The discounts, dispensing fees and rebates are reconciled on a dollar for dollar basis. Aetna will reconcile the discount and dispensing fee guarantees within 90 days after the end of the contract year. Aetna will reconcile the rebate guarantee within 180 days after the end of the contract year. The generic dispensing rate guarantee is reconciled separately based on the generic dispensing rate performance guarantee document on a dollar for dollar basis subject to an annual maximum of \$250,000. Aetna will reconcile this guarantee within 90 days after the end of the contract year.

Attachments:

3.2.10.5 Performance Guarantees (use tables provided in Attachment G2)

Please complete the Excel worksheet "Performance Guarantees Worksheet" and provide the completed worksheet as an attachment to the RFP. Detailed instructions are provided in the worksheet.

Answer: 1: Attached

Detail:

Options:

1. Attached
2. Not Attached

Attachments:

3.2.10.6 Are you willing to put fees at risk for network expansion if needed?

Answer: Aetna is willing to discuss the need for network expansion with State of Alaska.

Attachments:

3.2.10.7 Are you willing to guarantee savings in this proposal? If so, please explain.

Answer: Aetna is providing financial guarantees for discounts, dispensing fees, rebates and generic dispensing rates. Aetna is also providing guarantees for pharmacy services as outlined in the Pharmacy Service Performance Guarantee document. Aetna can provide ROI Guarantees for Rx Check and Save a Copay should State of Alaska decide to purchase either of these optional programs.

Attachments:

3.2.10.8 Are you willing to place fees at risk for meeting certain performance standards and guarantee outcomes under the Contract?

Answer: Aetna is placing a flat dollar amount at risk for pharmacy services as outlined in the Pharmacy Service Performance Guarantee document. Aetna can provide ROI Guarantees based on the cost of the program for Rx Check and Save a Copay should State of Alaska decide to purchase either of these optional programs.

Attachments:

3.2.10.9 Confirm you will not charge the State for claim payments not authorized by the State's plans when such payments were erroneously authorized by Contractor's employees, subcontractors or joint venturers, including pre-authorizations issued by Contractor's employees, subcontractors or joint venturers, causing the State's plans to incur costs for non-covered services.

Answer: Confirmed. Once you report a member's termination and we load it into our mainframe, we update eligibility information in the pharmacy claim system within 24 to 72 hours. When participating pharmacy submits a claim online, the system automatically checks eligibility and notifies the pharmacist. If the claim was incurred while the member was covered, the claim is eligible for reimbursement in accordance with the benefit plan provisions. If the claim was incurred after the member terminated, the claim is rejected.

Attachments:

3.2.10.10 When are performance penalties paid out?

Answer: Performance penalties are paid out as follows on an annual basis: Within 90 day after the end of the contract year for discount guarantees, dispensing fee guarantees, service guarantees, generic dispensing rate guarantees and Save a Copay. Within 180 days after the end of the contract year for Rebate guarantees and 12 months after the end of the contract year for Rx Check.

Attachments:

3.2.10.11 Can tracking and reporting of the performance standards be based on State-specific data?

Answer: Yes, with the exception of certain Service Guarantees which will be based on Book of Business data.

Attachments:

3.2.10.12 Please confirm that you will permit and cooperate with internal audits on any aspect of the administration of the program, as the State determines to be necessary and appropriate. State personnel or outside auditors that the State selects may perform these audits, including audits that may take place after the end of the contract period.

Answer: Confirmed. We will share information with a qualified auditor under a strict confidentiality agreement that prohibits disclosure of this information to any third party, and will not use this information for any purposes other than the audit. Auditors must have no conflict of interest, past business or other relationships which would prevent the auditor from performing an independent audit to conclusion. A conflict of interest includes, but is not limited to, a situation in which the audit agent:

- Is employed by an entity, or any affiliate of the entity, which is a competitor to Aetna's benefits or claims administration business or Aetna's mail order and specialty pharmacy businesses.
- Is affiliated with a vendor subcontracted by Aetna to adjudicate claims or provide services in connection with Aetna's administration of benefits or provision of mail order and specialty pharmacy services.

For the purpose of this proposal, we define an “audit” as performing a review of claim transactions for the purpose of assessing the accuracy of benefit determinations. We perform all claims audits in our Hartford, CT headquarters or our Minnetonka, MN office.

Audits must be commenced within two (2) years following the period being audited. The size of the audit sample may not exceed 250 claim transactions, without Aetna's written consent and the payment of fees as assessed by Aetna.

We are not responsible for paying the State of Alaska's audit fees or the costs associated with the audit. Claim audits are subject to the above referenced audit standards in the case of a physical, onsite, claim-based audit. In the case of electronic claim audits that follow standard pharmacy benefit audit practices where electronic re-adjudication of claims is requested and processed offsite, you may elect to audit 100 percent of claims. The State of Alaska is entitled to one annual pharmacy claim audit.

Attachments:

3.2.10.13 Please confirm that you will provide claims, payment documentation and other necessary information required for the State to complete its annual health funds audits.

Answer: Confirmed.

Attachments:

3.2.10.14 Do you agree to a fund implementation audit, prior to effective date, up to \$50,000 to be performed by a firm of the State's choosing?

Answer: 1: Yes

Detail: Aetna agrees to fund an implementation audit up to \$50,000.

Options:

1. Yes
2. No

Attachments:

3.2.10.15 Please indicate whether or not you agree with the following statements regarding Audits.

	Agree
You will allow auditing of your operations as they relate to the administration and servicing of this account.	1: Agree
Your organization will not charge for services rendered in conjunction with the audit.	1: Agree
If problems are discovered, follow-up audits will be paid by your organization.	2: Disagree

Detail: Extraordinary expenses incurred by us, and not included in our cost allocation formula, will be the customer's responsibility. When an audit is conducted on behalf of the customer's self-funded plan, the customer is responsible for paying the audit fees assessed by an audit firm or any of the extraordinary administrative expenses. Any payment by Aetna resulting from the audit must be based upon documented findings agreed to by both parties, and must be solely due to our actions or inactions and based on any liability as set forth in our specific contract with the customer.

It is our policy and position that we will not pay the customer's audit vendor fees. Because the audit vendor is to provide opinion to the customer on the quality of our services, Aetna paying all or part of the costs associated with the vendor's audit could impact the objectivity of the audit.

Attachments:

3.2.10.16 Do you use a statistically significant sample for internal audits?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.10.17 Do you have a dedicated internal audit staff?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.10.18 With what frequency is the claims processing function audited by an external auditing firm?

Answer: 4: Other: [An independent audit firm conducts a SAS 70 audit twice a year. SAS 70 is an auditing standard set forth by the American Institute of Certified Public Accountants (AICPA).]

Detail:

Options:

1. Daily
2. Weekly

3. Monthly
4. Other: [Text]

Attachments:

3.2.10.19 With what frequency is the claims processing function audited internally?

Answer: 2: Weekly

Detail: We check the accuracy of our claim processing system as follows:

Routine

Each week, our audit technicians review numerous pharmacy claims to verify our system is adjudicating the claims properly.

After Program/System Changes

When we make hardware or software changes, our technical staff and business subject matter experts perform stringent testing on the claim processing system. Testing includes change-specific scenarios followed by a full system regression test. All areas must sign-off on the new functionality before it goes into production to promote a smooth implementation.

Options:

1. Daily
2. Weekly
3. Monthly
4. Other: [Text]

Attachments:

3.2.10.20 Are audits performed on a pre- or post-disbursement basis?

Answer: 3: Both

Detail:

Options:

1. Pre-Disbursement
2. Post-Disbursement
3. Both

Attachments:

3.2.10.21 How are claims selected for audit?

Answer: 1: Random by system

Detail:

Options:

1. Random by system
2. Set percent per day
3. Set number per approver per day/week
4. Diagnosis
5. Dollar amount

6. Other. Please specify: [Text]

Attachments:

3.2.10.22 The State has the right to audit any data necessary to ensure the Offeror is complying with all contract terms, which includes but is not limited to 100% of pharmacy claims data, which includes at least all National Council for Prescription Drug Program (NCPDP) fields from the most current version and release; pharmaceutical manufacturer and wholesaler agreements; [retail pharmacy contracts; mail and specialty pharmacy contracts to the extent they exist with other vendor(s)]; approved and denied utilization management reviews; clinical program outcomes; appeals; information related to the reporting and measurement of performance guarantees; etc.

Answer: 2: No

Detail: We welcome independent audits of relevant records and documentation by the State of Alaska or their representatives, provided no audit interferes with our business operations or the confidential interests of our company or another party. We have assumed for the purpose of this proposal that an “audit” is defined as performing a review of claim transactions for the purpose of assessing the accuracy of benefit determinations and shall be subject to mutual agreement as to nature, scope, format, structure and cost.

Audits must be commenced within two years following the period being audited.

The size of the audit sample may not exceed 250 claim transactions for an onsite audit, without Aetna's written consent and the payment of fees as assessed by Aetna.

Aetna is not responsible for paying the State of Alaska's audit fees or the costs associated with the audit. We work from established audit guidelines that are accepted in this industry and we are confident we can meet your needs in this important area as well.

In order to successfully support an onsite audit, APM needs a minimum of four weeks to prepare and pull supporting documentation for the audit. Aetna supports hundreds of audits annually and needs to ensure that there is minimal disruption to the operation.

Aetna will share information with a qualified auditor under a strict confidentiality agreement that prohibits disclosure of the information to any third party and will not use this information for any purposes other than the audit. In addition, the qualified auditor must have no conflict of interest or past business or other relationship which would prevent the auditor from performing an independent audit to conclusion. A conflict of interest includes, but is not limited to, a situation in which the audit agent:

(i) Is employed by an entity, or any affiliate of such entity, which is a competitor to Aetna's benefits or claims administration business or Aetna's mail order or specialty pharmacy businesses

(ii) Is affiliated with a vendor subcontracted by Aetna to adjudicate claims or provide services in connection with Aetna's administration of benefits or provision of mail order or specialty pharmacy services. Auditors must enter into an appropriate confidentiality agreement with, and acceptable to, Aetna prior to conducting any audit.

Claim audits are subject to the above referenced audit standards in the case of a physical, onsite, claim-based audit. In the case of electronic claim audits that follow standard pharmacy benefit audit practices where electronic re-adjudication of claims is requested and processed offsite, the State of Alaska may elect to audit 100 percent of claims. The State of Alaska is entitled to one annual claim

audit.

Rebate Audits

While our manufacturer rebate contracts are considered proprietary, we would allow the State of Alaska or a mutually agreed upon third party auditor to conduct this type of audit. Every effort will be made to provide the State of Alaska with information sufficient to confirm the payments to them are accurate.

The audit will target a review representing approximately 15 percent of your rebate dollars, which cover the most highly utilized drugs. When permitted by our rebate agreements, we will disclose the financial exhibits of the contract, including the manufacturer name, drug name and rebate percentage for the drugs agreed upon between Aetna and the pharmaceutical manufacturer.

The drugs to be audited will be selected by you based on rebate dollars. We will work with you to target the fewest unique contracts required for audit so that the selected drugs represent approximately 15 percent of rebate dollars or no more than five contracts, whichever is lower. In addition to the contracts, we will provide access to documents governing the calculation, invoicing, remittance, accounting and allocation of rebates received for the identified drugs. APM will provide a report identifying those drugs to the State of Alaska for review prior to the audit.

Our network provider and pharmaceutical manufacturer contracts are considered proprietary and confidential; therefore, they cannot be released for customers to audit.

We believe this process will provide the State of Alaska with information sufficient to satisfy the transparency requirements of the contract.

Options:

1. Yes
2. No

Attachments:

3.2.10.23 The State has the right to conduct audits at any time during the contract term upon 30-days written notice to the Offeror.

Answer: 1: Yes

Detail: In order to successfully support an onsite audit, APM needs a minimum of four weeks to prepare and pull supporting documentation for the audit. Aetna supports hundreds of audits annually and needs to ensure that there is minimal disruption to the operation.

Claim audits are subject to the previously described audit standards in the case of a physical, onsite, claim-based audit. In the case of electronic claim audits that follow standard pharmacy benefit audit practices where electronic re-adjudication of claims is requested and processed offsite, the State of Alaska may elect to audit 100 percent of claims. The State of Alaska is entitled to one annual claim audit.

Options:

1. Yes
2. No

Attachments:

3.2.10.24 The State has the right to audit post termination.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.10.25 The Offeror will not limit the time period of paid claims to be audited.

Answer: 2: No

Detail: Audits must be commenced within two years following the period being audited.

Options:

1. Yes
2. No

Attachments:

3.2.10.26 The State must not be responsible for any of the Offeror's expenses related to an operational or financial audit, including the provision of records.

Answer: 1: Yes

Detail: You will not be responsible for paying our audit-related expenses as long as they fit within our standard audit provisions. Likewise, we are not responsible for paying your audit fees or the costs associated with the audit. We work from established audit guidelines that are accepted in this industry and we are confident we can meet your needs in this important area as well.

Options:

1. Yes
2. No

Attachments:

3.2.10.27 The State has the right to audit at no charge except at a direct pass-through of any data retrieval fees, which may be required if data requested has already been stored.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.10.28 The State has the right to audit more than once per year if the audits are different in scope or for different services.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.10.29 The State has the right to perform additional audits during the year of similar scope if requested as a follow-up to ensure significant/material errors found in an audit have been corrected and are not recurring or if additional information becomes available to warrant further investigation.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.10.30 Offeror shall provide reasonable cooperation with requests for information, which includes but is not limited to the timing of the audit, deliverables, data/information requests and your response time to our questions during and after the process.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.10.31 Offeror shall provide a response to all “findings” that receives within 10 days, or at a later date if mutually determined to be more reasonable based on the number and type of findings.

Answer: 1: Yes

Detail: We typically request 15 business days but are willing to discuss this in greater detail with the State of Alaska.

Options:

1. Yes
2. No

Attachments:

3.2.10.32 Offeror agrees to permit auditing and support client requested auditing of electronic invoice reviews with each invoice.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.10.33 Offeror will support, not impede, the State's auditing of performance metrics at any time during the contract term.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.10.34 Offeror conducts a type II SAS70 audit at least annually at no cost to the State.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.10.35 Offeror will refund the State for any claims agreed to be errors within an audit and outside the audit period if a systemic error was found that found to be in other time periods based on Offeror's research.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.10.36 Confirm that you will handle all mandatory reporting to CMS and states that have surcharges such as New York and Massachusetts.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No. Explain: [Text]

Attachments:

3.2.10.37 The State requires the ability to audit the vendor administering its Medicare Part D drug program. Describe any audit requirements or restrictions regarding your services and confirm that the State will not be responsible for any audit expenses incurred by your organization.

Answer: We welcome independent audits of relevant records and documentation by our customers or their representatives, provided no audit interferes with our business operations or the confidential interests of our company or another party. We have assumed for the purpose of the proposal that an "audit" is defined as performing a review of claim transactions for the purpose of assessing the accuracy of benefit determinations and shall be subject to mutual agreement as to nature, scope, format, structure and cost.

Audits must be commenced within two years following the period being audited.

The size of the audit sample may not exceed 250 claim transactions for an onsite audit, without Aetna's written consent and the payment of fees as assessed by Aetna.

Aetna is not responsible for paying your audit fees or the costs associated with the audit. We work from established audit guidelines that are accepted in this industry and we are confident we can meet your needs in this important area as well.

In order to successfully support an onsite audit, APM needs a minimum of four weeks to prepare and pull supporting documentation for the audit. Aetna supports hundreds of audits annually and needs to ensure that there is minimal disruption to the operation.

Aetna will share information with a qualified auditor under a strict confidentiality agreement that prohibits disclosure of the information to any third party and will not use this information for any purposes other than the audit. In addition, the qualified auditor must have no conflict of interest or past business or other relationship which would prevent the auditor from performing an independent audit to conclusion. A conflict of interest includes, but is not limited to, a situation in which the audit agent:

- (i) Is employed by an entity, or any affiliate of such entity, which is a competitor to Aetna's benefits or claims administration business or Aetna's mail order or specialty pharmacy businesses
- (ii) Is affiliated with a vendor subcontracted by Aetna to adjudicate claims or provide services in connection with Aetna's administration of benefits or provision of mail order or specialty pharmacy services. Auditors must enter into an appropriate confidentiality agreement with, and acceptable to, Aetna prior to conducting any audit.

Claim audits are subject to the above referenced audit standards in the case of a physical, onsite, claim-based audit. In the case of electronic claim audits that follow standard pharmacy benefit audit practices where electronic re-adjudication of claims is requested and processed offsite, you may elect to audit 100 percent of claims. You are entitled to one annual claim audit.

Attachments:

3.2.11 Appeals

3.2.11.1 Describe your method for processing appeals for certification review, claim review and/or billing appropriateness.

Answer: We provide a nationally standardized process for resolving member complaints and appeals to enhance our ability to handle complaints and appeals in a consistent and timely fashion. Some states have requirements that are different from federal requirements. State requirements supersede only when they are more advantageous to the member (e.g., more aggressive turnaround times for response). For example, the State of Alaska requires that post-service utilization review appeals be resolved and written notice sent to the member within 18 working days. We recognize the AlaskaCare plan is not subject to the Alaska Division of Insurance Statutes, but we could accommodate if this were to ever change in the future. Aetna's law department will support the business area in the interpretation of applicable law.

COMPLAINTS

Our Customer Service Representatives (CSRs) respond to most member inquiries at the point of contact. If the issue cannot be resolved during the call, the CSR forwards the complaint to the Customer Resolution Team (CRT) for handling, and, if needed, to the appropriate business area for investigation and response. We will have a concierge for the State's members with local representatives in Juneau and Anchorage who will be familiar with the kinds of issues facing Alaska members and provide a high level of satisfaction. Members who are not satisfied with the response may file an oral or written complaint and/or appeal.

APPEALS

To start the appeals process, the member or provider/representative acting on behalf of the member submits a verbal or written request asking for a change in the initial determination decision. The member or authorized representative has 180 days after receipt of a coverage decision to file an appeal. A written notice stating the result of the review will be forwarded to the member. If the member or authorized representative is not satisfied with the outcome of the Level I appeal decision, they may submit an oral or written request, within 60 days of receipt of a Level I decision, for further appeal review. For clinical appeals, the second level review is performed by a practitioner who typically treats the condition, performs the procedure, or provides the treatment under review and was neither involved in the original denial of coverage determination or Level I appeal.

If a Level II appeal is denied, the written notice includes all specific reasons for the denial, including the clinical rationale, reference to applicable plan provisions, medical and dental information reviews, and any other applicable appeal procedures that may be available.

EXTERNAL REVIEW

Aetna will support and administer an external review. The member will have four months from the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination to request an external review. Upon receipt of a request for external review, Aetna will perform a preliminary review to determine whether i) the member was covered by the plan on the date the services were requested or provided, ii) the adverse determination does not relate to the member's failure to meet the requirements for eligibility under the terms of the group health plan, iii) the member has exhausted the plan's internal appeal process (unless not required under the interim final regulations); and iv) the member has provided all the information and forms required to process the external review. The plan must issue notification in writing to the member if complete but ineligible with notification to include the reason for its ineligibility and contact information for the Employee

Benefits Security Administration (toll-free number 866-444-3272). If not complete, the notification must describe the information needed to make the request complete and must allow the member to perfect the request within the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

The IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review and must deliver the notice of final external review decision to the member and the plan. If the IRO overturns the decision the health plan is required to immediately provide coverage or payment or authorize services as applicable. The decision of the independent reviewer is binding on Aetna and the State. Members are not charged a professional fee for the review.

An expedited process is available when the determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the member or would jeopardize the member's ability to regain maximum function and the member or provider on behalf of the member has filed a request for an expedited internal appeal.

Attachments:

3.2.11.2 Explain how you use staff medical professionals and/or outside consultants to review disputed claims for medical necessity and billing appropriateness.

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

CRTs are comprised of complaint and appeal analysts who are responsible for all member appeals. Medical directors make appeal decisions with a clinical element. The medical directors review the clinical evidence provided against current medical standard of practice as well as Aetna clinical policies and procedures.

The medical director is board certified in an area of clinical medicine with experience in private practice. We require leadership experience in managed care and demonstrated accomplishments in the areas of:

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

Our medical directors are required to have an M.D. or D.O. degree and be board certified in a recognized specialty including post-graduate direct patient care experience. We also require an active and current state medical license without encumbrances and a minimum of three to five years experience in the health care delivery system, for example, clinical practice and health care industry.

OUTSIDE CONSULTANTS

Aetna will support and administer an external review. The member will have four months from the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination to request an external review. Upon receipt of a request for external review, Aetna will perform a preliminary review to determine whether i) the member was covered by the plan on the date

the services were requested or provided, ii) the adverse determination does not relate to the member's failure to meet the requirements for eligibility under the terms of the group health plan, iii) the member has exhausted the plan's internal appeal process (unless not required under the interim final regulations); and iv) the member has provided all the information and forms required to process the external review. The plan must issue notification in writing to the member if complete but ineligible with notification to include the reason for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-3272). If not complete, the notification must describe the information needed to make the request complete and must allow the member to perfect the request within the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

The IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review and must deliver the notice of final external review decision to the member and the plan. If the IRO overturns the decision the health plan is required to immediately provide coverage or payment or authorize services as applicable. The decision of the independent reviewer is binding on Aetna and the State. Members are not charged a professional fee for the review.

An expedited process is available when the determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the member or would jeopardize the member's ability to regain maximum function and the member or provider on behalf of the member has filed a request for an expedited internal appeal.

Attachments:

3.2.11.3 Describe how you retain medical consultants that represent various specialties for use in pre-authorization and claims resolution.

Answer: For clinical appeals, the second level review is performed by a practitioner who typically treats the condition, performs the procedure, or provides the treatment under review and was neither involved in the original denial of coverage determination or Level I appeal.

In addition, our precertification nurses refer cases to a medical director when:

- The available clinical information does not meet decision-making guidelines
- The length of stay exceeds guidelines

Our medical director may discuss the individual member's situation with the attending physician. If necessary, the medical director may also ask another physician of the same or similar specialty to review. Only our medical directors can make denial decisions based on medical necessity.

We employ over 100 full-time medical directors in varied roles. Major specialties include:

- Ob/gyn
- Cardiology
- Oncology
- Neonatology
- Gastroenterology
- Pediatrics
- Internal medicine
- Orthopedics

- General surgery
- Ophthalmology

Attachments:

3.2.11.4 Describe your multi-level appeals process for administrative and clinical denials.

Answer: A Level I appeal is defined as a verbal or written request by a member, or a member's authorized representative, requesting a change in an initial determination decision. This includes but is not limited to requests related to the following:

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

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

Expedited appeals: 36 hours

Pre-service appeals: 15 days

Post service appeals: 30 days (For Alaska insured business we currently use a 18 day timeframe for post-utilization of review appeals, and could put this in place for Alaska if amenable)

If the member or authorized representative is not satisfied with the outcome of the Level I appeal decision, they may submit an oral or written request, within 60 days of receipt of a Level I decision, for further appeal review. For clinical appeals, the second level review is performed by a practitioner who typically treats the condition, performs the procedure, or provides the treatment under review and was neither involved in the original denial of coverage determination or Level I appeal.

If a Level II appeal is denied, the written notice includes all specific reasons for the denial, including the clinical rationale, reference to applicable plan provisions, medical and dental information reviews, and any other applicable appeal procedures that may be available, including the External Review.

Attachments:

3.2.11.5 Describe how you will meet the State's appeal process requirements and confirm you will be able to provide copies of all claim and appeal documents to the State for appeals that reach the State's level.

Answer: We provide a complete packet that includes all documentation used in making original claim and appeal determinations when fiduciary responsibility shifts to the State.

Attachments:

3.2.11.6 Confirm that you will participate, if needed, in administrative hearings resulting from denial determinations.

Answer: Confirmed. We will defend any lawsuit originating during or after completion of the first two levels of appeal. After all levels of appeal and the External Review option, if applicable, are

exhausted, there is a Voluntary Appeal process available through the State. The State becomes responsible for defense of any lawsuit originating from the Voluntary Process.

Attachments:

3.2.11.7 Provide the percentages of total claims processed monthly that are appealed for other clients of similar size to the State.

Answer: Approximately 0.2% of all claims received are appealed. We do not track appeals by client size.

Attachments:

3.2.11.8 Of your total denials, provide the percentage of services that are generally overturned on appeal.

Answer: In 2011, approximately 28% of decisions were overturned and 65% of decisions were upheld as a result of an appeal. The remaining 7% were either partially overturned or were redirected to the customer/employer for handling.

Attachments:

3.2.11.9 Do you have a dedicated appeals staff?

Answer: Yes. We have an internal team who is dedicated to appeals resolution.

Attachments:

3.2.11.10 Confirm the State will have a single point of contact for appeals related inquiries.

Answer: Confirmed. The State's Plan Sponsor Liaison (PSL) is the single point of contact for appeals related inquiries. The PSL serves as an extension of the State's account management team. They are located in the customer service center and act as a single point of contact for the State to assist you in resolving escalated issues. Your PSL will work with the appeals team and other Aetna resources to obtain all of the necessary information surrounding inquiries.

Attachments:

3.2.11.11 Please provide copies of all appeal decision notices you use.

Answer: 1: Attached

Detail:

Options:

1. Attached
2. Not attached

Attachments: [Aetna Appeal Letter Sample.doc](#)

3.2.11.12 Describe other services you offer prior to or during appeal.

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

CRTs are comprised of complaint and appeal analysts who are responsible for all member appeals.

The State will also have a health concierge who can assist members with the appeal process, as well as local service representatives within our Anchorage and Juneau offices.

Attachments:

3.2.12 Data Analysis

3.2.12.1 Data Collection

3.2.12.1.1 Do you utilize a data warehouse for reporting and claim and trend analysis?

Answer: Yes.

Attachments:

3.2.12.1.2 Describe your organization's data warehousing and population health analytical services, including software used.

Answer: One of our most differentiating assets, our vast data warehouse, consists of 18 terabytes of integrated claim, membership, product and provider information.

The data warehouse is larger and more sophisticated than standard database management systems available in the marketplace. It is sourced by numerous operational systems such as:

- Enrollment/eligibility
- Claims administration
- Provider applications
- Patient management applications

The data warehouse encompasses the following product lines:

- Medical
- Pharmacy
- Dental
- Vision
- Disability
- Behavioral Health

From this data warehouse we execute numerous data analytic, reporting, trending, predictive modeling and data mining processes and activities.

Software

Our Data Warehouse is on the IBM p-Series class machinery running AIX. At this time, we are using AIX software version 5. 3 Power 5 Technology and DB2 version 8.2. The Data Warehouse and reporting data marts are currently being upgraded to Power 6 Servers with DB2 9. 5.

We are committed to keeping the environments and software up to date with product releases from our vendor partners. In addition, we constantly and consistently evaluate our environment for performance and currency and upgrade hardware and software as appropriate.

Attachments:

3.2.12.1.3 What resources do you provide from a health data analyst perspective to support your clients?

Answer: Your account team can provide you with an extensive range of unique reporting and modeling capabilities to meet the needs of your organization. They will act as an extension of your own resources with the primary goals of identifying plan and clinical management opportunities and supporting data-driven decision-making. They will also access other areas of our analytic infrastructure, including reporting, information technology, web-based support, and PhD/masters-level

researchers as needed in support of your goals.

We have a number of modeling tools to support your pharmacy benefits. We provide all modeling services described below at no additional cost.

RxPerspectives Review

The RxPerspectives review offers a customized and comprehensive look at your prescription plan's financial and service-related metrics. The report includes trends associated with price, product, utilization and comparisons with customers of similar demographic makeup and our book of business. The report also monitors the impact of any plan design or clinical strategies implemented by you, identifies additional strategies and forecasting that could improve the performance of the benefit, and makes specific recommendations supported by your unique data.

The RxPerspectives report supports our consultative approach to account management and enables you to construct a plan design and make new program decisions based on facts. Your account team will use the RxPerspectives review to make plan design recommendations that are aligned with your goals. Team members can also suggest programs or initiatives that focus on issues unique to your plan, reduce overall health care spending, and improve health outcomes.

Personalized Opportunity Analysis - Identifying Big Picture Opportunities

Using the Personalized Opportunity Analysis (POA), we will provide you with the tools and ongoing analyses of your results to clearly explain and optimize your spend. The POA, based on your actual data, will provide actionable channel, therapy and identify the opportunities for savings and performance improvement. We will then use the POA to deliver recommendations based on your needs and goals.

Plan Design

The pharmacy team will use our consultative tools to measure the financial impact of various plan design changes and assess your plan performance.

For example, we can work with you to determine the savings associated with:

- Changing copays
- Adding Choose Generics cost-sharing options
- Implementing Aetna Rx Home Delivery® mail order options
- Comparing coinsurance versus copayment plan designs

Program-Specific Modeling

Your pharmacy account team can analyze how specific programs or initiatives (e.g., Save a Copay®, Aetna Rx Check® programs) will impact your pharmacy plan. We can present how these programs will impact spending while improving member health.

Attachments:

3.2.12.1.4 If yes, please provide the name of the warehouse and indicate if the State will have access to data and reporting. If there is an additional cost, please indicate the cost on the rate sheet.

Answer: Aetna Rx Tools, our online report tool and decision support system, accommodates the differentiation of clinical, financial, and utilization data analysis. Secure online access will enable you to query large volumes of adjudicated retail, mail and specialty prescription claims without the frustrations of software updates.

Product Functionality

You can define the way you manage pharmaceutical costs with use of an extensive portfolio of preformatted management reports and the freedom to create and customize reports.

Preformatted Reports

You can easily generate preformatted reports in Aetna Rx Tools by selecting the desired preformatted report, identifying the search criteria from preselected dimensions and then retrieving your results.

Customized Reports

Customized reporting options are virtually unlimited with this tool. You have the ability to design and format custom reports, beginning with hundreds of variables from the following industry dimensions:

- Standard Dimensions
- Beneficiary
- Cardholder
- Pharmacy
- Prescriber
- Claims
- Drug
- Metrics

Advanced Features

The following user-friendly features are available with every report you generate.

Drilling

The drill function enables you to analyze any underlined variable or metric on an active report with greater detail. Aetna Rx Tools generates a new report each time you drill, and houses the original report in the “History List” within the project.

Graphs

The system allows you to set the display and format styles for reports. This feature provides an easy switch from grid mode (rows and columns) to graph mode or vice versa.

Additional Features

Advanced features allow you to display totals; edit standard reports; export reports to Excel, a text file, HTML or PDF; as well as print, save, and format.

Training and Support

Your account team will provide you with the training and ongoing support to you so you are able to take full advantage of the many benefits of the tool.

We typically provide training for one to four users over the telephone. We can provide training for five or more users at your location, or at one of our Aetna offices.

Our technical and clinical teams offer consultative services to assist you and your users with any additional reporting issues or requirements.

Attachments:

3.2.12.1.5 Explain whether your organization will release detailed claims data to a central data warehouse for non-AlaskaCare health plan related analysis. Indicate if you are paid to provide this data.

Answer: All customer data is included in our enterprise data warehouse. We access claims and related information from that data warehouse for a number of mandatory and/or legally permissible purposes, including health care operations, reporting to governmental and other oversight agencies, research and data mining activities. There may be circumstances where we use customer information obtained through the data warehouse and are compensated for such use. In these instances, the data is used in a manner that does not link it to any specific customer or member. No compensation is made to any customer for the use of this data.

Attachments:

3.2.12.2 Reporting

3.2.12.2.1 Attach samples of your standard reporting package. Label attachment "Standard Reporting Package"

Answer: 1: Attached

Detail:

Options:

1. Attached
2. Not Attached

Attachments: [Question 3.2.12.2.1 Standard Reporting Package.xls](#)

3.2.12.2.2 Attach a list and detailed description (including frequency) of the reports provided on a standard basis (at no additional cost).

Answer: 1: Attached

Detail: Aetna Health Information Advantage, our powerful information application software tool created by Aetna Informatics, makes performance experience data available in real time through the Internet.

Our standard quarterly reporting package is the ideal tool for benefits managers, placing valuable information right at their fingertips. Interactive data analysis can be performed on topics such as key measures, utilization and membership. These topics, called modules, are produced at the customer level by funding arrangement and product type on an incurred basis. The modules offer a high-level view of the current data as well as book of business and prior year comparisons.

Each module can be drilled down into more detailed reporting and graphs allowing users to group and refine how they look at the data with options such as time period, products, age, gender, region, pharmacy detail, geographic and provider specific detail. Reports can be saved or downloaded into Microsoft® Excel for review, analysis and electronic communication.

Preformatted reports are also available at the customer level by funding arrangement and product type on an incurred claim basis. The reports offer a view of the current year's and the prior year's data, illustrating utilization and financial trends in a concise, graphical format. The reports are available quarterly, within 45 days following the end of the reporting period.

The standard preformatted report package provides data on the following:

- Key Statistics Pharmacy - Provides a summary of key financial statistics and cost trends. It includes pharmacy program performance measurements, such as claim cost, utilization rates and per eligible and utilizing member statistics. It also provides comparison statistics for our book-of-business

average, which is valuable in evaluating program performance.

- **Key Statistics by Generic, Brand Single-Source and Brand Multi-Source** - The report consists of a more detailed analysis of generic, brand single-source and brand multi-source claims. Brand single-source drugs are those drugs on the market whose patent has not expired; therefore, generic drug alternatives are not available. Brand multi-source drugs are drugs that have a generic alternative that could have been dispensed.
- **Formulary Analysis** - Provides detailed financial information by generic, brand formulary and brand nonformulary. It provides a further breakdown by retail, mail order drug pharmacies and Specialty. It outlines the number of pharmacy claims, the calculated ingredient cost, dispensing fees, sales tax, copay amount and paid amount by each subcategory outlined.
- **Retail, Mail Order and Specialty Comparison Analysis** - This report outlines the number of claims, total paid amount and employee versus employer cost sharing by retail, mail order and specialty drugs.
- **Top 30 Drugs by Number of Claims** - The report shows important financial, membership and utilization information for the top utilized drugs ranked by number of claims.
- **Top 30 Drugs by Number of Paid Amount** - This report shows important financial, membership and utilization information for the top utilized drugs ranked by paid amount.

Information is encrypted in both systems so that your utilization information remains secure.

Options:

1. Attached
2. Not Attached

Attachments: [Question 3.2.12.2.1 Standard Reporting Package.xls](#)

3.2.12.2.3 Are you able to provide reporting that allows the State to see trends in claim activity information by different organization units?

Answer: Yes. Interactive data analysis can be performed on topics such as key measures, utilization and membership. These topics, called modules, are produced at the customer level by funding arrangement and product type on an incurred basis. The modules offer a high-level view of the current data as well as book of business and prior year comparisons.

Each module can be drilled down into more detailed reporting and graphs allowing users to group and refine how they look at the data with options such as time period, products, age, gender, region, pharmacy detail, geographic and provider specific detail. Reports can be saved or downloaded into Microsoft® Excel for review, analysis and electronic communication.

Attachments:

3.2.12.2.4 Describe any custom reporting and data dashboards you have created for your clients, be specific and how they integrated into the full suite of services being proposed.

Answer: Customized ad hoc reports are available upon request from Aetna Informatics. Aetna Informatics assigns business consultants on a fee-for-service basis to support local customers, provide tailored information and respond to analytic needs. Requested reports are made available electronically through e-mail in Microsoft Excel® format.

Commonly requested ad hoc reports capture:

- Breakdown of claim utilization by subset of employee population
- Clinical analysis of specific drug therapy (e.g., migraine medications)
- Comparison report - prior year versus current year data

Our pharmacy claim system captures numerous data elements that are used in combination to generate customized or ad hoc reports. Common data elements used include:

Prescription Information

- Number
- Quantity
- Professional fee
- Fill date
- Days supply
- Copay
- Refill number
- Ingredient cost
- Paid amount

Drug Information

- National drug code (NDC)
- Name
- Dispense as written (DAW) indicator
- Maximum allowable cost (MAC) indicator
- American Hospital Formulary Service class number
- Generic code
- Package size

Physician Information

- Name
- Plan
- Department
- Number
- Specialty
- Begin date
- End date

• Provider Information

- Number
- Name
- Address
- City
- State
- Zip code
- Phone
- Begin date
- End date

Attachments:

3.2.12.2.5 Are reports available via the web?

Answer: Yes.

Attachments:

3.2.12.2.6 Are you able to accommodate requests for ad-hoc or customized reporting (including utilization information) at no cost to the State? If there is an additional cost, please indicate the cost on the rate sheet.

Answer: Customized ad hoc reports are available upon request from Aetna Informatics. Aetna Informatics assigns business consultants on a fee-for-service basis to support local customers, provide tailored information and respond to analytic needs. Requested reports are made available electronically through e-mail in Microsoft Excel® format.

We will provide you with a predetermined amount of pre-paid hours for ad hoc reporting. Prepaid hours may be used for ad hoc reporting and other analytic projects. Once the prepaid hours are exhausted, a time spent charge of \$200 per hour for report generation/programming and \$350 per hour for analytic/consulting services is charged per project. Prepaid hours are not available for use with technical programming staff.

Attachments:

3.2.12.2.7 If you are able to accommodate ad- hoc or customized reporting, what is the normal turnaround time to fulfill such request.

Answer: Turnaround time on customized ad hoc requests varies, and is quoted before production commences. It is based upon the complexity of the request and the volume of reports being prepared. Most projects are generally delivered within three to five business days from the time the quote is accepted by the customer. Very complex and/or high volume ad hoc report requests may require longer delivery timeframes.

Attachments:

3.2.12.2.8 Will you provide performance review reports by each different group/plan at least quarterly or more frequently if requested at no additional charge?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.12.2.9 Will you provide clinical program management outcome reports quarterly?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

3.2.12.2.10 List all your client website reporting capabilities and please be specific.

Answer: Aetna Health Information Advantage, our powerful information application software tool created by Aetna Informatics, makes performance experience data available in real time through the Internet.

Our standard quarterly reporting package is the ideal tool for benefits managers, placing valuable information right at their fingertips. Interactive data analysis can be performed on topics such as key measures, utilization and membership. These topics, called modules, are produced at the customer level by funding arrangement and product type on an incurred basis. The modules offer a high-level view of the current data as well as book of business and prior year comparisons.

Each module can be drilled down into more detailed reporting and graphs allowing users to group and refine how they look at the data with options such as time period, products, age, gender, region, pharmacy detail, geographic and provider specific detail. Reports can be saved or downloaded into Microsoft® Excel for review, analysis and electronic communication.

Preformatted reports are also available at the customer level by funding arrangement and product type on an incurred claim basis. The reports offer a view of the current year's and the prior year's data, illustrating utilization and financial trends in a concise, graphical format. The reports are available quarterly, within 45 days following the end of the reporting period.

The standard preformatted report package provides data on the following:

- **Key Statistics Pharmacy** - Provides a summary of key financial statistics and cost trends. It includes pharmacy program performance measurements, such as claim cost, utilization rates and per eligible and utilizing member statistics. It also provides comparison statistics for our book-of-business average, which is valuable in evaluating program performance.
- **Key Statistics by Generic, Brand Single-Source and Brand Multi-Source** - The report consists of a more detailed analysis of generic, brand single-source and brand multi-source claims. Brand single-source drugs are those drugs on the market whose patent has not expired; therefore, generic drug alternatives are not available. Brand multi-source drugs are drugs that have a generic alternative that could have been dispensed.
- **Formulary Analysis** - Provides detailed financial information by generic, brand formulary and brand nonformulary. It provides a further breakdown by retail, mail order drug pharmacies and Specialty. It outlines the number of pharmacy claims, the calculated ingredient cost, dispensing fees, sales tax, copay amount and paid amount by each subcategory outlined.
- **Retail, Mail Order and Specialty Comparison Analysis** - This report outlines the number of claims, total paid amount and employee versus employer cost sharing by retail, mail order and specialty drugs.
- **Top 30 Drugs by Number of Claims** - The report shows important financial, membership and utilization information for the top utilized drugs ranked by number of claims.
- **Top 30 Drugs by Number of Paid Amount** - This report shows important financial, membership and utilization information for the top utilized drugs ranked by paid amount.

Information is encrypted in both systems so that your utilization information remains secure.

Attachments:

3.2.12.2.11 In addition to typical claims file requests for use by case and disease management vendors, please confirm that, if requested by the State and with the appropriate confidentiality agreements in place, you will provide full claims detail, which include pricing information, to State's third parties? Note any limitations and/or fees for such requests.

Answer: Confirmed.

Attachments:

3.2.12.2.12 Provide a sample rebate report that will be provided with each payment to the State and its consultant which include a breakdown of rebate payments by; a) therapy class, and b) manufacturer.

Answer: 1: Attached

Detail:

Options:

1. Attached
2. Not Attached

Attachments: [Question 3.2.12.2.12. - Rebate Report Sample.xls](#)

3.2.13 Financial

3.2.13.1 Subrogation

3.2.13.1.1 Do you charge for subrogation?

Answer: Yes.

Attachments:

3.2.13.1.2 If you answered Yes to the previous question, please indicate the charge for subrogation.

Answer: We are offering subrogation on an incentive basis. If the State of Alaska engages Aetna to provide comprehensive subrogation services, we will retain a fee of 30% of recovered amounts. We have an agreement with the firm of Rawlings & Associates to provide these services. If the state does not accept the incentive based payment structure for subrogation, Aetna would not be able to provide subrogation services.

Attachments:

3.2.13.2 Banking

3.2.13.2.1 Provide a sample of your administrative fee invoice.

Answer: 1: Attached

Detail:

Options:

1. Attached
2. Not Attached

Attachments: [Aetna Fee Invoice Sample.pdf](#)

3.2.13.2.2 Describe your process for printing checks, including whether they are produced daily, weekly, monthly or other. Describe whether the timing is different for members than for providers and your

process for replacing a lost check when notified by a member or provider that they did not receive the check.

Answer: We mail member EOBs and checks daily when there is a member payment or request for additional information from the member. We produce EOBs in Erlanger, KY by an off-site print vendor.

We age and bulk in a schedule provider EOBs and checks, whether for network or non-network providers. This allows delivery within 24 days of the claim received date. We send the majority on either a weekly or biweekly schedule, and on a consistent day of the week determined by state location of the provider. A provider EOB accompanies each provider draft. The EOB breaks down the payment by patient and gives pertinent information about the payment and non-covered expenses.

Members can contact their health concierge and member services if they did not receive a check. We will work with the member to replace the lost check as soon as possible.

Attachments:

3.2.13.2.3 Describe whether the timing for printing checks is different for members than providers and your process for replacing a lost check when notified by a member or provider that they did not receive the check.

Answer: EOBs will go out daily, and not aged when there is a member payment or request for additional information from the member. Members can contact their health concierge and member services if they did not receive a check. We will work with the member to replace the lost check as soon as possible.

We age and bulk provider EOBs and checks, whether for network or non-network providers. This allows delivery within 24 days of the claim received date. We send the majority on either a weekly or biweekly schedule, and on a consistent day of the week determined by state location of the provider.

Attachments:

3.2.13.2.4 What measures are in place to ensure that reimbursements are issued to the proper party?

Answer: We have end to end quality measures in place to ensure payment accuracy. In addition to an extensive array of system controls, we perform the following prepayment audits:

- Trainee Audit - Initially, the business unit provides mentors/auditors to audit 100 percent of claims processed by trainees. As each trainee's results reach an acceptable level in a category, the percentage of claims reviewed decreases.
- Draft Authority Limit Audit - Each individual in the service center has a specific draft authority limit. Supervisory or management personnel review claims above that limit.
- Prepayment Review - We audit all claims equal to or greater than \$7,000. The quality auditors report to our National Customer Operations (NCO) Claim Quality department.
- Itemized Bill Review - For certain large inpatient facility claims from network facilities, we offer Itemized Bill Review (IBR), an additional feature of our National Advantage Program (NAP). We have partnered with a vendor to review these claims for billing errors prior to claim adjudication. IBR reviews inpatient facility bills with submitted expenses of \$20,000 or more incurred at a network facility (excluding per diem arrangements). We pay the claim based on standard billing practices and in accordance with the facility's contractual arrangements. The State must participate in NAP in order

to elect IBR.

We perform the following audits on a post-payment basis:

- **Stratified Quality Audit** - Using an industry accepted stratified audit methodology, the population of processed claims are segregated into dollar categories (strata) based upon the amount paid. A sampling of claims is randomly selected from within each strata. Results are extrapolated over the entire population based upon the weight of each strata to the population.
- **Daily Processor Audit** - Our auditing staff audits claims through a system-generated, random selection process. We examine claims for payment, procedural or coding errors. We audit a minimum of 20 claims per processor each month. The quality auditors report to our NCO Claim Quality department.
- **Auto-adjudicated Claim Audit** - Our Quality Assurance Policy includes a monthly audit of auto-adjudicated claims at the office level (204 claims per claim office key, per quarter, if available) with a maximum of 10,000 audits per quarter at the enterprise level.
- **Auditor Re-audit** - Auditors are subject to a re-audit of their work based on a stratified sample. This audit validates the accuracy of the auditors and compliance with the audit program. Overall results are reported for Pay Incidence, Pay Dollar and Total Claim Accuracy.
- **Bank-Cleared Claim Draft Audit** - Our corporate office oversees our automated check auditing system that monitors each bank-cleared check.
- **Corporate Audit** - Any of our service centers may be subject to an audit by our Corporate Audit department on an unscheduled, unannounced basis to evaluate the effectiveness of controls over processes and procedures.
- **Medical Bill Audit** - We have a comprehensive medical bill audit program in conjunction with external suppliers that includes hospital bill audits; DRG audits for DRG code validation; and targeted contract compliance audits for inpatient and outpatient facility claims.

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

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

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

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

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

In addition, we are also subject to SOX and SSAE 16 SOC 1 review.

Attachments:

3.2.13.2.5 Explain whether you offer direct deposit of participant benefit reimbursement and define for which benefits covered by this proposal the direct deposit service is available.

Answer: Member direct deposit is available for FSA and DCAP. It is not available for member reimbursement at this time under the Pharmacy plan.

Attachments:

3.2.13.2.6 Do you require that self-funded plans use a specific bank for funding claims? If yes, indicate name of the bank.

Answer: Yes. We use a joint benefit payment clearing account (i.e., a Single Account Multiple Participant or SAMP account) at Bank of America or Citibank Delaware. The State subscribes to this account by signing a banking agreement that we forward to our bank.

The State is identified as payer to show that benefit payments go directly from the State to employees. We are shown as the State's agent.

Attachments:

3.2.13.2.7 Please confirm you will establish a separate bank account on the State's behalf.

Answer: Confirmed.

Attachments:

3.2.13.2.8 Confirm that you will set up the State's account structure based upon their requirements.

Answer: Confirmed.

Attachments:

3.2.13.2.9 Please confirm you will process claims and issue checks from the bank account you established on the State's behalf.

Answer: Confirmed.

Attachments:

3.2.13.2.10 Please confirm you will request an electronic transfer of funds from the State at regular intervals on a "checks cleared" basis and that the request will be by active employee claims and retiree claims; retirees claims will be split by medical and DVA expenses as well as by retirement system.

Answer: Confirmed. We have assumed daily.

Attachments:

3.2.13.2.11 Please confirm you will provide the State with a monthly report reconciling the account balance, claims drafts and electronic transfers.

Answer: Confirmed.

Attachments:

3.2.13.2.12 For self-funded plans, confirm that no imprest balance is required.

Answer: Confirmed.

Attachments:

3.2.13.2.13 What is the frequency for ACH transfers for claim funding?

Answer: We request funds from the State's designated bank when recorded claims total at least \$20,000 and on the first banking day of each month. We assume that based on the number of members, the State will be funding claims on a daily basis.

Attachments:

3.3 State Objectives

3.3.1 Plan Design

3.3.1.1 Please describe how you can assist the State with identifying and implementing possible plan enhancements that would support the states objectives as identified in Section 1.0 of the RFP.

Answer: The State of Alaska has clearly articulated a vision and objectives that will transform health care delivery in the State. The vision and objectives require the State to partner with an organization that is innovating and evolving at a rapid rate to fully support the short and long term objectives. Aetna is an organization that can support the objectives and continue to bring forth approaches and solutions critical to the State of Alaska's future success through four key pillars:

INNOVATION, DESIGN AND PERFORMANCE EXCELLENCE- Aetna is the administrator for 643 national account customers, 318 public and labor organizations, 197,467 Medicare customers, 1,257,110 Medicaid members, and 17,818,931 commercial members. This portfolio of customers is the result of continuously innovating and supporting our customers. Our insured book of business is also important as we also require all of the innovation and support, the same as our self-funded customers.

We have a culture of innovation at Aetna and have developed multiple areas of the organization to support organizational improvements from all of our employees. This ranges from innovation at every level of the organization to our Emerging Business Unit focused on developing critical customer solutions. This innovation has resulted in on-going enhancements in how we are improving our operations to both streamline the administrative processes and enable design solutions to support our customers.

Our innovation, design and performance excellence enables us to support the following State of Alaska objectives:

- Embedding clinical decision support tools into daily practice
- Using information technology to support patient education, patient care planning, coordination of care, and monitoring of compliance
- Comprehensive collection, analysis and utilization of data to inform and guide policy and plan design decisions
- High accuracy in claims processing
- Quality customer service

CONSUMER ENGAGEMENT - The age of the consumer is here and Aetna fully recognizes this as a key area to cost management. We are creating the critical support for the member with the personnel and technology to provide information and advocacy through the method sought by the member. We truly believe that the support the State of Alaska requires to transform health care is through One Member at a Time. Our Health Concierge Service model, which is a component of the medical bid, is the My AlaskaCare Single Point of Contact. The My AlaskaCare SPOCs are specially trained personnel with the tools to be the member advocate and truly the "Concierge" role across the full benefit program continuum. Our technology is the other mechanism that puts the power of transparency, clinical decision support and provider directories (in and out of network) at the

member's fingertips via web and mobile phones. For the State of Alaska, the My AlaskaCare SPOC and web and mobile tools are a key cornerstone to supporting your members both in and out of Alaska. It supports the advocacy and member experience across Aetna and all of the State of Alaska benefit programs essential to delivering upon State of Alaska objectives.

Our consumer engagement enables us to support the following State of Alaska objectives:

- Encouraging patients to engage in the management of their own health
- Providing them with resources and skills to obtain appropriate health care services
- Using information technology to support patient education, patient care planning, coordination of care, and monitoring of compliance

EVIDENCE-BASED MEDICINE - Aetna has not wavered from using evidence-based medicine to manage our customers' benefit programs on both a self-funded and fully insured basis. This begins with our disciplined approach to developing clinical policies based on evidence-based medicine. Our Clinical Policies are often used by TPAs and other insurance carriers, because of the disciplined approach and rigor around the on-going review process. Our Care Engine technology is the Clinical Decision Support the State of Alaska is seeking by ensuring evidence-based medicine is applied to all medical and pharmacy claims. The application of evidence-based medicine includes our dental program that leverages our Dental Medical Integration grounded on dental care that drives medical costs.

Our evidence-based medicine enables us to support the following State of Alaska objectives:

- Designing the delivery system to ensure the provision of effective, efficient clinical care
- Embedding clinical decision support tools into daily practice
- Using information technology to support patient education, patient care planning, coordination of care, and monitoring of compliance
- Increasing overall value through cost reduction and improved health outcomes and improved quality of health care
- Comprehensive collection, analysis and utilization of data to inform and guide policy and plan design decisions

PROVIDER COLLABORATION - Our network management is built on sound principles beginning with evidence-based medicine approach to our clinical policies to our reimbursement approach in Alaska. Our experience in core network management and breadth of our book of business will further support the necessary network development in the State.

Our provider collaboration enables us to support the following State of Alaska objectives:

- Designing the delivery system to ensure the provision of effective, efficient clinical care
- Embedding clinical decision support tools into daily practice
- Using information technology to support patient education, patient care planning, coordination of care, and monitoring of compliance
- Increasing overall value through cost reduction and improved health outcomes and improved quality of health care
- Comprehensive collection, analysis and utilization of data to inform and guide policy and plan design decisions

Our experience across these four cornerstones in Alaska and the lower 49 will allow us to support the State of Alaska's objectives across each of the RFP components. When integrating each of the RFP components, we can deliver a fully integrated comprehensive solution that will support the goals and objectives, which includes delivering the cost controls so critical to the future of the State of Alaska benefit program.

As a leading integrated health plan, we will work with you to manage your pharmacy and medical costs as if they are our own. We deliver a competitive price and innovative quality management and cost. We provide the capabilities and focus of our pharmacy experience with the benefit of an integrated approach to patient management. Under the headers below, we have described some of the additional ways we can achieve significant and lasting cost reductions for the State while improving health care quality for members. These include:

- Reducing costs through formulary management and steerage
- Improving medication adherence and lifestyle choices
- Managing care to meet member and provider needs

Reducing Costs Through A Value-Based Formulary

We manage our formulary under the lowest net cost approach. Under this approach:

- Tier 1 - Generics are covered
- Tier 2 - Preferred brands are covered
- Tier 3 - Non-preferred drugs are covered

It is our intent to negotiate competitive prices for formulary medications and preferred products.

Working to Reduce Overall Trend

Occasionally, a more expensive product is clinically more effective at treating disease states than others in the same therapeutic class. While many of our competitors may simply offer the lowest cost drugs, we take a holistic approach.

Because we provide both medical and pharmacy benefits, we are concerned with your overall trend. Therefore, we include the drug that is clinically more effective at treating disease states to help reduce overall trend through reduced physician office visits, hospitalizations and emergency room visits.

We not only manage pharmacy trend, but we also account for the impact on medical trend. This unique style helps to differentiate us from other PBMs in the industry.

Reducing Costs by Promoting Mail Order

We are encouraging the State of Alaska to offer our mandatory mail order option. We currently offer three plan options for filling maintenance drugs. These include:

- Open - Members can fill their prescriptions at mail or retail. They save the most when they use mail order.
- Flexible - After one, two or three retail fills, members pay a greater cost-sharing percentage (i.e., 50%, 60% or 75%) to cover maintenance drugs. Members pay less if they fill maintenance drugs through mail order.
- Maximum Value - After one, two or three retail fills, members pay the full drug cost if they fill maintenance drugs at retail.

This helps you capitalize on mail order discounts. The advantage of operating multiple in-house mail-order pharmacies is that we can better manage escalating pharmacy costs while continually providing quality service.

Reducing Costs By Promoting Generics

We also offer a variety of plan designs that encompass cost management and cost-sharing features that we can tailor to fit your needs. We increase awareness of generics as safe, effective alternatives to brands through the following programs:

Promoting Generics Through Plan Design

We offer many copay options. The primary offerings are two-tier and three-tier copayment options. Outside of a single tier copay option, all other plan designs allow members to obtain generics at a lower copay level than brands. We also offer the following generic substitution options:

- **Choose Generics** - Members pay the difference in cost between a brand and generic in addition to their copay if a generic is available but the member requests that the pharmacy dispenses a brand. If the brand is medically necessary, the physician can request an exception for the brand to pay at the copay level. If the exception is approved, the member would pay the applicable brand copay only. We strongly encourage self-funded customers to implement this option due to the considerable cost savings they can achieve.
- **Generics Only** - This plan design covers only generics, at the applicable copay. Members can obtain brands, but they will pay 100 percent of our negotiated rate.
- **Choose Generics with Dispense as Written (DAW) Override** - Members pay the difference in cost between a brand and generic, plus the copay if a generic is available and they request that the pharmacy dispenses the brand. If the physician indicates, DAW on the prescription, the member pays only the copay. While we can offer this plan, we strongly encourage customers to implement our standard Choose Generics program.
- **Copay Spread** - Customers can select plans that will give their members a copay spread of at least \$15 to \$20 between Tier 1 and Tier 2 and Tier 3 drugs, giving meaningful incentive to choose Tier 1 or Tier 2 preferred drugs. Most customers implement this in addition to standard Choose Generics. While we can offer only a copay spread, we strongly encourage customers to compliment this with our standard Choose Generics program.

Promoting Generics At Retail

We also promote generics at retail through our MAC program and through our Generic Uptake Program.

- **MAC program** - We are offering the State of Alaska our MAC program at both retail and mail order. This generic substitution policy encourages cost-effective dispensing. When a prescription is requested on behalf of a member for a brand name drug, and there is a generic equivalent, or a multisource brand that is included on the MAC list, we reimburse at the MAC rate to encourage the generic or multisource substitution.
- **Generic Uptake Program** - Through the Generic Uptake Program, we encourage retail pharmacists to discuss generic alternatives with members. The program focuses generally on new multisource brands that have a generic replacement opportunity. When members fill prescriptions for applicable brands, a hard-coded edit stops the claim from paying and prompts the dispensing pharmacist to discuss the generic alternative with the member. Based on their professional judgment, pharmacists can override the edit and dispense the applicable brand, or they can dispense the generic.

Promoting Generics At Mail Order

We also incorporate a number of strategies to increase generic utilization at mail order:

- Aetna Rx Home Delivery® generic promotion - We maximize generic utilization at mail order by switching the brand to the equivalent generic when there is an FDA-approved, therapeutically equivalent generic available and if the physician or the member has not indicated that the brand is preferred. In cases in which the member or prescribing physician indicates that the brand is preferred, we call members and inform them that a generic equivalent is available that can save them money. If requested by members, we may contact their prescribing physician to obtain a new prescription that authorizes a generic in place of the brand.

- Brand to Generic Outreach Program - Through this program, we identify members who have filled a brand through mail order during the past four months when there is a therapeutically equivalent generic available. We then send letters to these members to let them know that their brand has a generic alternative and that the generic would save money.

Promoting Generics To Physicians

We also offer programs that encourage physicians to write prescriptions for therapeutically equivalent generics, when appropriate.

- Aetna Rx Check® Brand to Generic Program - This program uses a retrospective DUR approach. We have prescription drug claims systematically analyzed for possible physician outreach based on program algorithms. We specifically designed this program to encourage and increase generic utilization. This program determines if a prescriber has written a DAW prescription for a brand that has an A-rated generic equivalent available. We will fax a letter to the prescriber to encourage them to move the member to the appropriate generic equivalent, if they believe it is appropriate, so that their patient will save money on future copayments or coinsurance. You can purchase this program individually or on a bundled basis.

- MedVantx® - We offer a generic sampling program through our agreement with MedVantx. With this program, we have had secure cabinets stocked with prepackaged generics added to selected physicians' offices in the same area as the brand sample storage. This allows physicians to dispense a generic sample instead of a brand sample. The cabinets contain up to 20 different generics used in treating 9 categories of illness, including diabetes, high blood pressure, heartburn and depression.

Member Communications

Educating members and providers is an important part of our cost-management strategies and helps promote the use of generic alternatives.

- Over-the-counter (OTC) - Each introduction of an OTC drug raises unique issues which we review on a case-by-case basis to determine whether the generic will remain on our formulary and whether the OTC will be added to the customer's plan design. Generally, our standard self-funded pharmacy benefit plans do not cover prescription drugs that have an OTC equivalent available. When a generic is available as an OTC, we will send a letter to members currently taking the generic and notify them that the drug is no longer covered, and they should use the OTC alternative.

- Prescription Savings Program - We provide this ongoing member education program which informs members about how they can save money on prescription drugs and help control health care costs by using less costly formulary or generic drugs. Through the program, we send a maximum of three letters per drug, per year to members in open formulary pharmacy plans who are taking certain non-preferred brands. The letter encourages members to speak to their physicians about changing their prescriptions to a preferred brand, or to a generic drug in order to reduce their copayments or to help keep pharmacy costs affordable. The letters include the member's actual copay amount for generic,

preferred brand and non-preferred brands, based on the benefit plan. Also included is a copay savings calculation that estimates the member's annualized copay savings if they switch to either a less expensive preferred brand or generic alternative. This makes it easy for members to see at a glance how much money they could save by switching to another drug.

- **Save a Copay®** - This program steers members from selected brands, to preferred generics by waiving copays for six months after making the switch. At the end of the six-month period, members are only responsible for the lowest applicable copay outlined in their pharmacy benefits plan. We pre-select members based on their utilization of the targeted drugs to participate, so no enrollment in the program is necessary. This program is available for an additional fee of \$1.00 per letter sent.

Improving Medication Adherence And Lifestyle Choices

We also offer adherence programs to reduce overall costs, improve medication adherence and close gaps in care. We are committed to you and your employees on the issue of adherence. We will work diligently with you to explore the complexities surrounding each to improve the experience of your members, helping them achieve optimal health and ultimate savings to you and their plan.

We have described the programs we currently offer. Unless otherwise noted, our adherence programs are available at no additional cost.

Adherence to Drug Therapy

We engage members through education and reminder communications. This solution monitors over 34 different drug classes used to treat nine conditions. We identify members using one of these drugs, when they fill a prescription. We will then engage the member in the following ways:

- **Adherence Education Letter** - Approximately 10 days after the first fill
- **Refill Reminder Message** - Approximately 14 days before the next refill
- **Missed Refill Communication** - Approximately 10 days after a missed refill

Pharmacy Advisor Counseling

We alert pharmacists at local CVS/pharmacies to counsel members regarding diabetes and cardiovascular conditions. We provide the pharmacist with the information they need regarding the member right away. The pharmacists receive training to be able to address diabetes, as well as high blood pressure, high cholesterol, coronary artery disease and congestive heart failure and will be able to see any applicable gaps in care or refill-related issues and address them with the member.

Members using our mail order program will receive the same counseling. We will have one of our pharmacists reach out to the member by phone when we receive their prescription and the advisory notification.

MedQuery

We differentiate ourselves from many competitors through an integrated solution that analyzes more than just active prescriptions. A PBM standard is to provide drug-interaction alerts that result from analyzing a member's active prescriptions. While we too can offer this service, our MedQuery program surpasses this ability. Our approach is different because we will analyze and integrate the full range of the member data, including:

- Medical data
- Pharmacy data
- Laboratory data

We use this integrated data to identify opportunities for improved care and deliver member specific, evidence-based treatment guidelines to physicians. Additional data elements include 24 months of historical medical and pharmacy claims, member eligibility (demographics) and lab data.

The MedQuery program applies more than 1,100 clinical algorithms to match the integrated data to current evidence-based medical research and, if an opportunity for improved care is identified, a communication is generated on member-specific treatment guidelines and faxed to their physicians' office. Because we have the medical, pharmacy and lab data available in real-time, we know right away that the member's health may be in jeopardy and will call the physician within hours, versus weeks.

Specialty Pharmacy Adherence Support

Our specialty care management nurses receive monthly reports for members taking specialty drugs. They review these reports to identify members not filling their prescriptions. A nurse will call a member who is not complying with their treatment and encourage them to continue taking their prescribed medication and provide any support the member may need. The nurse tracks the conversation with the member, and if appropriate will contact the prescribing physician to discuss the members' lack of compliance.

Chronic Medication List Report

Our Chronic Medication List Report is an online report that allows the physician to see how we scored them on a variety of factors including drug-to-drug interactions. The physician can see which specific members had drug-to-drug interactions. With this information, the physician can intervene and discontinue one of the interacting medications, or change it to a different drug. This ensures that the member does not continue taking drugs that can have a negative impact on their health.

Aetna Healthy Actions - Rx SavingsSM

We offer Aetna Healthy Actions Rx Savings, to encourage members living with chronic conditions to continue taking their drugs. Compliance may lead to improved health outcomes and a healthier lifestyle.

The conditions/drug classes include diabetes, asthma, heart failure, high cholesterol and high blood pressure. Members receive reduced copays for generic and preferred brand drugs when taking drugs within the specific therapeutic classes. This program is available for an additional fee.

Our Pharmacy Advisor Counseling and Adherence to Drug Therapy programs are available to all customers as part of our core enhanced pharmacy benefits management plan. Self-funded customers can opt-in to any of these programs, at no additional cost. We recommend that you take advantage of these programs we have designed to assist in member compliance and lowering future medical costs.

Aetna Rx Healthy Outcomes

This program promotes drug adherence and sustained positive health outcomes for members who survive an Acute Myocardial Infarction (heart attack), Coronary Artery Stent Placement or Acute coronary syndrome. This high touch member outreach program targets post heart attack members often before they even leave the hospital, and offers member drug cost share reduction and member outreach to promote adherence.

The program begins after criteria is met and a letter is generated and mailed within two weeks or less of the incident. Other types of outreach, such as pharmacist outreach, occur shortly thereafter.

Improved adherence for targeted members will lead to better health outcomes and savings for you and

your employees. Aetna members are identified as program participants through the ATV system, and outreach and adherence measures begin almost immediately at/or shortly after hospital discharge.

Pharmacy Ambassador

Our Pharmacy Ambassador program uses a pharmacist to act as an extension of the Health Concierge team to identify members with complex care considerations. The role of the Pharmacy Ambassador is to review the drug regimen of a customer's membership and identify potential issues and opportunities for adherence counseling and therapy optimization. The Pharmacy Ambassador acts as an extension of the health concierge and care management team and is available for grand rounds, assistance with precertification and team education on disease/therapy specific best practices.

As a natural extension of these teams, the Pharmacy Ambassador has access to Aetna Total View to review member progress and help them stay on track with their activities. There is an additional fee for this program, which we can customize to meet the needs of your employees and their families.

Care Management That Meets Member And Provider Needs

We employ a retrospective DUR approach for our condition management programs. By reviewing adjudicated pharmacy claims, or pharmacy and medical claims, we can identify and reach out to providers for the following programs:

- **Controlled Substance Use** - We improve member safety and quality of care related to chronic inappropriate use of controlled substances. We mail letters to physicians with a report of members who we have identified with chronic, long-term controlled substance use. We also mail letters to members asking them to speak with their physician and referring them for behavioral health support.
- **Migraine Management** - This program's goal is to reduce the number of annual brain scans, ER visits and inpatient visits related to migraines. We identify members by reviewing claims. Once identified, we mail letters explaining the program, a brochure and a diary/action plan. We emphasize discussing the condition with their physician.
- **Heart Care for Life (HCFL)** - This program encourages long-term compliance with drug therapy following a heart attack. We reinforce adherence and provide comprehensive education for members recovering from a heart attack. We also reach out to the physician with a program letter, actionable materials, brochures and a member roster containing compliance data.

Specialty Clinical Support

We offer proven clinical, quality-tested programs that educate and support members taking specialty drugs. We provide clinical support to every member who fills a drug through Aetna Specialty Pharmacy®.

Upon receiving specialty orders, we contact members and discuss their disease state and determine their unique needs. We then offer members therapy-specific individualized support throughout their treatment.

- Confirm dose and medical necessity
- Schedule medication delivery
- Provide additional education and self-injection training
- Coordinate home injections/infusions
- Coordinate home health care
- Determine supplies to send with medication
- Outreach to ensure refills are available when needed

- Provide extra emotional support for members and caregivers
- Screening for medication adherence issues including side effects, co-pay concerns, etc.

If members have major concerns or adherence issues, our nurses refer them to our Specialty Health Care Management area for additional support.

Specialty Health Care Management

This is an enhanced specialty care management solution that applies to select specialty drugs. This nurse team supports members with the following conditions or receiving the following therapies at no additional cost:

- HIV
- Asthma (adult and pediatric)
- Hepatitis C
- Pulmonary arterial hypertension
- Oncology
- Osteoporosis
- Intravenous immunoglobulin (IVIG)
- Crohn's Disease
- Rheumatoid arthritis
- Transplant
- Multiple sclerosis
- Enzyme

Identifying Members for Specialty Health Care Management

Although we identify members for specialty care management in many ways, we primarily identify them when we see that they are:

- Newly diagnosed and/or new to a therapy
- Having issues with adherence
- Referred by another area within Aetna

Assessing Members through Specialty Health Care Management

Once identified, one of our nurses conducts an assessment call. The nurses who complete initial member assessments have experience in specialty therapies and medications.

During the assessment call, the nurse will:

- Confirm treatment is appropriate
- Verify the member is able and motivated to succeed
- Understand the member's risk for non-compliance
- Review the member's medical history (including co-morbidities)
- Provide clinical support resources to resolve identified knowledge gaps

Engaging Members through Specialty Health Care Management

Based on the first assessment, we risk stratify members to determine the level of follow up needed and develop a customized care plan. The nurse will coordinate with the physician's office and provide additional education and support to the member, as needed, to implement an effective care management strategy.

- Developing a Call Schedule - The nurse will establish a call schedule with the member. We tailor the

frequency of these calls to how much support the member needs.

- **Developing a Care Plan** - Every care plan is specific to the individual's needs but all identify long-term goals and actions. The nurse will continually adjust the care plan based on changing member needs. For instance, if the member begins struggling with new side effects, we may adjust the care plan to increase intervention.
- **Integrated, Cross-Functional Support** - Our specialty care management program offers integrated coordination with Aetna's medical and behavioral health solutions. This means we can increase member engagement in Aetna's disease management, case management, behavioral health and wellness programs.

Attachments:

3.3.2 Policy Development

3.3.2.1 Please describe how you can support the State in policy development through the use of data driven analysis and best practice recommendations. Please include any additional resources your organization can provide.

Answer: Aetna has both experience as well as the underlying infrastructure to support the State in policy development. Our geographic footprint and the fact that we provide coverage in Alaska and the lower 49 are benefits to the State in policy development. This experience and our disciplined approach with evidence-based medicine provide us with a unique position to support the State in policy development.

On a national basis, we remain focused on fostering compliance with the Affordable Care Act (ACA). We will continue to help our customers with the implementation of ACA. We will continue to advocate for workable regulations and needed legislative changes to avoid the unintended consequences of higher costs and needlessly complicated requirements on our customers. We will work with public policy leaders and legislators to fix the serious issues that continue to plague our health care system.

A significant element of policy development is the understanding of health care delivery and the variation by geography. The Account Team and advisory teams covering clinical and Alaska care delivery are a critical element to the policy development process. This team will leverage national and regional resources in the areas of clinical policy development, government affairs, Accountable Care Solutions, Primary Care Medical Home Enablement, Medicaid and Medicare program administration, health care reform, transparency and alternative payment approaches (e.g., reference based pricing and case rates) to name a few. Overall, we have the infrastructure and resources to support the State's policy development as well as a determination of pilot opportunities.

Our process will be to work with the State on developing the areas of policy development including the goals in specific areas. The team will leverage our national resources to identify best practices and approaches to impact the State's goals. Our sessions with the State will leverage the clinical and Alaska specific expertise to uncover opportunities. In addition, we will have participation by our subject matter experts to address emerging solutions in the market and address policies to support deployment of those solutions.

Once areas are identified we will work with our internal resources for the analysis of the data available. We will leverage our resources that handle our internal evaluation processes including data analytics, review of evidence, and understanding of provider and member impact. We have supported organizations in the review and development of policies for their own organization as well as State

legislation. While we do not provide legal advice, we have resources to support review and make recommendations on the type of changes that can change care delivery. Our role in health care reform emphasizes our desire to impact cost and quality in the health care delivery. The State of Alaska is in a unique position to drive health care delivery through policies that support the change. Our Alaska experience combined with the national resources can support the development of policy for the State of Alaska program only as well as for the State.

We envision a key component of the policies to be a potential demonstration of projects that explore changes to care delivery in the State. Our robust experience with Accountable Care Organizations and Patient Centered Medical Homes will be valuable in not only developing solutions, but guiding set up of changes in the delivery system.

We have a number of modeling tools available to support your pharmacy benefits plan. On a quarterly basis, our RxPerspectives Report supports our consultative approach to account management and enables you to construct a plan design and make new program decisions based on facts. Through the RxPerspectives Report, the team will provide recommendations that we align with your goals. We provide all modeling services described below at no additional cost.

Personalized Opportunity Analysis - Identifying Big Picture Opportunities

Using the Personalized Opportunity Analysis (POA), we will provide you with the tools and ongoing analyses of your results to clearly explain and optimize your spend. The POA, based on your actual data, will provide actionable channel, therapy and identify the opportunities for savings and performance improvement. We will then use the POA to deliver recommendations based on your needs and goals.

Plan Design

The pharmacy team will use our consultative tools to measure the financial impact of various plan design changes and assess your plan performance. For example, we can work with you to determine the savings associated with:

- Changing copays
- Adding Choose Generics cost-sharing options
- Implementing Aetna Rx Home Delivery® mail order options
- Comparing coinsurance versus copayment plan designs

Program-Specific Modeling

Your pharmacy account team can analyze how specific programs or initiatives (e.g., Save a Copay®, Aetna Rx Check® programs) will affect your pharmacy plan. We can present how these programs will influence spending while improving member health.

We will provide clinical guidance to ensure any program changes work to meet your goals. The team has access to clinical modeling and savings tools, which they use to determine any associated savings.

Attachments:

3.3.3 Innovation

3.3.3.1 Briefly describe the four most important ways you propose to assist the State in controlling health costs in Alaska now and in the future.

Answer: We believe the four most important ways four most important ways we can support the State in controlling health care costs in Alaska now and in the future, aligns to our four pillars. Overall, we believe the State must align with an organization that materially takes the State beyond a transactional

administrator and to an organization supporting its strategic direction. The State of Alaska has clearly outlined a vision and objectives that require an organization that provides the infrastructure, tools and resources to support the development and deployment of its strategy.

Aetna is uniquely situated due to its role in providing insurance coverage in Alaska today and the sophisticated customer base operating in Alaska and the lower 49. Our experience in Alaska and the lower 49 with government and commercial customers supports the State's strategies both now and in the future. The four most important ways we support the State are:

- **CONSUMER ENGAGEMENT** - Consumer engagement is not only one of the State's objectives, but a critical area of Aetna's strategic direction. This is a demand from our customers operating in Alaska and lower 48 as well as an area critical for Aetna under the Accountable Care Act. The ability to control costs is highly dependent on consumer engagement and alignment to supporting members through the optimal method for that member.

Consumer Engagement is one member at a time and a key cornerstone of our solutions for the State and controlling costs. Our proposed solutions and development are focused on both personnel and technology to address the various mediums members want and need to engage. We provide the critical level of advocacy and support that helps the member navigate their State of Alaska benefit program:

- o It begins with the My AlaskaCare Single Point of Contact, which is through our Health Concierge Service model and part of our medical proposal. This model is our next level of customer service that transforms health care from a transactional service to full advocacy for your members. This team is designed to respond to all member inquiries and personalize each call, but more importantly act as the advocate across the full benefit offerings by the State of Alaska. This team is specially trained and tested to ensure they are fully qualified to support the member through every facet of the health care delivery system and across all of the State of Alaska's benefit program and vendors. Health Care is very complex and the My AlaskaCare Single Point of Contact will support the member in navigating the delivery system and truly being the health care advocate. This team is trained to listen to verbal queues from each call and take the member call "personally." A simple way to think about it is a Concierge will communicate the time the parade starts just like any Service Representative, but will then take it to the next level and support the member in determining how they will get there, the time it will take, other logistical challenges and even schedule the transportation if necessary. As we think of the complexities of health care and supporting the State in achieving its objectives, this level of service and advocacy is essential.

- o **On-line and Mobile Tools** - Another critical facet of consumer engagement is providing members with tools to support pharmacy decisions. As we support the State in driving consumer engagement, on-line and mobile tools are essential tools. Aetna has robust tools with clinical decision support and cost of care.

In order to fully support members in accessing our on-line tools, we have developed the Ask Ann feature. This is the member's virtual assistant for the website to support them in easily locating the information or tools they are seeking.

- o **Managing Chronically Ill Members**

Specialty Health Care Management is an enhanced specialty care management solution that applies to select specialty drugs. Although we identify members for specialty care management in many ways, we primarily identify them when we see that they are:

- Newly diagnosed and/or new to a therapy
- Having issues with adherence

- Referred by another area within Aetna

Once identified, one of our nurses will conduct an assessment call. The nurses who complete initial member assessments have experience in specialty therapies and medications. During the assessment call, the nurse will:

- Confirm treatment is appropriate
- Verify the member is able and motivated to succeed
- Understand the member's risk for non-compliance
- Review the member's medical history (including co-morbidities)
- Provide clinical support resources to resolve identified knowledge gaps

Based on the first assessment, we risk stratify members to determine the level of follow up needed and develop a customized care plan. The nurse will coordinate with the physician's office and provide additional education and support to the member, as needed, to implement an effective care management strategy.

- Developing a call schedule
- Developing a care plan
- Integrated, cross-functional support

o Experts - Between all of the Aetna companies, we have experts covering all facets of the mental, physical and clinical elements of consumer engagement. Our proposed annual strategy and deployment process reflect the complexities associated with member adoption of change and the critical time investment needed to develop the solutions that your State of Alaska members will embrace. We will provide the necessary expertise to develop solutions that both support the State of Alaska's objectives and will be embraced by your members through a consumer-oriented roll out. This support addresses all elements of design and incentives.

The ability to support cost management is dependent on consumer engagement. Members must make the changes necessary to achieve their optimal health. Our investments in the expertise to develop solutions are fully empowered by the personnel, tools and resources we make available to the members. Health care is extremely complex and success in both health improvement and corresponding cost reductions come from fully providing the members with the support they need. The role of Consumer Engagement will have a material impact on costs that will vary based on the State of Alaska's deployment decisions, but will likely be cost savings of 5% or greater.

- **EVIDENCE-BASED MEDICINE** - Aetna has placed extensive rigor on integrating evidence-based medicine throughout our operations. This transcends all of the Aetna programs.

Our support for the State of Alaska is based on tools and processes as well as our ability to support policy development and ensuring it translates all the way through to claim payment.

o Aetna has over 600 (630 CPBs on Aetna.com) clinical policies in place today that are based on evidence based medicine. We have clinical resources focused on reviewing medical evidence and at least annually updating our clinical policies to address latest evidence. In addition, we work with providers in the event new studies support a change in the clinical policies. Our policies are embedded in our network contract requirements and claims payment that will either reduce or deny payment for services not aligned with our clinical policies. These are directly connected to our pharmacy program.

o Controlling Overall Trend Through Formulary Management

We manage our formulary under the lowest net cost approach. We cover generics in the first tier, preferred brands in the second tier and non-preferred drugs in the third tier. We negotiate competitive prices for formulary drugs and preferred products. Occasionally, a more expensive product is better at treating disease states than others in the same therapeutic class. While many of our competitors may simply offer the lowest cost drugs, we take a holistic approach. Because we provide both medical and pharmacy benefits, we are concerned with your overall trend that balances cost and quality. Therefore, we include the drug that is clinically more effective at treating disease states to help reduce overall trend through reduced physician office visits, hospitalizations and ER visits. We not only manage pharmacy trend, but we also account for the impact on medical trend. This differentiates us from other PBMs.

- **OPERATIONAL EXCELLENCE** - Operations is often an overlooked facet of the cost management for an organization. As both an administrator and insurance carrier, we fully understand the importance in market leading operations and the impact this has on all facets of cost management and the consumer experience. A key area for pharmacy is our on-going enhancements to our processes and clinical programs. We learn and build to align with the needs of our customers who need programs to both manage cost and quality, but enable the critical attraction and retention. Our National Account and Public Sector customers demand the level of service that Aetna delivers.

- o **Improving Adherence Through Innovative Programs**

Our adherence programs reduce overall costs, improve medication adherence and close gaps in care. We have described the programs we currently offer. Unless otherwise noted, our adherence programs are available at no additional cost.

- **Adherence to Drug Therapy** - We engage members through education and reminder communications for over 34 different drug classes used to treat 9 conditions.

- **MedQuery** - This program is different because we analyze and integrate the full range of the member data, including medical, pharmacy and laboratory data. We use this integrated data to identify opportunities for improved care and deliver member specific, evidence-based treatment guidelines to physicians. Additional data elements include 24 months of historical medical and pharmacy claims, member eligibility (demographics) and lab data.

- **Specialty Pharmacy Adherence Support** - Our nurses receive monthly reports for members taking specialty drugs and identify members not filling their prescriptions. They call these members and provide any needed support. The nurse tracks the conversation with the member, and if appropriate will contact the prescribing physician to discuss the members' lack of compliance.

- **Aetna Healthy Actions - Rx SavingsSM** - We offer Aetna Healthy Actions Rx Savings, to encourage members living with chronic conditions to continue taking their drugs. Compliance may lead to improved health outcomes and a healthier lifestyle. The conditions/drug classes include diabetes, asthma, heart failure, high cholesterol and high blood pressure. Members receive reduced copays for generic and preferred brand drugs when taking drugs within the specific therapeutic classes. This program is available for an additional fee

- **Aetna Rx Healthy Outcomes** - This high-touch member outreach program targets post heart attack members often before the even leave the hospital. It offers member drug cost share reduction and member outreach to promote adherence.

- **Pharmacy Ambassador** - A pharmacist works as an extension of the Health Concierge and medical management teams to identify members with complex care considerations. The Pharmacy

Ambassador would review the drug regimen of the State's membership and identify potential issues and opportunities for adherence counseling and therapy optimization.

o Reporting Data And Providing In-Depth Analysis

Our standard quarterly reporting package will place valuable information right at your fingertips. You can perform interactive data analysis on topics such as key measures, utilization and membership. We produce these topics, called modules, at the customer level by funding arrangement and product type on an incurred basis. The modules offer a high-level view of the current data as well as book of business and prior year comparisons.

Each module can be drilled down into more detailed reporting and graphs allowing users to group and refine how they look at the data with options such as time period, products, age, gender, region, pharmacy detail, geographic and provider specific detail. Reports can be saved or downloaded into Microsoft® Excel for review, analysis and electronic communication.

Preformatted reports are also available at the customer level by funding arrangement and product type on an incurred claim basis. The reports offer a view of the current year's and the prior year's data, illustrating utilization and financial trends in a concise, graphical format. The reports are available quarterly, within 45 days following the end of the reporting period.

The standard preformatted report package provides data on the following:

- Key Statistics Pharmacy
- Key Statistics by Generic, Brand Single-Source and Brand Multi-Source
- Formulary Analysis
- Retail, Mail Order and Specialty Comparison Analysis
- Top 30 Drugs by Number of Claims
- Top 30 Drugs by Number of Paid Amount

In addition, your assigned Clinical Account Executive (CAE), Kristi Coulter, will help you make critical decisions for your pharmacy benefit plans. She will regularly meet with you. On an annual basis, Kristi will also provide RxPerspectives, an in-depth annual executive summary that will outline your cost and utilization metrics, key performance metrics and financial results. RxPerspectives includes the following:

- Estimates of potential savings based on your utilization
- Specialty pharmacy trend, cost and utilization metrics
- Forecasting Trends - Therapeutic categories to watch based on your population
- High Cost Claimant Analysis - Identifies members with greater than \$12,000 in spend
- A year-to-year comparison of your drug spend by retail, mail and specialty
- Benchmark comparisons of your data against key metrics of our best-in-class customers, as well as benchmark results compared to our book-of-business

Operations brings everything together in a fashion that translates to an overall impact. We commit to working with the State to continuously measure and determine opportunities for improvement. Our resources and analytics will provide the State with critical information to make informed decisions and achieve the strategic objectives. We recognize success in achieving those objectives relies on a partner that continuously evolves and brings market leading approaches to the table. We commit to being that partner and bringing forth solutions specific to Alaska.

Attachments:

3.3.3.2 Please provide a white paper with information on innovative steps your organization is prepared to implement in order to assist the State is achieving its vision as stated in Section 1.0 of the RFP. Include any programs or innovations that have proven successful with other similar clients. Focus on cost containment and cutting edge health care support, as well as integration with other key vendor partners.

Answer: 1: Attached

Detail:

Options:

1. Attached
2. Not Attached

Attachments: [Question 3.3.3.2 - White Paper.doc](#)

3.3.4 Performance Incentives

3.3.4.1 In accordance with Section 3.2 of the RFP, please describe in detail any proposals you are including with your cost proposal relative to fee increments for accomplishing state objectives as outlined in Section 1.0 of the RFP such as:

- a. Cost Containment Fee Increment. An annual fee increment in an amount to be proposed by the Offeror to be awarded if cost growth per member declines xx% from the prior fiscal year and claims processing accuracy audits show claims processing accuracy exceeds 98% for the fiscal year.
- b. Cost Reduction Fee Increment. An annual fee increment in an amount to be proposed by the Offeror to be awarded if overall claims costs are less than xx% from the prior fiscal year and claims processing accuracy audits show claims processing accuracy exceeds 98% for the fiscal year.

Note that these are examples and the State is willing to review other proposed performance incentives.

Answer: Pharmacy Trend Incentive: In Year 1, July 1, 2013 through June 30, 2014, Aetna will measure the net Pharmacy trend that results from our products and programs, including but not limited to discount and dispense fee relativities and our clinical and cost management programs. The Pharmacy trend performance based incentive will apply to active and Pre-Medicare retirees only. Aetna will provide a net Pharmacy trend incentive for Year 2 (July 1, 2014 through June 30, 2015) Year 3 (July 1, 2015 - June 30, 2016), Year 4 (July 1, 2016 - June 30, 2017) and Year 5 (July 1, 2017 - June 30, 2018).

Definition: The net Pharmacy trend will be determined from the following equation:
7/1/2013 through 6/30/2013 Actual Allowed Pharmacy Claims

Base Year Pharmacy Allowed Claims -1

Base year claims are finalized two months after the start of the guarantee period. When establishing the first year base claims we will use July 1, 2012 through June 30, 2013 allowed claims.

This measurement will be reported using data from Aetna's Informatics data warehouse.

Reconciliation: The net Pharmacy trend expected (based on actual enrollment) will be compared to the net Pharmacy trend achieved.

Performance Incentive: If the actual net Pharmacy trend is below the maximum net Pharmacy trend

target, Aetna will be awarded an increase to The State of Alaska Pharmacy administrative fees. The Pharmacy administrative fee will be increased by an amount equal to \$0.10 per subscriber per month for each full percentage point that the actual net Pharmacy trend is below the maximum net Pharmacy trend target. The maximum increase to the fees as reward for achieving net Pharmacy trends that are below the maximum net Pharmacy trend will be \$0.50 per subscriber per month.

Total Overall Net

Pharmacy Trend Achieved Cumulative Performance Incentive
(per subscriber per month)

>= 7% \$0.00

>=6% and <7% \$0.10

>=5% and <6% \$0.20

>=4% and <5% \$0.30

>=3% and <4% \$0.40

<3% \$0.50

The Pharmacy trend incentive will be reconciled on an annual basis based on allowed Pharmacy claims for the year being measured compared to base year allowed Pharmacy claims. We will reconcile our actual achieved net Pharmacy trend on an annual basis and determine our performance incentive based on the above table. Payments for each Annual Settlement will be due 45 days from the date of reconciliation.

At the end of each quarter Aetna will calculate the cumulative discount for all claims incurred from start of the policy period through the last day of the year being reconciled to establish the amount of per subscriber per month amount performance incentive. Aetna will then bill the State of Alaska the annual settlement amount calculated as follows:

Annual Settlement = (Cumulative performance incentive PSPM X Total billed subscribers for the billed months up until close of quarter) - previous annual settlements paid.

Conditions for the Guarantee:

- This guarantee only applies to the in-network medical claims and Aetna direct-contracted networks for active and Pre Medicare retirees and will remain in force during the period 07/01/2013 - 06/30/2014.

- This trend incentive applies only to pharmacy claims.

- The minimum enrollment in the PPO plans is 19,000 active employees and Non-Medicare eligible retirees.

- If the enrolled total group, or subscriber type total varies in size by more than 10% from the assumption. We have assumed the following totals by subscriber type:

- 6,523 Active

- 13,457 Non-Medicare Eligible Retiree

- 22,884 Medicare Eligible Retirees

- 42,864 Total Subscribers

- The guarantee may be revised if there is a 5% or greater change in the projected cost factors related to the combination of geography, age, and gender in any site with at least 100 subscribers enrolled or a 10% change in the total number of subscribers enrolled in each individual Aetna product or in aggregate, including the impact of new or terminating locations and/or groups.

- We reserve the right to negotiate with State of Alaska the appropriate changes to this incentive if there are any changes to the current or proposed benefit plans or if there is a change in government laws or regulations that have a quantifiable impact on claim costs.
- The trend guarantee will remain as stated for years 2-5. These conditions will be re-evaluated each year, and Aetna reserves the right to reset these terms at that time.

Attachments: [CONFIDENTIAL Pharmacy Trend Incentive.doc](#)
[REDACTED Pharmacy Trend Incentive.doc](#)

3.4 Cost

3.4.1 Fees

3.4.1.1 Confirm you have completed the rate table, and included any additional costs identified within the questionnaire.

Answer: Confirmed

Attachments:

3.4.1.2 Confirm that your rates are guaranteed for at least 3 years.

Answer: Confirmed for Total Population and Confirmed for Non Medicare Population

Attachments:

3.4.1.3 You understand that any response except "Yes" within this section may result in an adjustment to the pricing terms and fees you input in other sections within this RFP and/or may disqualify your offer from being considered.

Answer: Yes

Attachments:

3.5 Response Attachments - PBM

3.5.1 Pharmacy Benefit Management Pricing Tables

Please complete the Excel worksheets in Attachment F2 and provide the completed worksheets as an attachment to the RFP. Detailed instructions are provided in the worksheet.

Attachment [Attachment F2 - Pharmacy Benefit Management Pricing Tables and Examples.xls](#)

Answer: 1: Attached

Detail: We have also included a redacted version of each file we consider confidential, with the confidential information removed. Only redacted files, may be released in an open records requested.

Options:

1. Attached
2. Not Attached

Attachments: [Attachment F2 - Pharmacy Benefit Management Pricing Tables and Examples1.xls](#)
[EGWP Fee Exhibit.xls](#)
[EGWP Financial Assumptions..doc](#)
[Pharmacy Financial Assumptions.docx](#)
[Pharmacy Financial Exhibit Alternate pricing.xlsx](#)
[Pharmacy Financial Exhibit.xlsx](#)

[REDACTED Attachment F2 - Pharmacy Benefit Management Pricing Tables and Examples1.xls](#)
[REDACTED EGWP Fee Exhibit.doc](#)
[REDACTED Pharmacy Financial Exhibit Alternate pricing.doc](#)
[REDACTED Pharmacy Financial Exhibit.doc](#)

3.5.2 Please complete an attach the following file labeled "Attachment I2 - Pharmacy Benefit Management Services Implementation and Performance Guarantees.xlsx"

Attachment [Attachment I2 - Pharmacy Benefit Management Services Implementation and Performance Guarantees.xlsx](#)

Answer: 1: Attached

Detail: We have also included a redacted version of each file we consider confidential, with the confidential information removed. Only redacted files, may be released in an open records requested.

Options:

1. Attached
2. Not Attached

Attachments: [CONFIDENTIAL Pharmacy Trend Incentive.doc](#)
[REDACTED Pharmacy Trend Incentive.doc](#)
[Aetna Specialty Pharmacy Overall Guarantee.doc](#)
[Attachment I2 - Pharmacy Benefit Management Services Implementation and Performance Guarantees.xlsx](#)
[EGWP Financial Guarantee..doc](#)
[Pharmacy Financial Guarantee.docx](#)
[Pharmacy Generic Dispensing Rate Guarantee.docx](#)
[Pharmacy Service Performance Guarantees.docx](#)
[REDACTED Aetna Specialty Pharmacy Overall Guarantee.doc](#)
[REDACTED EGWP Financial Guarantee.doc](#)
[REDACTED Generic Dispensing Rate Guarantee.doc](#)
[REDACTED Pharmacy Financial Guarantee.doc](#)

3.5.3 Please complete an attach the following file labeled "Attachment J7 - Pharmacy Benefit Management Services GeoAccess and Network Analysis.xlsx"

Attachment [Attachment J7 - Pharmacy Benefit Management Services GeoAccess and Network Analysis.xlsx](#)

Answer: 1: Attached

Detail:

Options:

1. Attached
2. Not Attached

Attachments: [Attachment J7 - Pharmacy Benefit Management Services GeoAccess and Network Analysis.xlsx](#)

3.6 Reference Documents - PBM

3.6.1 Attachment G2 - Pharmacy Benefit Management Services Cost Scoring Methodology.docx

Document: [Attachment G2 - Pharmacy Benefit Management Services Cost Scoring Methodology.docx](#)

3.6.2 Attachment H2 - Pharmacy Benefit Management Scoring Methodology Example.xlsx

Document: [Attachment H2 - Pharmacy Benefit Management Scoring Methodology Example.xlsx](#)

4 Healthcare Management

4.1 Company Profile

4.1.1 General

4.1.1.1 Describe your company's ownership structure. Explain why your organization is best suited to provide Healthcare Management services.

Answer: The ultimate parent of our companies is Aetna Inc., a publicly traded Pennsylvania corporation. Aetna has over 35,000 employees nationally with 15 of those in Alaska.

Aetna is best suited to provide the services the State of Alaska is seeking in this RFP, due in large part to the overall breadth of the Aetna group of companies. The State of Alaska's objectives to transform healthcare in the State of Alaska require an organization that can support this along with all of the State of Alaska's objectives. Aetna's strategic direction, investments and full breadth of the Aetna portfolio will be leveraged to support the State of Alaska. We believe the transformation will take place one member at a time through our support in engagement through the program or method for which that member can be engaged.

The State of Alaska clearly needs an organization that has the full breadth of resources and capabilities to deliver both in Alaska and the lower 48. We are an organization that is not only known for its medical claim and network administration for many of the Fortune 100 and Public entities, but we also have active and retiree fully insured book of business. Our role in the State of Alaska covers each of these and provides the State of Alaska with a partner that will bring other plan sponsors to the table to support the health care transformation.

The Aetna portfolio that will benefit the State of Alaska includes ActiveHealth Management.

Although independently operated, ActiveHealth is a wholly owned subsidiary of Aetna, Inc. Aetna purchased ActiveHealth over 8 years ago, seeing the need to work with a company that was not only deeply grounded in evidenced-based medicine, but also a company with over 15 years of experience working with millions of members in care management programs and strategies across payors, not just tied to a single payor. ActiveHealth works with over 12 other health plans, 350 data sources, and integrates our services with over 40 other vendors. We are uniquely positioned to offer the State expertise and flexibility as you chose your best in class solutions, but when integrated across other Aetna services, can bring even better outcomes and unique member experiences breaking through typical barriers.

We have extensive experience along the healthcare continuum and we are truly innovative with each client with whom we partner....but what bidder won't say the same thing to the State of Alaska? We are truly different in that our unique technology, systems and clinical resources propel ActiveHealth and our parent Aetna to the top of industry surveys measuring health and wellness innovation and program capabilities. We have also been privileged to be awarded unique and exciting health and wellness program contracts with some states across the nation that have some of the most challenging populations in terms of obesity and health care costs. States such as Mississippi (highest prevalence of obesity in the nation, 8 years running), Kentucky, West Virginia and North Carolina. These partners and other large plan sponsors with diverse populations, rural populations and strong bargaining units have helped us become acutely aware of the need for client customized solutions.

Over the past 14 years, we have become very nimble at finalizing, implementing and maintaining custom integrated care management programs for our clients. Additionally, we are actively engaged in

creating unique solutions for hospital systems, provider groups and other health care system partners that will result in unique network and physician compensation designs that tie directly into health care reform.

We are prepared to work with the State of Alaska to design a program that makes sense for all parties, including outcome goals, metrics and guarantees. Within our response you will find more standard responses that reflect potential designs and guarantees however, we believe a truly successful partnership with you will require deeper more detailed discussions that what can adequately be outlined within the RFP response as designed. Our references will prove to you that these are not just empty promises and words at Aetna and ActiveHealth.

We recognize that the State of Alaska desires a partner with a proven track record of success across the spectrum of requirements included in your RFP. We feel strongly that we are uniquely qualified for this opportunity having successfully provided integrated disease and wellness solutions for our clients, including many employer benefit plans for more than a decade.

We invite the State to visit our home page (<http://www.activehealth.com/>) to review the breadth and depth of our published studies, awards, and innovative program designs that validate our thought leadership, clinical expertise, and outcomes focus. In addition, we have provided several studies within our response that highlight our success at impacting health cost and risk through our wellness approach. We are also prepared to guarantee our performance.

Aetna is an organization built to support the development of the State of Alaska's short and long term strategy and more importantly to bring forth and deploy strategies to reduce costs, engage members and improve the overall health of the population. We pride ourselves on developing partnerships to deliver long term success and this will be critical for the State of Alaska's health care transformation.

At Aetna and ActiveHealth, we are passionate about making sure that the State exceeds the objectives laid out within this RFP and we look forward to the opportunity to create a customized solution that is easy for members to use and effective in the reduction of health risk. You have our joint commitment to continually enhance our existing relationship through programs like those offered in our proposal.

Attachments: [Executive Summary.pptx](#)

4.1.1.2 Describe how your company meets and exceeds the minimum requirements listed in Section 2.7 of the RFP.

Answer: Healthcare Management - Offeror must have:

i. provided healthcare management services for at least one employer of 6,000 or more employees for at least 5 years. We exceed this requirement in that 100% of our employer partnerships have a minimum of 6,000 employees. Typically, our partners have more than 15,000 employees. Aramark is an example of a client we've served for at least 5 years.

ii. provided healthcare management services for at least one group of 20,000 or more retirees for at least 5 years . We provide healthcare analytics and management services to Blue Cross Blue Shield of South Carolina. The South Carolina State Health plan is one of the employer groups we have served for more than 5 years at BCBSSC, and they have over 25,000 retirees in their plan.

iii. provided healthcare management services for a government employer or public retirement plan for at least 3 years. We service many government employers across many sectors. One example is our unique program we have in place with the Tennessee Valley Authority.

Please find additional supporting information attached on how Aetna meets all the State of Alaska's minimum requirements.

Attachments: [1.a Signed Attachment B - Offeror Information and Certification.pdf](#)

[1.b Attachment B - Offeror Information and Certification.docx](#)

[2. Subcontractor Commitment Letters.zip](#)

[3. Minimum Qualification Question 2.1.1.2 Response- CONFIDENTIAL.doc](#)

[3. Minimum Qualification Question 2.1.1.2 Response- REDACTED.doc](#)

[4. State of Alaska Business Licence.pdf](#)

[5. State of Alaska Certificate of Authority.pdf](#)

[6. Legal Clarifications \(Deviations\).doc](#)

[7. Plan Clarifications.xlsx](#)

[8. Confidentiality Request.docx](#)

4.1.1.3 Provide client references for whom you provide (or have provided) the same services you are proposing to the State that meet the following qualifications. The same reference may be used to meet one or more qualifications but five distinct references must be provided.

- A client with more than 6,000 employee participants for at least 5 years;
- A client with at least 20,000 retiree participants for at least 5 years;
- A client you have had for two years or less;
- A client whose contract has ended with you in the last two years; and
- A governmental client for at least 3 years.

	Client 1	Client 2	Client 3	Client 4	Client 5
Name of client					
Type of business					
Beginning year of providing service to client	2008	2005	2011	2007	2008
Number of participants (total Lives)	55,000	330,000	550,000	190,000	44,000
Name, address and telephone number of the designated client representative					
Types of coverage or plans provided; and	Clinical Decision Support, Disease Management, Wellness Program, Portal including HRA and PHR.	Clinical Decision Support	Clinical Decision Support, Disease Management, Complex Care Management (incl BH and Oncology specialty programs) Maternity, NurseLine, Wellness, Portal including	. Clinical Decision Support, Disease Management, Portal incl HRA and PHR, Incentive Tracking and DART Reporting Analytics	Clinical Decision Support, Nurseline, Disease Management and Portal incl HRA and PHR

	Client 1	Client 2	Client 3	Client 4	Client 5
			HRA and PHR, CareTeam Technology and PCMH care management., DART Reporting Tool		
Reason for Termination (if applicable)	Not applicable	not applicable	Not applicable	Termed 1/1/2011. Termed due to diminishing state budget and lack of engagement. Client stated lack of engagement was not due to clients efforts. Population was not receptive to outreach.	Not applicable

Detail: CONFIDENTIAL - The names, addresses and phone numbers of Aetna/Active references are confidential.

Attachments:

4.1.1.4 Describe a situation in which you brought a client's healthcare plan trend down. This client should be similar to the State of Alaska in size, as well as in industry.

Answer: ActiveHealth launched a robust healthcare management program with the North Carolina State Health Plan (NCSHP) in 2011, providing Disease Management, Maternity, Nurseline, Lifestyle coaching, Portal and Mobile services. While the NCSHP is larger than the State of Alaska health plan with over 540,000 members, we support various divisions and segments that are of similar size to the Alaska plan. Since the program launch ActiveHealth has engaged 81 percent of eligible members in our healthcare management programs. Our engagement rates across programs with incentives such as their "Stork Rewards" Maternity program are 98%.

Such positive engagement rates coupled with the clinical excellence that is the foundation of our programs, has already delivered \$163 million dollar savings and an ROI of 6:1 across our combined programs.

North Carolina is one of the first states where the state health plan is instituting a broad-based strategy to move members toward a community-based Patient-Centered Medical Home (PCMH) model of care. In January of 2012, ActiveHealth began to identify and transition high-risk members -- those most in need of intensive management -- to participating primary care providers. Our provider based population health management tool, Active CareTeam, provides practitioners access to valuable, integrated and actionable patient data in the form of a condition registry stratified by risk level, dashboard. CMS and other customized quality metrics at the point of care.

We have already enrolled over 135,000 members in our new provider based ACO solution with NCSHP, and will have PCMH models in 61 out of 100 counties by the end of 2013.

Attachments: [4.1.1.4 North Carolina Case Studies.pdf](#)

4.1.2 Account Management Team

4.1.2.1 Please submit a written narrative providing a thorough description of the proposed account management structure. Your narrative must include the following:

- I. An organizational chart depicting the account management structure.
- II. The individuals who will comprise the account management team.
- III. For each individual on the proposed account management team:
 - a. name
 - b. title
 - c. physical work location where normally based
 - d. years of industry experience
 - e. years with organization
 - f. level of educational attainment
 - g. resume
 - h. years in current position
 - i. level and scope of decision making authority.
- IV. How often the account management team will meet with the Project Director and/or his designee(s) and whether the account management team will meet in person with the State on a quarterly basis in Alaska or other locations to be specified by the State.
- V. Maximum number of accounts assigned to each member of the account management team.
- VI. List other projects and or plans anticipated to be implemented by each member of the account management team during 2013/2014 and evaluate their impact on each member's ability to implement the scope of work set forth in the RFP relative to Healthcare Management component.

Answer: a. Name

Maureen Hydok RN, MBA

b. Title

VP, Account Management

c. physical work location where normally based

Home office is based in Park City, Utah Maureen works very closely with our clinical team based in Greenwood Village, Colorado

d. years of industry experience

Maureen possesses over 25 years of industry experience.

e. years with organization

Almost 5 years

f. level of educational attainment

Maureen possesses an RN, BSW and an MBA.

g. Resume

Maureen Hydok has over 25 years in the healthcare industry where she has worked in leadership positions in the health plan and provider space. Maureen joined ActiveHealth management in 2008 and is currently servicing a large state account. Additionally, Maureen has lead clinical teams in developing new technology and business processes to improve quality, performance and control costs. Maureen earned her nursing and social work degrees at the University of Vermont and her master's in business with a focus in healthcare management from the University of Phoenix.

h. years in current position

Almost 5 years

i.level and scope of decision making authority.

The VP of Account Management is accountable to the State to assure decisions are expedited. Our VP's of Account Management can make all decisions within the scope of the State contract. Matters that require an increased scope beyond the contract are expedited through the VP of AM through our supporting teams and administration. Maureen's primary accountabilities will be to;

- Coordinating day-to-day services

- Addressing questions from the State as single point of contact

- Managing an Implementation Manager & Data Configuration Coordinator

- The Implementation Manager and Data Configuration Coordinator are both supported by the Implementation Director for issue escalation or performance issues.

IV.How often the account management team will meet with the Project Director and/or his designee(s) and whether the account management team will meet in person with the State on a quarterly basis in Alaska or other locations to be specified by the State.

The account team will meet with the Project Director as often as desired to meet the goals and objectives of the State. Typically we meet with our clients weekly during implementation and the first 3 months of the program and then every two weeks the second quarter of the program, and monthly thereafter for status and project work. Again, our team is available to meet as often as needed and desired of the client and the account team. We minimally meet in person with our clients on a quarterly basis for a formal review of the agreed upon dashboard to review program outcomes, successes and problem solve any challenges.

V.Maximum number of accounts assigned to each member of the account management team.

Number of accounts varies by size, complexity and industry. Typically our account managers that support state clients are assigned no more than 3 accounts. Supporting roles such as clinical leads, business and reporting analysts, and communications specialists case loads vary depending on current projects and client goals. We are also thoughtful about not assigning the account team more than 3-4 new accounts so they can fully focus on a flawless implementation and on-going support.

VI.List other projects and or plans anticipated to be implemented by each member of the account management team during 2013/2014 and evaluate their impact on each member's ability to implement the scope of work set forth in the RFP relative to Healthcare Management component. Actual projects launching in July 2013 are not known at this time but we can provide this information as it becomes available and as we progress through this RFP process.

We have also included an Organizational Chart for the team that will support the State of Alaska, if Aetna provides the integrated medical and healthcare management business.

Attachments: [4.1.2.1 Account Org Chart.docx](#)

[4.3.3.4 Aetna Accountable Care Information.zip](#)

[State of AK - Org Chart.ppt](#)

4.1.3 Organizational Capacity

4.1.3.1 Confirm you, as the Offeror, have reviewed and understand the information presented in the Introduction section of the RFP.

Answer: 1: Confirmed

Detail:

Options:

1. Confirmed
2. Not Confirmed

Attachments:

4.1.3.2 Identify and describe how all aspects of the work for each function identified below will be organized and staffed.

1. Company Profile
 - a. HIPAA Compliance
 - b. Communications
 - c. Information Technology
 - d. Integration with Other Vendors
2. Patient Value Chain
 - a. Customer Service
 - b. Establishing Population Needs
 - i. Identification
 - ii. Health Risk Assessment
 - iii. Biometrics
 - c. Outreach
 - d. Incentives
 - e. Participation
 - f. Effectiveness
 - g. Healthcare Management Services
 - i. Wellness Services
 - ii. Nurse Call Line
 - iii. Disease Management Programs
 - iv. Maternity Management
 - v. Employee Assistance Program (EAP)
 - h. Quality Control
 - i. Performance Guarantees
 - i. Data Analysis
 - i. Data Collection
 - ii. Reporting
 - j. Financial
3. State Objectives
 - a. Plan Design
 - b. Policy Development
 - c. Innovation
 - d. Performance Incentives

In responding to this question you must include the following information:

- a. A work flow chart depicting how the work associated with each function will be performed and a narrative describing the processes depicted in each flow chart. In your narrative please specifically address, for each function:
 - i. The role of customer service and communications.

- ii. Special expertise, if any, that you can provide the State with respect to each function.
 - iii. Your experience and background in performing each specific function.
 - iv. How your system technologies uniquely position you to perform each specific function.
 - v. What innovation you can provide to the State with respect to each specific function.
 - vi. How you will coordinate with other Contractors who may be awarded Contracts under this RFP.
 - vii. If applicable, specify how the process will be different for members outside of Alaska.
- b. Whether the specific function will be managed and staffed by you, a subcontractor or joint venturer.
 - c. If the function will be managed and/or staffed by a subcontractor or joint venturer, please identify the subcontractor or joint venture and identify how long the subcontractor or joint venturer has been providing the service to a client of similar size to the State.
 - d. If the function will be managed and/or staffed by a subcontractor or joint venturer, explain how communication and coordination occurs between your organization and subcontractors or joint venturers who will provide the functional service.
 - e. Describe your organization's process for quality oversight of all subcontracted vendors and joint venturers and provide sample corrective actions used if performance needs to be improved.
 - f. Please include an organizational chart depicting all personnel or positions that will be assigned to accomplish each function.
 - g. Please identify the geographic location where the work associated with each identified function will be performed, including which functions will be performed exclusively in Alaska.
 - h. For any function that will not be performed exclusively in Alaska, please identify the total number of positions that will be based in Alaska for each function.
 - i. Please identify the proposed point-of-contact for each function.
 - j. Please identify customer service hours of operation for each function. Specify hours of operation by Alaska Standard Time and the applicable time zone where the function will be performed if not in Alaska.
 - k. Please identify for which functions you will provide onsite support. For example, open enrollment meetings and health fairs.
 - l. If the Project Team includes the role of a Medical Director, or similar position, please provide the following information:
 - a. The role of the Medical Director in each function.
 - b. A description of how the Medical Director will support the medical management process and assigned staff.
 - c. Whether the Medical Director will be located in Alaska.
 - d. Whether the Medical Director is/will be licensed as a physician in the State of Alaska.
 - e. If the Medical Director is/will not be licensed as a physician in the State of Alaska, is the Medical Director licensed as a physician elsewhere? If so, where?
 - f. Whether the Medical Director will be subject to the review and approval of the Project Director.

Answer: Please refer to the attached "RESPONSE TO 4.1.3.2" document for a complete description of our capabilities to provide each function requested above.

Attachments: [RESPONSE TO 4.1.3.2.docx](#)
[ActiveHealth Organization Chart.pdf](#)
[State of AK Organizational Chart.ppt](#)

4.1.3.3 Provide a copy of your standard Administrative Services Organization contract.

Answer: 1: Attached

Detail: We have attached both an ActiveHealth sample contract, and an Aetna sample contract. The Aetna sample contract would be applicable if Aetna provides the integrated medical and healthcare management services.

Options:

1. Attached
2. Not Attached

Attachments: [Aetna Sample Master Services Agreement.pdf](#)
[ActiveHealth Sample Employer Contract.doc](#)

4.1.4 Implementation Plan

4.1.4.1 Identify and describe, by function, how you will execute a successful implementation for each aspect of the work set forth in Section 1.04 of the RFP instructions relative to the Healthcare Management component. For each function, please provide:

- I. A work flow chart depicting how the implementation work associated with each function will be performed and a narrative describing the processes depicted in each flow chart.
- II. Whether the specific function will be managed and staffed by you, a subcontractor or joint venturer.
- III. If the function will be managed and/or staffed by a subcontractor or joint venturer, please identify the subcontractor or joint venturer and identify how long the subcontractor or joint venturer has been providing the service to a client of similar size to the State.
- IV. If the function will be managed and/or staffed by a subcontractor or joint venturer, explain how communication and coordination occurs between your organization and subcontractors or joint venturers who will provide the functional service.
- V. Describe your organization's process for quality oversight of all subcontracted vendors and joint venturers and provide sample corrective actions used if performance needs to be improved.
- VI. An organizational chart depicting the implementation management team structure.
- VII. Whether you will provide an Alaska-based implementation project manager during the term of the implementation.
- VIII. The individuals who will comprise the implementation management team.
- IX. For each individual on the proposed implementation management team:
 - a. name
 - b. title
 - c. physical work location where normally based
 - d. years of industry experience
 - e. years with organization
 - f. level of educational attainment
 - g. resume
 - h. years in current position
 - i. level and scope of decision making authority

- j. whether the individual management team member will be exclusively assigned to the implementation until completion. For those individuals not assigned exclusively to the implementation, please identify the amount of time they will be devoted to the implementation.
- X. The geographic location where the work associated with each identified implementation function will be performed, including which implementation functions will be performed exclusively in Alaska.
- XI. For any implementation function that will not be performed exclusively in Alaska, please identify the total number of positions that will be based in Alaska for each implementation function.
- XII. The proposed point-of-contact for each implementation function.
- XIII. Timeline for implementation
- XIV. How often the implementation team will meet with the Project Director and/or his designee(s) and whether the implementation team leader will meet in person with the State on a monthly basis in Alaska or other locations to be specified by the State.

Answer: Please refer to the attached exhibit "4.1.4.1 Implementation" as well as "4.1.4.1 Sample Implementation Project Plan."

Attachments: [4.1.4.1 Implementation v2.docx](#)
[4.1.4.1 Sample Implementation Project Plan.pdf](#)

4.1.4.2 Will you provide welcome kits as part of the implementation? If so, please identify and describe all information that will be contained in the welcome kits. If there is an additional cost, please indicate the cost on the rate sheet.

Answer: Yes; We provide welcome kits as part of the implementation - to key human resource staff, high volume provider groups, and to all program candidates within the population at program launch. Our account and implementation teams would work with the State to develop impactful communications and approach for delivery that would drive early program adoption and on-going best in class engagement for all programs.

Our standard program welcome kit features a series of printed, online and telephonic welcome messages to all candidates across the entire covered population that educate the member regarding the value of the program, frequently asked questions, and information regarding next steps to engage in the identified program relative to their risk status. Program communications are carefully developed with focus groups and input from our client advisory group and typically focus on "what's in it for me" messaging that catches the attention of the membership. Program incentives are also carefully communicated in the welcome kit. For the Lifestyle coaching program an additional welcome kit is provided which includes a healthy cookbook, a pedometer, a waist circumference measuring tape and a home exercise band and program. Our tobacco coaching program includes the participants NRT as part of their welcome kit.

Our account management and communications experts work with the State to develop a structured endorsement and communication strategy and plan for the program launch as well as on-going campaigns. We work closely with the Project Director to provide training and support to key staff such as human resource staff and wellness coordinators that will come into contact with members to assure they can appropriately represent the goals and objectives of the HCM programs. We would also work closely with any community and hospital based programs, other vendors and provider organizations, to provide them welcome kits to encourage member participation in programs.

We are able to examine historical data to identify high volume clinics, practices and providers. To increase early adoption we work with the State to develop communications that inform providers that some of their patients will be participating in one of our care management programs, that they might receive clinical decision support alerts, that they can access their patient's prepopulated PHR through our member web portal with the member's permission, and our contact information. We have also

sponsored outreach programs to provider groups and hospitals to discuss program launch and assure they are well educated about the goals and objectives of the State's program and program elements and processes.

ActiveHealth notifies physicians when their patients engage with a disease management nurse in our program. The notification includes the member's name and a brief description of the program, frequently asked questions, and contact information. Nurse initiated interventions are delivered to providers by telephone, letter and fax, depending on the level of severity. Providers employ any one of these communication tools to update member data. As mentioned above, the physician can call our toll-free number and discuss our findings and the patient's care plan with a disease management nurse or medical director. Nurses from our dedicated team and our onsite medical director provide targeted outreach to treating physicians when a patient is clearly struggling with complex issues and not achieving desired goals. If a physician would like to discuss a Care Consideration, we are staffed to support inbound calls and always have a medical director available for a direct physician to physician conversation. Our respect for the physician's unique knowledge of their patients has led us to strongly believe in providing the opportunity for feedback and in setting up a rotation schedule for our full-time physicians to provide coverage for any inbound physician telephone calls.

There are no additional fees for our standard welcome kits. We typically meet client requests for customization to engagement and communication materials without additional fees. Extensive changes to materials may require scoping and pricing.

Attachments: [4.1.4.2 Outreach Samples.zip](#)

4.1.4.3 Please confirm that your cost proposal includes the cost of all implementation expenses. If not, please identify all additional costs on the rate sheet.

Answer: Confirmed; Our cost proposal includes the cost of all implementation expenses.

Attachments:

4.1.4.4 Please confirm that you will provide run-out administration, including communications and data support for transition to a new Contractor for a period of 12 months following contract termination. If there is an additional cost, please indicate the cost on the rate sheet.

Answer: Confirmed; We will provide run-out administration, including communications and data support for transition to a new Contractor for a period of 12 months following contract termination at no additional cost.

Attachments:

4.1.4.5 Within your implementation team, is employee compensation tied directly to performance?

Answer: Yes; across all teams compensation is tied directly to performance.

Attachments:

4.1.4.6 Please outline your procedures for loading patient payment histories from the prior carrier. If there is an additional cost, please indicate the cost on the rate sheet.

Answer: Data is absolutely key to optimize our customer service and care management programs and we have best in class capabilities working with any data format and content to assure we're maximizing the creation of a longitudinal medical record for each member. Our implementation process includes an evaluation of all available historical data that may be available for use. We prefer to receive 2-3 years of historical eligibility, pharmacy and medical claims data. When available, we also incorporate lab value, health risk assessment, bio-metric and disability data from historical sources.

The age, quality and content of all historical data is evaluated with each client to ensure that including

each source makes sense clinically and programmatically. Additional sources of data beyond those stated above, would be evaluated with the client to determine its incremental value as risk identification, stratification or condition validation information. Should these additional data sources be jointly considered valuable, business requirements for ingest along with any potential additional costs and installation timelines, would be developed and shared with you for approval.

We do not translate previous risk scores from other vendors into our own because of the wide variations in risk evaluation methodologies that exist between vendors. We have also found that this can create significant confusion with members and damage the engagement process.

Once all historical data sources have been incorporated into our program design, they would be analyzed within our evidenced based predictive modeling algorithms, the CareEngine. The entire population's historical and current data would be analyzed to identify broad risk spectrum gaps-in-care, validate the presence of more than 200 acute or chronic condition risks and identify lifestyle or wellness risks. Because the CareEngine system can run these algorithms in real-time, risk identification can occur anytime new data is ingested, including while a member is completing their health risk assessment on-line.

The output from this risk identification varies depending upon the audience to which it is intended to be communicated. State of Alaska members will see easy to understand high, medium, or low risk indicators throughout their health portal and in their health report generated through the completion of the health assessment.

Our studies have shown that members prefer this simplified, easy to understand communication regarding their risk level versus a numerical score. For our coaching teams, the risk scoring output is far more detailed. Not only does the CareEngine provide our team with the high, medium or low risk score, but it also provides additional detail regarding which risks were identified and why, and stratifies those risks by risk type and impactability.

Additionally, where member risks are identified, the CareEngine system pushes through to our team all gaps-in-care by risk level to further specify which actions we should undertake on behalf of that member's optimal health targets. As these risks are communicated to our coaching teams, our system also pre-populates risk specific assessments, to provide a more pre-sensitized, member-specific interview engagement process.

We also incorporate current and previous program participation in our implementation process and will work carefully with the State to assure members receive appropriate communications introducing the new care management process and programs, including transitions in incentive programs.

Finally, the historical and current data allows our integrated system to identify risk specific gaps-in-care that are then communicated to treating providers across the population. This allows us to potentially impact even those members who are not fully engaged with coaching, condition management or physical activity programs based upon their relationship with their treating provider. This final process is also helping ActiveHealth and our clients become more capable of taking advantage of health care reform as physicians increasingly engage with us electronically via health information exchanges and electronic medical records.

Attachments:

4.1.5 HIPAA Compliance

4.1.5.1 Confirm your organization is in compliance with and will administer the proposed benefit plan (s) in accordance with all applicable legal requirements, including HIPAA, COBRA, DOL, ERISA, and state and local mandates.

Answer: Confirmed; Our programs are in compliance with all applicable legal requirements, including HIPAA, COBRA, DOL, ERISA, and state and local mandates. To support Aetna's current ongoing operation within Alaska, our internal compliance department performs ongoing review of all applicable mandates in Alaska.

Attachments:

4.1.5.2 Describe how you maintain confidentiality of patient and plan data.

Answer: Aetna and all wholly owned subsidiaries such as ActiveHealth are compliant with HIPAA security, privacy, and transaction standards. Our servers are located in a secure datacenter within our facilities. Access to the server is controlled and granted on a need basis. Customer data is protected by access control to the database and physical servers. Access to these is audited at regular intervals to ensure compliance with company and regulatory policies. Network connections are secured using industry standard network security technology including firewalls, intrusion detection systems, Virtual Private Networks, ongoing vulnerability scanning.

Applications are reviewed by the technical architecture team to ensure adherence to identified best practices. This includes (a) Guarding against malicious user input (b) Ensuring access to the database is through stored procedures guarding against SQL injection (c) Ensuring all traffic to the application is over encrypted protocols such as HTTPS and Secure FTP.

All customer data is transmitted using Secure FTP or Secure HTTP (HTTPS). Customer data is protected in the database by securing it against unauthorized access. Backup Media are encrypted using HP Backup and Recovery solutions before they are sent offsite.

Attachments:

4.1.5.3 Confirm you are currently receiving eligibility files in the HIPAA 834 format

Answer: Confirmed; We are currently receiving eligibility files in the HIPAA 834 format.

Attachments:

4.1.5.4 Are your eligibility and claim systems compliant with recently updated HIPAA regulations?

Answer: Yes; our eligibility and claim systems are compliant with recently updated HIPAA regulations. We maintain internal processes that protect the confidentiality of patient-specific medical information in light of HIPAA patient protection and privacy regulations, COBRA, DOL, ERISA, and state and local mandates. The network managed by our data analytics division is secured by an ICSA certified firewall and has been subjected to third party audits. All PHI is encrypted in the user interface so that no HIPAA identifiable data exists in the final database. Aetna has template confidentiality documents and HIPAA specific language built into our contracts to protect all parties to this project. Member level detail is not shared with employer clients. Additionally, for clients below a mutually agreed size, we would recommend limiting some of the reporting capabilities because of the potential risk of employee PHI exposure. For example, we typically suppress reporting on disease specific clinical information should there only be a few members with those conditions.

Attachments:

4.1.5.5 Please list the dates in which your eligibility and claims systems were reviewed or validated against the updated HIPAA regulations.

Answer: We verify and validate compliance with HIPAA regulations through continuous controls monitoring (as opposed to a periodic inspection), reinforced by annual baseline reviews and annual independent vulnerability scans last performed in February and finalized March 27, 2012.

All our applications to which HIPAA regulations apply are under continuous controls monitoring and enforcement. This includes the use of Data Loss Prevention tools to prevent the release of Protected

Health Information and/or Personally Identifiable Information to any but authorized parties. Our DLP tools scan all outbound emails for PHI and PII content and automatically encrypt messages if any is detected. All data received from or sent to external parties is transmitted via 256-bit SSL, which automatically encrypts the data.

Attachments:

4.1.5.6 Was an outside auditor/reviewer employed for HIPAA review/validations of these two systems?

Answer: Yes; We conduct third party security assessments and audits on an annual basis during the first quarter of each calendar year. ActiveHealth's latest audit was completed by Ernst and Young LLP on March 27th, 2012.

Attachments:

4.1.5.7 How soon after the contract award will you provide the HIPAA companion guide for creating eligibility files that load to your system?

Answer: Upon award of contract we will provide the State our HIPAA Companion Guide for creating the eligibility files.

We have provided our Aetna HIPAA 834 Companion Guide.

Attachments: [Aetna HIPAA 834 Companion Guide.docx](#)

4.1.5.8 Confirm your ability to administer HIPAA creditable coverage notices.

Answer: Confirmed; We are able to administer HIPAA creditable coverage notices.

Attachments:

4.1.6 Communications

4.1.6.1 Confirm that you are able to customize all communication/educational materials to include the AlaskaCare logo as the prominent feature.

Answer: 1: Confirmed

Detail: We can customize all communications and key educational materials to include the AlaskaCare logo as the prominent feature. After each coaching call members are provided with individualized educational materials from our expansive library. The cover letter accompanying these educational materials reviewing the coaching session and next steps can also be customized to include the AlaskaCare logo.

We have a suite of turn-key posters, flyers, letters, push e-mails and mobile reminders that can be co-branded to help raise awareness of our programs and services. Our web site can also be co-branded and customized messaging from the State can be updated quarterly. We also provide links within the member portal regarding local and regional community and hospital programs and resources to assure members have one place to find all relevant information.

Options:

1. Confirmed
2. Not Confirmed

Attachments:

4.1.6.2 Can you provide communication materials in an electronic and editable format for use by the State in their communications? If there is an additional cost, please indicate the cost in the rate sheet.

Answer: Yes; we provide at no additional cost communication materials in an electronic and editable format for use by the State.

Attachments:

4.1.6.3 Please confirm all communications/educational materials will be submitted to the Project Director, or his designee, for review and approval before dissemination to members. If you cannot confirm, please explain.

Answer: Confirmed; all communications and educational materials will be submitted to the Project Director, or his designee, for review and approval before dissemination to members. We have extensive experience creating educational materials that meet State requirements.

Attachments:

4.1.6.4 Please describe the process that will be implemented to ensure that internal reference source(s) provided to your personnel are consistent with the State's documentation such as plan participant communication materials, plan documents, etc.

Answer: During implementation, we will collect latest versions of all existing documentation, such as plan participant communication materials, plan documents, etc. Documentation is approved by the state and then entered into our nurse and customer service workflow software and registered with an expiration date defined by the State. Our Account Management team establishes ongoing reference source update processes with you to assure we are clear regarding your communications process, timeframes, and overall expectations. Typically this often includes annual updates underscored by ad hoc processes should a client alter plan documents or change vendors and referral processes.

To keep our vendor referral processes up to date, we participate and are willing to facilitate vendor summits where all involved parties describe their existing services and role within the State's health strategy. Work flows are documented and updated to reflect the most current and effective integration processes. We deliver an overview of the services we are implementing and offer comprehensive training for tools like our nurse workflow software portal. We describe our communication plan, the program hierarchy, referral processes, integration, online vendor portal and other tools. All vendors leave with a binder detailing roles and responsibilities, referral processes and other summary information.

After the initial summit, information is kept up to date by each partner although we are happy to lead this process. We will also conduct onsite training for your vendors during implementation.

We also prefer to launch our new partnerships with a cultural overview provided to our clinical team by the client, either by webex or onsite at our service center. Our entire clinical and operations team will attend as we find it extremely effective for our staff to have direct interaction with our client sponsors and Project Directors to engage in dialogue around any questions regarding the State's program goals, objectives, plan design, demographics and culture.

Attachments:

4.1.6.5 Is the creation, customization, production, and distribution of the materials itemized below included in your cost proposal?

- I. If there is an additional cost for any of the items listed below, please indicate each additional cost on the rate sheet.
- II. Will each of the items listed below be made available online?

- III. Please identify any additional communication and/or educational materials not listed below that are included in your cost proposal, and provide an example of each where possible.
- IV. Please identify any additional communication and/or education materials not listed below that you can provide for an additional fee. Please indicate each additional cost on the rate sheet.

	Can Provide?	Included in Fees?	Can Customize?	Included in Fees? If no, include fee on rate sheet
Educational Flyers	1: Yes	1: Yes	1: Yes	1: Yes
Brochures	1: Yes	1: Yes	1: Yes	1: Yes
Activities related documents (monthly health logs, etc.)	1: Yes	1: Yes	1: Yes	1: Yes
On-line wellness portal	1: Yes	1: Yes	1: Yes	1: Yes
Printed Newsletters	1: Yes	1: Yes	1: Yes	1: Yes
General Letters and Correspondence Sent to Employees	1: Yes	1: Yes	1: Yes	1: Yes
Healthcare reminders (preventive screenings)	1: Yes	1: Yes	1: Yes	
Other: <i>describe</i>	1: Yes	1: Yes	1: Yes	1: Yes

Detail: Other: Lifestyle welcome kit and Tobacco Nicotine Replacement Therapy are also provided at no additional cost.

For no additional charge, online and print materials can be co-branded or single branded with the State's preferred logo. Our standard program includes co-branding and other client specific customizations that can be applied to a large library of existing materials. For example, there are spaces within our HRA and member web portal for client-specific announcements and messaging. The State will have the opportunity to make suggested recommendations based on the specific characteristics of the employee population, emphasizing lessons learned from other communications that have successfully worked previously within the organization.

If the State would like to develop a completely customized communication campaign requiring development of new content for announcing all programs and services, alter the program design or develop a custom website to provide program information, this can be accommodated at an additional charge based on the request and required resources. Very few of our clients find this necessary and over 98% of our clients find our educational and communication materials thorough, effective and meeting grade level requirements.

Attachments:

4.1.6.6 What is the average number of work days from placing an order to time of delivery for the following communication materials?

	Average Days to delivery
Letters & General Correspondence	10
Brochures	10
Flyers	10
Newsletters	10
Activities-related documents	10

Detail: The average number of work days will vary based upon factors such as client approval process and extent of customization. Standard materials can be shipped within 48 hours, however if extensive

customizations will be necessary, 30-45 business days will be necessary to develop and approve, along with shipping and handling.

Attachments:

4.1.7 Information Technology

4.1.7.1 Describe how your company will use its systems technologies to perform each aspect of the work set forth in Section 1.04 of the RFP instructions relative to the Healthcare Management component.

Answer: Our clinical technology capabilities are best in class which is why we are the choice to power Healthcare Management programs for health plans, large employer and state plans across the country. Our systems assure consistent protocols and data integration across all programs to assure the most current evidenced based medicine. Our technology assures credibility with members and providers that provides them with individualized actions to close gaps in care, decrease negative lifestyle choices, and better avoid and manage chronic conditions. We would appreciate the opportunity to demonstrate the details of our technology capabilities. Our programs are powered by three proprietary systems working off of a single integrated database to the State and Buck at your convenience. Our technology is fully integrated to assure one consistent view of all data, whether it's being viewed by our internal teams or by the provider or member on their portal. Our technology is comprehensive and key systems are our CareEngine clinical decision support system, ActiveAdvice, our nurse workflow software, and our online member web portal.

1. The CareEngine(R) System

Member identification follows the clinical predictive model continuously developed by the ActiveHealth Research and Development team comprised of over 30 full-time providers (physicians, nurses and pharmacists), Clinical Programs & Product Management team for the past 13 years. The validity of the CareEngine predictive model was validated against chart review for disease identification and found to be >98% valid relative to clinician-documented conditions. The validity and reliability of the predictive model have further been reviewed by the NCQA for accreditation (currently accredited for Disease Management programs).

Real-time CareEngine analytics analyze HRA, diagnostic, procedure, pharmacy, laboratory, HIE, patient-reported (from telephonic and online coaching sessions) and physician-reported data to generate an internal "Member Health Profile". The member health profile is incorporated into what is known as a "Member Health State", which is composed from thousands of "Monitored Events" representing both gaps in care as well as care patterns (e.g. multiple ER visits, hospital discharge without outpatient follow-up, complicated hospital courses) along with "Markers" of disease and pre-disease risk (e.g., at risk for diabetes, at risk for CAD). Additional "marker" algorithms also look for patterns of care indicative of other types of future risk, such as care patterns indicating the need for Preference-Sensitive Decision Support (e.g. for low back pain, knee or hip replacement, which can often see highly variable practice patterns among local orthopedic surgeons). Other care patterns are programmed into the rule sets to identify the imminent need for care coordination (e.g., cancer workups, where sequential symptom, imaging, and biopsy is detected that suggests a patient may need additional care coordination as well as psychosocial support in an Enhanced Case Management capability). Note that this identification, rather than triggering from a hospitalization event, tries to identify a pattern prior to the actual hospitalization, so that care patterns can still be influenced to improve the health and economic outcome for the member.

Particular emphasis is placed upon "impactable" items identified during the course of stratification. Members are identified and then hierarchically assigned to the best-matching set of wellness & disease management interventions using the predictive model, the output of which is made available to the

nurses. It is important to note that the output of the CareEngine predictive model is clinically-driven, rather than identification strictly based on predicted future cost. There is both a summary numeric score as well as a narrative output that describes the member's conditions, co-morbidities, at-risk conditions, and specific actions they must take to mitigate future risk. This profile is made user-friendly and presented to the member themselves on our MyActiveHealth member portal so that they, too, can act upon it immediately.

The CareEngine Predictive Model (CSID) has historically been developed, and continues to be developed, with attention to directly integrate with nurse workflow and the ActiveHealth nurse workflow platform, ActiveAdvice. This means that output, in the form of validated conditions/disease, comorbidities, at-risk states, and care considerations, are electronically loaded into the ActiveAdvice nurse/coach workflow system on a regular basis, along with numeric scores indicating the overall opportunity for disease modification and health outcomes improvement. Nurse Managers are thereby able to select and prioritize sub-groups of members for outreach and engagement, often performing an additional layer to try to reach the highest-of-the-highest-risk members first, and then continuing along with the rest of the population. Incremental updates are also electronically delivered, such as if new data is found that changes a member's risk or opportunity, this, too is reflected in the Predictive Model output to ActiveAdvice. This is often most apparent in members who take the Health Risk Assessment, which can probe and uncover many more risks that are not always discovered through claims analyses (e.g. tobacco use pattern, dietary habits, weight / body mass index, exercise habits, and psychosocial stress level).

In addition, the nurses are able to see a uniquely detailed and actionable summary view of the predictive model. Rather than simply present raw numeric data (as is common with many cost-driven models), the CareEngine predictive model is clinically driven. Therefore, we are able to deliver a more detailed clinical view in the form of a "scoring note" and also a "justification" view. The "scoring note" is named from the weighted scoring methodology contained in the algorithms, and reveals the specific risk level for each condition, and the modifiability or "impactibility" of each. Thus, the nurse or coach can view a quick summary, e.g. "Diabetes - High - Impactible; Hypertension - Moderate - Impactible; At-Risk for Breast Cancer; Tobacco Use" and proceed quickly from a running start, knowing the data at hand. This scoring note also contains a summary of the Care Considerations - the specific modifiable gaps in care and actions to be taken - which make the nurse-member interaction far more targeted impactful than would otherwise occur, even with a predictive model in place.

Lastly, work is in progress to develop next-generation capabilities to perform regression analyses on existing data sets in order to refine prediction capabilities for hospitalization as well as re-admission, in order to identify members who may require outreach, engagement and intervention; if these modeling exercises yield satisfactory performance (i.e. R-squared), then there is a possibility they may be incorporated into the identification rules for certain tracks or programs.

2. ActiveAdvice Nurse Workflow Technology

ActiveAdvice, the system utilized by our disease management nurses, maternity program and lifestyle health coaches, and provides sophisticated workflow functionality including tracking of all medical management activity with members, documenting notes and scheduling tasks. The coach documents goal achievement in ActiveAdvice, such as weight loss, tobacco use status, nutritional and exercise activity as well as levels of stress which supports our reporting processes. ActiveAdvice technology is completely integrated with our reporting suite as well as the CareEngine, and is also utilized to support integration with external medical management programs. This integration allows for real time

data surveillance as our nurses and coaches add new member information acquired during coaching interactions.

Vendors involved with the State's program can access ActiveAdvice View, a portal with a window to summary information about a member's entitlement to and participation status in ActiveHealth Care Management programs. External vendors can use ActiveAdvice View to make referrals to ActiveHealth programs.

Data processing and integration from other programs would be managed by our data analytics division, which specializes in obtaining data from virtually any platform and format. We can integrate external data feeds as often as daily to ensure optimization of program effectiveness. ActiveHealth is able to provide multi-faceted data reporting on program performance. ActiveHealth develops fully integrated, seamless member experience processes with other health plans, PBMs, and lab vendors as well as HRA, wellness/lifestyle, behavioral, and disability programs. This includes shared access to CareEngine data and Care Considerations, cross-referral capabilities, and customized workflows to facilitate shared responsibility. We do this using both data feeds and work processes, which ensure information is shared when it is needed.

3. MyActiveHealth Member Web Portal and Mobile Capabilities

MyActiveHealth serves as the gateway for members to all online ActiveHealth programs. Built with flexibility in mind, the programs available to members can be configured to best meet the customer's needs. The available options include:

- A full featured, claims-populated and member-reported electronic Personal Health Record
- A comprehensive, proprietary Health Risk Assessment, that includes Health Actions, a prioritized and personalized health 'to do' list
- Online components to our NCQA-accredited Disease Management program
- Online components to our Lifestyle Coaching (wellness) program
- ActiveChallenge, powered by a partnership with Shape-Up, is a year-round wellness offering for employees.
- The Rewards Center, which is designed to accommodate various client incentive program configurations
- The MyActiveHealth website is currently accessible by smart phones, including the iPhone and Android, and supports SMS text message delivery and calendar reminders.

MyActiveHealth utilizes a variety of interconnection technologies to communicate with other systems. XML based Web Services are used extensively to provide communication with related applications and external trading partners. Additionally, MyActiveHealth is connected to the ActiveHealth Service Oriented Architecture (SOA) that provides the ability for sophisticated process orchestrations.

MyActiveHealth also possesses the ability to establish Single Sign On (SSO) capability with external systems to enable users to easily access the system from secure application environments that may be provided by their employer or other sponsoring organization.

Embedded in the MyActiveHealth website, the electronic Personal Health Record (PHR) provides a view for members into their health information. Features of the PHR include:

- Pre-population of health information from medical and pharmacy claims, and lab results feeds
- Pre-printed forms, including emergency wallet card and immunization record
- Ability to upload and store health-related documentation
- Spanish translation of the Personal Health Record

- Ability for member to grant access to physicians and others
- Organization of personal health records 'topically' (i.e., conditions, tests & procedures, immunizations, insurance information, health care team, health summary page)
- Suppression from display of specific 'sensitive diagnoses'
- Bi-directional persistency of data between PHR and HRA (a member only have to input information in one place and it will pre-fill in other applicable areas)

Our portal is also mobile enabled to assure easy access by members to their PHR and on-line tools and trackers to assure data consistency and access. We have several applications that members access on the go to assist them in better managing their lifestyle risks and conditions, despite their location and access to a computer. We would appreciate the opportunity to demonstrate our web and mobile capabilities to the State.

Attachments:

4.1.7.2 Does your automated data processing capability include the ability to interface with the State's health reporting eligibility system when fully operational?

Answer: Yes; we have integrated with other automated data processing capabilities so have no reason to think we won't be able to do the same with the State's system when operational. We have an entire data and analytics division which focuses on data processing and integration from other programs and specializes in obtaining data from virtually any platform and format. We can integrate external data feeds as often as daily to ensure optimization of program effectiveness. ActiveHealth is able to provide multi-faceted data reporting on program performance. ActiveHealth develops fully integrated, seamless member experience processes with other health plans, PBMs, and lab vendors as well as HRA, wellness/lifestyle, behavioral, and disability programs. This includes shared access to CareEngine data and Care Considerations, cross-referral capabilities, and customized workflows to facilitate shared responsibility. We do this using both data feeds and work processes, which ensure information is shared when it is needed.

We also work with many customers who use third party enrollment vendors; however, we typically do not directly interface with their systems to manage security and member privacy. The State can extract data and send our proprietary 2000-byte file layout, our new Consolidated Eligibility Format file or an ANSI standard layout for electronic processing. Because electronic submission tends to be more efficient and accurate, we encourage the State to implement an electronic submission method, regardless of the human resources information system you use. This process is available for initial and subsequent enrollments.

Additionally, our Account Team has the ability to access your system to review eligibility. We will have our personnel use your system to check eligibility when it has not yet been loaded into our system.

Attachments:

4.1.7.3 Describe the proprietary software that will be used in administration of this Contract, as well as any services or software purchased or licensed from outside vendors to update your system.

Answer: All software services are managed and provided directly by ActiveHealth. ActiveHealth programs are powered by three proprietary systems working off of a single database: the CareEngine clinical decision support system, ActiveAdvice nurse workflow software, and our online member web portal MyActiveHealth. These are described in detail in response to 4.1.7.1. Although the majority of

resources are internally sourced, we work with partners that provide some online content.

The MyActiveHealth portal includes a number of licensed content, including:

Healthwise Knowledgebase - 2005

Emmi Solutions - 2009

HeathDay - 2009

First Data Bank - 2005

HealthMedia - 2009

ActiveHealth receives scheduled content updates from these vendors and applies the updates accordingly. Effective issue resolution criteria is covered in all of our contracts with third party vendors. Additionally, ActiveHealth has a long standing (2003) relationship with a development/implementation company, Netsoft, USA.

ActiveHealth also works with vendor partner SironaHealth to deliver Nurseline services described in this proposal, but use a long standing automated process with ActiveAdvice View to guarantee seamless program delivery.

Attachments:

4.1.7.4 Are all data feeds for set-up and on-going maintenance included in your pricing? If not, please include the fees on the rate sheet.

Answer: Yes; data feeds for set-up and on-going maintenance are included in our pricing.

Attachments:

4.1.7.5 Please indicate any additional charges for any required manual interventions (workarounds) due to system interface incompatibility, file format issues, plan compliance, etc. on the rate sheet.

Answer: We have not experienced any system interface incompatibilities we couldn't resolve, but should that occur we would scope the issues and solutions with the State and confirm any additional fees before deploying any solutions. We will indicate any additional ad-hoc charges for any required manual interventions (workarounds) due to system interface incompatibility, file format issues, plan compliance, etc. on the rate sheet.

Attachments:

4.1.7.6 Describe your system access security process with members, providers and the State.

Answer: We are compliant with HIPAA security, privacy, and transaction standards. Our servers are located in a secure datacenter within our facilities. Access to the server is controlled and granted on a need basis. Customer data is protected by access control to the database and physical servers. Access to these is audited at regular intervals to ensure compliance with company and regulatory policies. Network connections are secured using industry standard network security technology including firewalls, intrusion detection systems, Virtual Private Networks, ongoing vulnerability scanning.

Applications are reviewed by the technical architecture team to ensure adherence to identified best practices. This includes (a) Guarding against malicious user input (b) Ensuring access to the database is through stored procedures guarding against SQL injection (c) Ensuring all traffic to the application is over encrypted protocols such as HTTPS and Secure FTP.

All customer data is transmitted using Secure FTP or Secure HTTP (HTTPS). Customer data is protected in the database by securing it against unauthorized access. Backup Media are encrypted using HP Backup and Recovery solutions before they are sent offsite.

The privacy and security of each member's personal information is extremely important to us. Protection of member information is carefully planned and tested.

To that end, we require five pieces of information for a member to register on our member portal; MyActiveHealth:

- * Full first name
- * Last name
- * Date of birth
- * Home zip code
- * Gender

All five pieces of information must match the eligibility file we receive from our customer exactly for the user to gain access. If access is granted, the member creates an ID and password, and also must provide a security question and answer for future use, if they forget their password.

Protection for Registered MyActiveHealth Users

Once a member registers for MyActiveHealth, additional security is in place. At log-in, a member is allowed to mistype his password three times. After the third incorrect password, the member is forced to reset his/her password by entering the correct answer to the security question that he/she set during registration. If the member answers the security question incorrectly three times, his account is automatically locked and the member must call a customer service representative to have it unlocked, providing his/her user name, password and answer to the security question.

If a registered MyActiveHealth user has forgotten the password, the member must supply the following to reset it:

- * User name
- * Date of birth
- * Home zip code
- * Answer to secret question identified at initial registration

If a registered MyActiveHealth user has forgotten his/her user name, the member must supply the following to retrieve it:

- * Full first name
- * Last name
- * Date of birth

Overall Security on MyActiveHealth

ActiveHealth maintains and enforces an Information Security Policy that expressly states that ActiveHealth will safeguard its resources from accidental and/or unauthorized use, loss, theft, modification, disclosure, or destruction.

ActiveHealth Management maintains firewall and proxy server technologies that are used to protect internal computer networks from unauthorized users accessing ActiveHealth's internal computing resources through the Internet. Violation exception reports are reviewed daily and concerns are resolved accordingly.

A data encryption feature is also in place and functioning for the transmission of confidential information over the Internet.

Attachments:

4.1.7.7 Describe the advantages of your Internet home page, including access and capability to communicate with the State and members on information regarding:

- a. Eligibility (name, address, covered dependents, etc.)
- b. Wellness Portal
- c. Health Risk Assessment
- d. Health improvement and education information
- e. Webinars

Answer: We constantly improve our portal to assure the best possible experience for our clients and their members. Our portal won "Web Health Gold Awards for Best Digital Health Information" These nationally respected awards are based on Content and Design, Creativity and User Experience. Our satisfaction surveys demonstrate that members find the portal very informative and easy to navigate. We have attached a screen shot of a sample home page and several other pages in the system that your members would see after completing a secure log in or moving to the page through a single sign on from your AlaskaCare website. You can see that all key areas for navigation are listed on the left hand side and easy to access. This includes the Health Assessment, Health Record (pre-populated), Health Center, Rewards Center, Health Actions (individualized for each member), and Resource Center. Members can easily click on any topic or can click on common questions which will efficiently link them to action steps, incentive or awards status, health information, health assessment, tools and trackers, etc. Please see below for a more detailed listing of our portal's capabilities.

A key differentiator of our member web portal is the ability to provide members with a personalized and actionable list of action items, referred to as Health Actions. The Health Actions are derived via the complex clinical algorithms in ActiveHealth's CareEngine system. The list may include discussing Care Consideration alerts with their physician, participating in other programs such as health coaching, making lifestyle changes or other actions. Members see a completion score of their progress toward completing the Health Actions, along with an image of a 'running person' which signifies action and health. If an incentive is offered for the completion of the Health Assessment, a message may be shown on the member's home page that provides details about the incentive. ActiveHealth will pre-load external websites based on a member's clinical profile. Members also have the ability to add links to their favorite health websites.

Other differentiating factors include:

HRA Integration with the Online Rewards Center, Disease Management, Lifestyle Coaching

Each activity or program participation requirement can be tracked and incentivized on various levels, which the member can view as they progress through their program. Points, dollars and other ways to incent the member for each activity can be tracked and displayed on the tool to ensure each member is aware of their goals and their progress on a daily basis. Members will also be notified when they complete all their required activities and meet their goals to receive the full incentive.

Another differentiator of our Health Risk Assessment is its integration within our overall program. Through the CareEngine, our products are seamlessly integrated and information freely and securely

shared - all with the end result of improved health care for our members. This integration along with real time actionable clinical feedback differentiates our HRA from others in the industry. Our ability to tie action oriented clinical recommendations in real-time, based upon the totality of data including HRA responses, and attach member actions to specific incentives through our Health Index system is another unique aspect of our approach. The Health Index provides members with an easily understood graphic depiction of their health risk and action steps to mitigate that risk.

Underlying Clinical Decision Support and Predictive Modeling Tools

A differentiator of the ActiveHealth PHR and HRA is the clinical decision support made possible through our patented CareEngine processing, and delivered electronically to members via the PHR, where the HRA resides. Many PHRs in the marketplace have medical records storage capabilities, but none have the interactive, messaging capabilities of the CareEngine. ActiveHealth's CareEngine system is at the core of all of our products and it is the sophistication and intelligence of the CareEngine that differentiates our offerings from all others.

Our patented CareEngine System technology compiles member data from a variety of sources such as medical and pharmacy claims, lab results and information provided directly from the member. The CareEngine analyzes this information against highly respected sources of evidence-based medicine to identify gaps in care, medical errors and quality issues. The gaps in care are then communicated to the member and the member's physician.

Our portal serves as the gateway for members to all online care management programs. Built with flexibility in mind, the programs available to members can be configured to best meet the customer's needs. The available options include:

- A full featured, claims-populated and member-reported electronic Personal Health Record
- A comprehensive, proprietary Health Risk Assessment, that includes Health Actions, a prioritized and personalized health 'to do' list
- Online components to our NCQA-accredited Disease Management program
- Online components to our Lifestyle Coaching (wellness) program
- ActiveChallenge, powered by a partnership with Shape-Up, is a year-round wellness offering for employees.
- The Rewards Center, which is designed to accommodate various client incentive program configurations

MyActiveHealth smart phone features

The MyActiveHealth website is currently accessible by smart phones, including the iPhone and Android, and supports SMS text message delivery and calendar reminders. The following capabilities are available for smart phones:

- Login, Register, Forgot Password & Username
- Health Actions / Alerts Page
- Health Records Section - Members can view health record pages, including Medications, Tests, Procedures, Health Center (Conditions list), Immunizations, Allergies
- Emergency Info (read only)
- My Health Team Page (read only)
- Account Info Section
- Health Trackers - Members have the ability to view, add new, and edit previously self-reported information, on the health trackers page including Blood Glucose, Physical Activity Trackers (Cardio, Mind-body, Strength training, Sports, Walking Steps, Other), Blood Pressure
- Incentives
- Care management applications that supplement members' online and telephonic engagement.

- Message Center
- Calendar
- Member goal setting
- Electronic delivery of Health Alerts
- Real-time interaction with ActiveHealth's CareEngine system
- CareEngine-validated conditions and lifestyle topics
- Member-entered conditions and lifestyle topics
- Clinical Risk Indicator (high/medium/low)
- Condition and lifestyle topic detail pages
- Access to NuVal, a nutritional scoring system
- Recommended Materials (based on member's clinical profile and indicated interests)
- Resource Center with:
 - Tools & trackers
 - Videos
 - Audio files
 - Health education content
 - Daily news feeds
- Monthly email summary alerting members to new and open items
- Telephonic and email member support

Details regarding our Personal Health Record

Embedded in the MyActiveHealth website, the electronic Personal Health Record (PHR) provides a view for members into their health information. Features of the PHR include:

- Pre-population of health information from medical and pharmacy claims, and lab results feeds
- Pre-printed forms, including emergency wallet card and immunization record
- Ability to upload and store health-related documentation
- Spanish translation of the Personal Health Record
- Ability for member to grant access to physicians and others
- Organization of personal health records 'topically' (i.e., conditions, tests & procedures, immunizations, insurance information, health care team, health summary page)
- Suppression from display of specific 'sensitive diagnoses'
- Bi-directional persistency of data between PHR and HRA, if purchased (a member only have to input information in one place and it will pre-fill in other applicable areas)

Details regarding our Health Risk Assessment

Through its electronic format and sophisticated branching logic, our Health Risk Assessment (HRA) dynamically customizes itself to each user based on age, gender, and any previously answered questions.

ActiveHealth recently released a new tool to expedite the completion time for the health assessment called "The Wizard". This interactive tool is an add-on option to the standard HRA that provides a method for members to complete just the required questions of the health assessment in approximately 8 - 10 minutes. While there are more than 400 questions in total, the average person, without any health conditions, will be presented with only 40 to 60 questions. Individuals with multiple health issues will be presented with additional questions.

As HRA data is captured, it is stored in the same database system that holds claims, pharmacy and laboratory data. Aggregated information is analyzed by our CareEngine system in real-time. Patient-provided information from the HRA, such as biometric data, tobacco use, diet, and over the counter medication, is fed into our CareEngine system to complete the member's clinical profile.

ActiveHealth's HRA is designed to provide assessments and identify candidates for our disease management, lifestyle coaching, and other health management programs. Information captured by the HRA can also lead to the generation of additional Care Considerations. Available in English and Spanish, ActiveHealth's 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.

If historical claims data is available for a member, it will be pre-populated in the online and telephonic versions of the HRA, minimizing the amount of information a member has to input and allowing them to view and interact more positively with the HRA. A member is encouraged to add information to the HRA that is not readily available through claims data, such as unhealthy habits, over the counter medications, other tests and procedures, allergies, etc. 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 CareEngine system to analyze for any potential adverse outcomes or provide suggestions to the member for their care management.

Topics Covered in the HRA

- Allergies (environmental, medications)
- Demographics & 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 - absenteeism (related to personal and family health)
- Complementary or Alternative Medical Therapies
- Advance directives

Online HRA Report

Immediate feedback in the form of a Health Report is presented to the member. The report summarizes the results of the HRA and provides information to educate and spur action. The Health Report is comprised of the following sections.

- Health Actions
- Health Coaching referral
- Clinical Risk Categorization
- Reminder
- Customer-specific Messaging Area

Telephonic HRA

An additional option, used most frequently with populations that may not have easy access to the internet, ActiveHealth Management can assist members over the phone in completing their online Health Risk Assessment.

Details regarding our Online Incentive Tracking

Through partner relationships ActiveHealth has the ability to design, control and fulfill an end-user program to reward participants for participating in goal-direct health-improvement or cost-saving

activities. After consulting with the State, we can propose a complete incentive campaign that includes identifying the activities or behaviors to be rewarded in order to drive ROI, incentive ideas, fulfillment and tracking plans, and ongoing promotion for that campaign. Our online member web portal includes a member facing incentive tracking tool, called Rewards Center, to view status, progress, award eligibility and other features.

Rewards Center Overview

ActiveHealth recently introduced an incentive tracking platform, Rewards Center, within our online member web portal, which allows participants to track their completed activities and progress. Implementation is flexible, as most clients want to create a customized member-level program. Each activity or program participation requirement can be tracked and incentivized on various levels, which the member can view as they progress through their program. Points, dollars and other ways to incent the member for each activity can be tracked and displayed on the tool to ensure each member is aware of their goals and their progress on a daily basis. Members will also be notified when they complete all their required activities and meet their goals to receive the full incentive. ActiveHealth will track whether the member meets the criteria for the incentive and coordinate with the organization fulfilling the incentive.

Differentiators

Our approach promotes incentive initiatives by encouraging the population to monitor compliance and track status by logging on to the member web portal, which includes an HRA, a PHR where worksite screening results will appear, trackers and an incentives reward center among other capabilities that can be customized to maximize the State's program.

The Rewards Center was designed to accommodate client-specific incentive program configurations, targeted to high impact membership groups or other categories. Clients are encouraged to add a customized message on the Rewards Page, including Welcome message, Instructional messages, and specific program or direction messages.

Each activity or program participation requirement can be tracked and incentivized on various levels, which the member can view as they progress through their program. Points, dollars and other ways to incent the member for each activity can be tracked and displayed on the tool to ensure each member is aware of their goals and their progress on a daily basis. Members will also be notified when they complete all their required activities and meet their goals to receive the full incentive.

Synchronized communications increase campaign impact

ActiveHealth will encourage the State's population to use our online member web portal with an incentive rewards center, and our communications campaign can be tailored to encourage your population to call our clinical operations center to speak with a staff member that will help them understand their incentive eligibility, progress toward the State initiatives, and overall health risk status. This provides a potential opportunity to refer the member to a disease management nurse or lifestyle coach. For members already participating in a program, coaches will remind them of future incentive milestones in need of completion.

Activity challenges enhanced by social networking and online incentives tracking

Should the State decide to incorporate social networking tools into future incentive initiatives, ActiveHealth can tailor incentives to a set of engaging social networking tools in ActiveChallenge, which participants access through a well-established and known entrance point (single sign-on) through the MyActiveHealth portal. ActiveChallenge serves to strengthen participation in traditional health coaching as members become more involved in their health, and ActiveHealth coaches can educate engaged members on the benefits of the ActiveChallenge program.

Incentive tracking through smart phones

As the State moves beyond awareness, to begin improving member health outcomes, ActiveHealth will provide innovative approaches to engage members beyond telephonic coaching - such as our member web portal tools that are accessible by iPhone and Android smart phones.

Customizable options

The Rewards Center was designed to accommodate specific client incentive program configurations, targeted to specific membership groups, as well as individual members. These are items that the infrastructure and/or User Interface were built to accommodate.

Clients are encouraged to add a customized message on the Rewards Page, including Welcome message, Instructional messages, and specific program or direction messages. These messages can be updated as frequently as quarterly with one month prior notice. Please see screenshots and sample messages on the following page.

Examples of successful incentive programs

One of ActiveHealth's clients recently requested an incentive strategy that would drive more long term activity. We responded with a combination of formulary based participation incentives and HRA completion incentives that were distributed over a long period of time with incentive distribution tied to a quarterly coaching session. This approach resulted in a significant increase in participation and long term improvement in outcomes. This required customized communications and data strategies across a broad spectrum of population demographics, including non-English speaking membership. Innovative engagement strategies have led to double and triple the typical non-incented engagement rates and resulted in significant increases in ROI and clinical outcomes. Adopting healthier habits that turn into long-term, sustainable behavior change requires effort and commitment, which is why the coaching program focuses on the fundamentals of wellness and health improvement, not quick fixes.

Attachments: [4.1.7.7 State of Alaska home page examples.pdf](#)

4.1.7.8 Describe what types of information are available through your wellness portal.

Answer: Our wellness portal serves as the gateway for members to all online ActiveHealth programs. Our portal is also mobile enabled which provides optimal access for members 24/7.

While some of the information available is general to enable member searches, KEY to our site is the personalization of the information to the specific needs of each member, driven by our analytics and data integration of claims, bio-metrics, health assessment, and coaching derived information. We know members are busy and need to have their necessary health actions, gaps in care and incentive information served up to them in an easy to navigate platform.

Our portal was also built with flexibility in mind, the programs available to members can be configured to best meet the customer's needs. The available options include:

- A full featured, claims-populated and member-reported electronic Personal Health Record
- A comprehensive, proprietary Health Risk Assessment, that includes Health Actions, a prioritized and personalized health 'to do' list
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- My Health Team Page (read only)
- Account Info Section
- Health Trackers - Members have the ability to view, add new, and edit previously self-reported information, on the health trackers page including Blood Glucose, Physical Activity Trackers (Cardio, Mind-body, Strength training, Sports, Walking Steps, Other), Blood Pressure
- Incentives
- This year we also released care management applications that supplement members' online and telephonic engagement.

Other features that are available to all members include:

- Secure registration and log on process.
- Home page with welcome message
- Message Center
- Calendar
- Member goal setting
- Electronic delivery of Health Alerts
- Real-time interaction with ActiveHealth's CareEngine system
- Health Center
- CareEngine-validated conditions and lifestyle topics
- Member-entered conditions and lifestyle topics
- Clinical Risk Indicator (high/medium/low)
- Condition and lifestyle topic detail pages
- Access to NuVal, a nutritional scoring system
- Health Links
- Recommended Materials (based on member's clinical profile and indicated interests)
- Resource Center with:
 - Tools & trackers
 - Videos
 - Audio files
 - Health education content
 - Daily news feeds
 - Monthly email summary alerting members to new and open items
 - Telephonic and email member support

Attachments:

4.1.7.9 Is the wellness portal managed by a subcontractor or joint venturer?

Answer: No, the wellness portal is managed by ActiveHealth, a wholly owned subsidiary of Aetna.

Attachments:

4.1.7.10 Explain your process of providing a secure electronic portal for members and providers to contact you via e-mail.

Answer: Our member web portal includes a capability to securely email with their personal Nurse/Coach. Any registered members using the portal are able to grant secure access to their provider to view their portal, personal health record, health risk assessment, etc.

Attachments:

4.1.7.11 Describe your company's use of current system technologies to notify customers of issues that relate to them.

Answer: ActiveHealth programs are tailored to the preference of our customers - using multiple mediums of communication to notify of issues that relate to them: phone, email, text, fax, and potentially instant messaging between an account manager and the State's staff.

Member-specific clinical issues are also delivered through the portal. For example, upon completing their assessment, HRA participants receive a real time feedback report detailing health improvement actions and triggering referrals to disease management, lifestyle coaching and maternity. With regard to messaging targeted to all users across the State's membership, our member web portal features a customizable welcome message among many features that could be used to distribute notifications.

Attachments:

4.1.7.12 Indicate services you offer to members and providers via e-mail and electronically.

Answer: ActiveHealth often deploys email blast campaigns and push notifications to interact with the entire population or subsections (i.e. a campaign for those members engaged, non-engaged, low/medium/high risk level, incentive eligible, and others depending upon the goals of the client). The MyActiveHealth member web portal includes a capability to securely email with a Nurse/Coach (if currently engaged in the program). Members using the MyActiveHealth member web portal are able to grant secure access to their provider to perform the same functionality. Both members and providers have electronic access to a personal health record with all historical information.

The MyActiveHealth website is currently accessible via smartphones, including the iPhone (iOS operating system), BlackBerry, Android devices and Windows Phone, and supports SMS text message delivery and calendar reminders. The following capabilities are available for smartphones:

- Login, Register, Forgot Password & Username
- Health Actions / Alerts Page
- Health Records Section - Members can view health record pages, including Medications, Tests, Procedures, Health Center (Conditions list), Immunizations, Allergies
- Emergency Info (read only)
- My Health Team Page (read only)
- Account Info Section
- Health Trackers - Members have the ability to view, add new, and edit previously self-reported information, on the health trackers page including Blood Glucose, Physical Activity Trackers (Cardio, Mind-body, Strength training, Sports, Walking Steps, Other), Blood Pressure, Pain Assessment, Caloric Intake, Waist Circumference
- Incentives
- Healthy Recipes
- A link to the NuWell mobile food tracker app
- A link to the iTriage mobile app download page

In 2012 we released the following Mobile Apps, available on iOS devices (iPhone, iPad and iPod Touch):

MealMonkey: A healthy eating tracker to provide members the ability to rate their meals on a scale of Healthy to Unhealthy, see a longitudinal view of their progress, learn healthy eating tips and new meal options

Questioning Autism - This free mobile app helps concerned parents collect information about their children and provide it to their pediatrician.

NuWell - This free app, available to MyActiveHealth registered members, scans the bar code of common foods and displays the NuVal score so users can upgrade shopping lists to achieve better nutrition.

The MealMonkey app will be launched for Android devices in February 2013.

We are also targeting for the release of care management applications in 2013 that will supplement members' online and telephonic engagement.

Attachments:

4.1.7.13 Describe electronic service methods you use to educate members in accounts you currently manage of similar size to the State of Alaska about health care issues.

Answer: The size of our clients does not affect the service methods we have available. We service accounts from 5,000 to 500,000 and all have the full benefit of our electronic capabilities. During contracting and implementation we look forward to working with the State to define the electronic service methods that will work best for your membership. All methods described in this proposal are available and included in our pricing, such as web, e-mail and mobile devices. Members interact with our program based upon individual preferences for communication and educational methods.

Education and support with online tools and resources, available at our web portal, include Healthwise educational content and brochures, HealthMedia digital coaching modules for Tobacco Cessation, Weight Management, Elevated Cholesterol, Hypertension, and more. Coaches are able to interact with participants through telephonic sessions, distribute educational content online through the web portal, email, text/chat and by mail.

The educational materials provided to members are developed by Healthwise, an organization that has 35 years of experience in writing for consumers with the goal of helping them make better health care decisions. Because the educational information at times needs to include medical terminology, the reading level as measured by Flesch-Kincaid or other formulas generally ranges from the 6th to 8th grade. The Healthwise approach is to emphasize "plain language" and accessibility, not just reading level.

Healthwise uses a variety of techniques to improve readability such as color and illustrations; clear titles; bulleted lists; consistent outlines; sidebars, charts and white space; and (in online applications) hypertext that further explains or defines terms and allows readers to dig deeper to get as much information as they need. Because many people learn best by looking at pictures, educational materials use photos, drawing and tables along with the text. Healthwise recently won the Clearmark Award from the Center for Plain Language.

ONLINE INTERACTIVE COACHING MODULES

Additional program materials include our HealthMedia(r) Lifestyle Coaching & Disease Management

interactive online digital coaching modules. All HealthMedia(r) products are backed by over 20 years of behavioral science research born out of the Health Media Research Laboratory (HMRL) at the University of Michigan. The HMRL provides ongoing research for HealthMedia(r), and in turn they build commercial Digital Health Coaching programs that are science-based, and deliver proven, measurable outcomes. The HealthMedia online coaching programs are dynamic and interactive, as the program incorporates logic based on the member's responses and clinical profile and presents tailored and relevant information to the user.

MyActiveHealth launched online self-care health and wellness educational tools in July 2010, with interactive digital coaching tools from HealthMedia(r). The following online modules are available:

Lifestyle Coaching Modules

- HealthMedia(r) Balance(tm) (Weight Management)
- HealthMedia(r) Breathe(tm) (Smoking Cessation)
- HealthMedia(r) Relax(tm) (Stress Management)
- HealthMedia(r) Nourish(tm), (Nutrition and Diet)
- HealthMedia(r) Move(tm) (Physical Activity)

List of Unique Modules

- HealthMedia(r) Balance(tm) (Weight Management)
- HealthMedia(r) Nourish(tm), (Nutrition and Diet)
- HealthMedia(r) Move(tm) (Physical Activity)
- HealthMedia(r) Care for Diabetes(tm)
- HealthMedia(r) Care for your Health(tm)
- HealthMedia(r) Overcoming Depression(tm)
- HealthMedia(r) Control(tm) (Hypertension)
- HealthMedia(r) Achieve(tm) (High Cholesterol)
- HealthMedia(r) Care for Your Back(tm)
- HealthMedia(r) Care for Pain(tm)
- HealthMedia(r) Breathe(tm), (Smoking Cessation)
- HealthMedia(r) Relax(tm), (Stress Management)

Disease Management Modules

- HealthMedia(r) Balance(tm) (Weight Management)
- HealthMedia(r) Nourish(tm) (Nutrition and Diet)
- HealthMedia(r) Move(tm) (Physical Activity)
- HealthMedia(r) Care for Diabetes(tm)
- HealthMedia(r) Care for your Health(tm)
- HealthMedia(r) Overcoming Depression(tm)
- HealthMedia(r) Control(tm) (Hypertension)
- HealthMedia(r) Achieve(tm) (High Cholesterol)
- HealthMedia(r) Care for Your Back(tm)
- HealthMedia(r) Care for Pain(tm)

In addition, our materials are available in English and Spanish. We incorporate health literacy standards to make our materials more effective tools for our members.

Attachments:

4.1.7.14 Provide an overview of your documentation, storage, retrieval and recovery of electronic files.

Answer: All data types, including self reported information from the member web portal, are stored in the Operational Data Store (ODS) and submitted to the CareEngine for clinical evaluation. Payer claims and member eligibility data is received from many sources (e.g., insurance carriers, pharmacy benefit managers, labs, payroll companies, HR departments, HR consulting companies, etc.). Members can enrich the data with information via our member web portal and PHR. When working with a program participant, a nurse or coach accesses an aggregated member medical record within the ODS, using ActiveAdvice nurse workflow software. Nurses and coaches use this integrated platform for documentation, storage, retrieval and recovery of electronic files.

High availability of our internal care management applications is achieved through redundancy at all levels. Load balancers front end all requests through the network into a bank of multiple web servers hosting the care management applications. The databases are highly available through a cluster of Active-Passive Nodes.

Attachments:

4.1.7.15 Explain your Computer Disaster Recovery plan. Provide the most recent outside assessment of its readiness.

Answer: We maintain formal Business Continuity and Disaster Recovery Plans, which are tested annually.

ActiveHealth's Recovery Time Objective is 72 hours or less. Our Recovery Point Objective is 96 hours or less. In our most recent test, key lessons learned included:

- * Include additional detailed documentation on certain aspects of the plan in the format of more sequential "hands on" procedures.
- * Create a dashboard for the tracking of problems which occurred during the testing. We currently use an Excel sheet which lists the issues and the responsible party. A dashboard system would be a more effective method in that weights can be applied and Management can track the results as well.
- * Do annual "table top" testing as well as the physical testing. This would ensure that all documentation and procedures are maintained and remain current.
- * Include diagrams and configurations in the plan for all critical applications.
- * Perform a Business Impact Analysis annually with the key stakeholders to ensure that Recovery Time Objectives are accurate and address the criticality of the application.

Our full Disaster Recovery and Business Continuity Plan is considered confidential, and not available for external release; however, ActiveHealth will provide access and logistics for an onsite review of our existing Business Continuity and Disaster Recovery Plans in response to requests arising out of an RFP, Security Assessment or Audit Processes.

Attachments:

4.1.7.16 Does the online system allow the State to assign different levels of access internally?

Answer: Yes; online systems allow role-based access for assigning different levels of access.

Attachments:

4.1.8 Integration with Other Vendors

4.1.8.1 Describe your procedures for implementation of ongoing treatment plans.

Answer: We manage the transition of participants from a previous care management program as part of the overall implementation work plan. The basic premise of the transition plan is that members participating in the current disease management, lifestyle coaching or maternity program will be notified that the program will be discontinued and a new program will begin. The transition process includes telephonically contacting those members who are actively engaged with a nurse in the current program, and offering them our care management program through a customized outreach process.

To facilitate the transition, an electronic case summary file listing all of the State's members who are actively engaged with a nurse in the current program is requested. The preferred case summary information includes member demographics (telephone number if available), conditions managed, stratification designation and description, and date indicator of last nurse contact.

Eligible members in the transition file are automatically loaded into our ActiveAdvice care management system, and outreach calls begin on the program start date. All transitioning members that have had nurse interaction with the prior vendor within the last six months will receive two outreach calls. The outreach calls are designed to complete an initial member assessment and develop a customized plan of care based on their prior disease management interaction and ongoing needs. If the nurse is unable to reach the member, a letter is sent to the member with contact information and a request for the member to call to participate in the program.

If the State is offering an overall program announcement, the transition notification can occur simultaneously. This communication will inform the member of the program change and provide a telephone number for members to contact ActiveHealth. ActiveHealth will work with the State to provide sample communications that can be customized to promote the program transition.

We have experience receiving transition files from other vendors such as Matria, SHPS, Healthways and Carrier-based programs. In situations where we have not worked with the existing vendor, we will develop a transition process based on our experience and with the goal of bringing all nurse engaged members into our program. At the same time, we will run our clinical predictive model on the entire population and all new members who are identified and have not been transitioned, will be brought into our program and go through our program's outreach process.

Attachments:

4.1.8.2 Are you able to accept electronic feeds of data or referrals from other vendor partners? If there is an additional cost, please indicate the cost on the rate sheet.

Answer: 1: Yes, included in base pricing

Detail:

Options:

1. Yes, included in base pricing
2. Yes, for an additional fee (indicated on rate sheet)
3. Yes, for an additional fee IF the number of contracted data feeds are exceeded (indicated on rate sheet)
4. No

Attachments:

4.1.8.3 Are you able to provide electronic feeds of participation data to an outside data aggregator or vendor partners? If there is an additional cost for providing or sharing the data, please indicate the cost on the rate sheet.

Answer: Yes; ActiveHealth regularly provides electronic feeds of participation data to an outside data aggregator or vendor partners.

Vendors involved with the State's program can access ActiveAdvice View, a portal with a window to summary information about a member's entitlement to and participation status in our Care Management programs. External vendors can also make referrals to our Care Management programs through the portal.

We develop fully integrated, seamless member experience processes with other health plans, PBMs, and lab vendors as well as HRA, wellness/lifestyle, behavioral, and disability programs. This includes shared access to CareEngine data and Care Considerations, cross-referral capabilities, and customized workflows to facilitate shared responsibility. We do this using both data feeds and work processes, which ensure information is shared when it is needed.

Attachments:

4.1.8.4 How often can you export data files to vendor partners? If there is an additional cost, please indicate the cost on the rate sheet

Answer: ActiveHealth can export data files as often as daily to the State's vendor partners.

Attachments:

4.1.8.5 Are you willing to provide monthly interface with the data integration vendor or other vendors for claims and utilization data? If there is an additional cost, please indicate the cost on the rate sheet.

Answer: 1: Yes, no additional cost

Detail:

Options:

1. Yes, no additional cost
2. Yes, additional cost (indicated on the rate sheet)
3. No

Attachments:

4.1.8.6 Does your program/system have the capability to share data with the following vendors or programs?

Answer: 1: Biometrics,
2: Case Management,
3: Demand Management/Nurse Line,
4: Disease Management,
5: EAP/Behavioral health,
6: Health Advocacy/Health Coach,
7: Health Plans/TPA,
8: Health Risk Appraisal,
9: Healthcare savings/FSA,
10: Healthcare savings/FSA,
11: Maternity Management,

- 12: Mental Health / Substance Abuse,**
- 13: Nurse and/or doctor line,**
- 14: On site clinics,**
- 15: PBM,**
- 16: Providers,**
- 17: Utilization Management,**
- 18: Wellness/Lifestyle management**

Detail: Provider EMR data exchange is possible but may require development, based on EMR requirements.

Options:

1. Biometrics
2. Case Management
3. Demand Management/Nurse Line
4. Disease Management
5. EAP/Behavioral health
6. Health Advocacy/Health Coach
7. Health Plans/TPA
8. Health Risk Appraisal
9. Healthcare savings/FSA
10. Healthcare savings/FSA
11. Maternity Management
12. Mental Health / Substance Abuse
13. Nurse and/or doctor line
14. On site clinics
15. PBM
16. Providers
17. Utilization Management
18. Wellness/Lifestyle management
19. Other, please specify: [Text]

Attachments:

4.1.8.7 Please describe how you will coordinate with other Contractors, if any, to manage functions such as data sharing, eligibility, coordination of benefits and payment of medical, pharmacy and healthcare claims.

Answer: We commonly develop fully integrated, seamless member experience processes with other health plans, pharmacy and lab vendors as well as bio-metric, wellness/lifestyle, behavioral, and disability programs. This includes shared access to CareEngine data and Care Considerations, cross-referral capabilities, and customized workflows to facilitate shared responsibility. We do this using both data feeds and work processes, which ensure information is shared when it is needed. Vendors involved with the State's program can access ActiveAdvice View, a portal with a window to summary information about a member's entitlement to and participation status in our Care Management programs. External vendors can use ActiveAdvice View to make referrals to our Care Management programs.

Attachments:

4.1.8.8 Does your system flag a member if they are enrolled in another vendor partner program so that members are not outreached to when already participating?

Answer: Yes; our system flags a member if they are enrolled in another vendor partner program, so there is not dual outreach. Successful implementation of the model envisioned by the State fundamentally relies upon seamless coordination of care. Starting at implementation, our team works closely with the State's third-party vendors and would establish appropriate referral rules along with the rules of engagement.

We established the following hierarchy to manage member outreach and prevent duplicate outreach, which can be confusing to members. Member management logic is based on the clinical priority the State defines, but typically we follow the following hierarchy;

- Transplant Management
- Maternity Management
- Case Management
- Chronic Condition Management
- Lifestyle Management

We take a member centric / holistic approach where the primary nurse addresses the member's chronic and acute issues and we offer co-management with specialty RN staff for oncology, maternity and transplant issues.

We also offer co-management with lifestyle coaching, certified diabetes educators, registered dietitians from our staff or other vendor or community programs.

Ultimately whether a member receives co-management or not is individually decided by the member.

Attachments:

4.1.8.9 Does your system make automated referrals to other care management programs (wellness, CM, maternity, health advocacy, EAP, quality, etc.)?

Answer: Yes; our system makes automated referrals to other care management programs. When ActiveHealth is providing services, the system automatically generates activities for internal staff to review patients for participation in the program. Examples include use of the predictive model to trigger outreach for participation. The system also ingests utilization management data and we use specific diagnosis and / or procedure codes to trigger screening for case management and other programs.

When we are referring externally, for example to the EAP vendor, this is done manually using a collaborative process developed during implementation. The referral to the external vendor could be via secure email, warm transfer, or other methods.

Attachments:

4.1.8.10 Describe your plans for integrating the services described in one program, such as the wellness program, with other programs such as disease management, utilization management, case management, claims processing and customer service. Please identify any difficulties you foresee in integrating these activities and your proposed solutions.

Answer: When all the services mentioned are being provide by Aetna and ActiveHealth we have seamless integration of member data and workflows without any difficulty.

When other State vendors are providing some of the services, we are experienced in acting in a leadership capacity and the "hub" role, coordinating patient care across the spectrum of available health management programs. We have developed fully integrated processes with many other health

plans and third parties which includes cross-referral capabilities, and customized workflows to facilitate shared responsibility. We use both data feeds and work processes to ensure information is shared when it is needed.

In order to optimize the coordination of care, we would work with the State and all vendor partners. Our goal is to ensure that other vendors have access to timely, relevant, and actionable information regarding members that are being managed across all State Care Management programs.

Timely data integration is critical. The ActiveHealth implementation team is well prepared to work with your information technology team so that we can ingest data as often as the State and your medical, pharmacy, lab and other vendors can send us the information. While we have standard data layouts, we typically start with a payer's layout. Additionally, we will work with your vendors to create timely data transfers. ActiveHealth has successfully implemented hundreds of data feeds from multiple sources. We are confident we can create the required data feeds up to a frequency of daily if the State vendors have the capacity to do so. This will allow for more real-time messaging to members and rapid communication with their treating providers. We typically provide monthly data feeds reflecting members enrolled and invited to enroll in the disease management program. We also receive membership listings from health plans and third parties, allowing us to flag or exclude members who would be co-managed. The frequency and format of this feed is mutually agreed upon.

We also accept and submit referrals from and to the health plans and third parties. We establish key contact points at each external health plan and third party to ensure that the referral process is timely. We develop mutually agreeable referral criteria and the format and frequency of referrals. If appropriate, we facilitate warm telephone transfers to and from the health plans and third parties.

On a monthly basis, (sometimes more frequently as the program is in early stages) we conduct case conferences with other program administrators to review cases and refine the processes for coordination and communication. Again, we are willing to take a leadership role in coordinating vendors to decrease the burden of the Program Administrator or Manager.

Attachments:

4.1.8.11 Explain how you can coordinate with an external weight management program, such as Weight Watchers At Work.

Answer: Yes; ActiveHealth will coordinate with an external weight management program, such as Weight Watchers At Work. Automated coordination could include bi-directional referral processes, warm and cold transfers, data feeds, monthly grand rounds and access to our ActiveAdvice nurse workflow portal. We will work with the State's external vendors to be able to cross-promote our programs (includes screening, HRA, incentives, coaching, etc.) For example we could provide informational flyers and other materials for external weight management to eligible participants. All interaction with external vendors, such as referrals, are reported upon in quarterly operational reports.

Attachments:

4.1.8.12 Describe your procedures for transition of ongoing management cases to a new vendor. Unlimited.

Answer: Should a transition become necessary, the assigned account manager will work with the client and the new vendor to provide them with transition information for members that are engaged in our Care Management programs. A schedule of data content and transfers will be mutually determined by the State, Aetna/ActiveHealth and the new vendor(s).

Case conferences and discussions can occur with the new vendor to review the program detail and member expectations.

Attachments:

4.2 Patient Value Chain

4.2.1 Customer Service

For **EACH** of the healthcare management programs you are proposing for the State, please provide the following information:

4.2.1.1 Will you provide the State with unit(s) dedicated to customer service? Please describe each healthcare management function supported by these customer service unit(s).

Answer: Yes, we will provide the State with a dedicated customer service unit. Our agents are capable of either answering all member questions, warm transferring members or providing follow up calls to members, specific to all healthcare management programs.

We are committed to transforming health care one member at a time, and this begins with providing exceptional service to each member how and when they need it.

INTEGRATED MEDICAL AND HEALTHCARE MANAGEMENT OFFERING

For the integrated medical and health management services, we are proposing our Aetna Concierge service model, which we are calling “My AlaskaCare Single Point of Contact”. The Aetna Concierge service model builds on the strong foundation of Aetna's standard member service experience with a more consultative approach that focuses on making every member call a more tailored and personal benefits experience.

My AlaskaCare Single Point of Contact is each member's concierge to navigate through their health care path. They help each member understand the barriers associated with health care, and access the resources and programs they have available to them. This personalized interaction enables a truly heightened level of engagement and creates an experience that opens the door to future personalized interactions and advocacy for the member.

Aetna Concierges receives special training to support the member across the total State of Alaska benefit offering, including the healthcare management programs. They are fully empowered by the Wiki Site that is a 360 degree view of member and provides the concierge with necessary information to understand “who the member is and where they are.”

Aetna Concierge also connects members to additional resources to help them get the most from their available benefits. Concierges are available to answer questions and connect members to relevant programs through internal warm transfers and external transfers to benefits provided by other carriers in order to simplify and provide a more seamless member service experience.

ALASKA BASED SALES SUPPORT CONSULTANT

In addition to My AlaskaCare Single Point of Contact, there will be four sales support consultant positions (SSC) for the State of Alaska. Two will be in Juneau and two will be in Anchorage. The representatives can meet with members either on-site or over the phone to assist with any provider or claim issues they may be experiencing. These four SSCs will have the same training as the concierges.

These representatives will have access to all Aetna systems and resources to support your members and any escalated issues from the State of Alaska team. We will work with the State of Alaska on the process to hand off member questions or issues to support resolution. The sales support consultant will also work closely with the State's team as well as Aetna's Field Account Management team.

Attachments:

4.2.1.2 Where will the dedicated office(s) be located and will those offices provide customer service for all healthcare management functions under this RFP?

Answer: For the wellness and disease management programs, we will provide on-site support at key locations around the State on a defined schedule. Our instate staff will be further supported by clinical and operational staff in our service centers around the country. Specifically for the wellness and disease management programs our additional staff in our Greenwood Village, Colorado office will be designated to work on behalf of the State of Alaska members.

INTEGRATED MEDICAL AND HEALTHCARE MANAGEMENT OFFERING

For an integrated medical and healthcare management offering, you will have a dedicated My AlaskaCare Single Point of Contact team in our Fresno Service Center, located at 1385 E. Shaw Avenue, Fresno, CA. There will also be four sales support consultants for the State. Two will be in Juneau and two will be in Anchorage. The sales support consultant will interface directly with State employees and their dependents regarding health benefits offered through the State's benefit program.

Attachments:

4.2.1.3 Please identify whether you will maintain, at a minimum, offices in Juneau and Anchorage to provide dedicated customer service to AlaskaCare members and providers served under the healthcare management function.

Answer: Yes, we will maintain offices in Juneau and Anchorage to provide our Single Point of Contact Model. We will also provide a schedule for on-site customer service across key locations around the State.

INTEGRATED MEDICAL AND HEALTHCARE MANAGEMENT OFFERING

For an integrated medical and healthcare management offering, Juneau and Anchorage offices will have two Aetna service representatives dedicated to the State. These representatives will act as an extension of State of Alaska and will be available for member service issues, plan benefit questions, support for the State's staff, coordination of program and services, and various other needs as they arise. Along with the account team, these individuals will primarily be responsible for ensuring a cohesive integration of all resources and programs.

The Anchorage representatives will be located in our Aetna offices and we will establish a lease for the Juneau representatives.

Attachments:

4.2.1.4 List how many customer service representatives will be dedicated to each program.

Answer: If we are selected as the healthcare management administrator only, we commit to having a team of customer service representatives that can support the State of Alaska at any time, including possible campaigns and peak call times.

We recommend a designated staff model because it provides flexibility in meeting staffing needs, resulting in better service.

Designated means there is a defined number of staff members whose primary responsibility is to support a particular account. This team would, as needed, have secondary and tertiary responsibility for other accounts within the group. We continually monitor volume and staffing.

INTEGRATED MEDICAL AND HEALTHCARE MANAGEMENT OFFERING

For an integrated medical and healthcare management offering, the State will have 23 concierge members dedicated to you. They will partner with all State members, connecting you to the right resources across your entire portfolio. In addition, the four sales support consultants will be fully dedicated to the State of Alaska.

Attachments:

4.2.1.5 Describe your training program for customer service employees.

Answer: We have a specific on-boarding process for all staff that includes several weeks of classroom training educating new staff regarding all programs, services, and systems. Weekly, monthly, and quarterly training continues for all staff by our dedicated training department. Newly hired Customer Service Associates (CSA) also receive training and mentoring by an experienced staff member for the first several months on the job. The CSAs also receive ongoing training for the population to which they are assigned. Quality assurance processes for new CSAs include direct observation and monitoring of telephone interactions with members until complete proficiency. A 30, 60, and 90-day review is performed with the CSA to discuss progress and additional learning needs before the CSA successfully completes the 90-day probationary period.

On-going monitoring of CSA's continue with supervisors listening to recorded calls and providing the CSA feedback and suggestions for improvements.

INTEGRATED MEDICAL AND HEALTHCARE MANAGEMENT OFFERING

The My AlaskaCare Single Point of Contact service model is supported by a robust training curriculum. We staff our Aetna Concierge teams with a mix of new and existing customer service professionals who possess the knowledge and aptitude to deliver a best-in-class member service experience.

The My AlaskaCare Single Point of Contact training aims to strengthen active listening skills that enable the Concierge to deliver truly personalized service to deliver the seamless “wow” (won over wonderfully) and high-satisfaction member experience ensuring that member will view their Aetna Concierge as a valuable resource and advocate who is available to support their ongoing needs.

Comprehensive Training

Comprehensive training provides Concierges with information about State of Alaska-specific benefits and employer culture to assist members within the context of the plan sponsor's organization, and enables the Concierge to serve as an extension of the State's culture, communications strategy, and HR benefits team.

High-touch, one-on-one support for Aetna Concierge representatives is provided by Aetna's Learning and Performance trainers and the Aetna Concierge leadership team throughout the comprehensive Aetna Concierge training curriculum. Aetna Concierge training is structured in such a manner that the

concierge will obtain and build upon in-depth product knowledge, consultative soft-skills, and plan sponsor-specific benefit, program, and cultural information in distinct modules and sections.

Once one section is learned, the Aetna Concierge representative is placed in a live phone environment for two weeks to allow them to use their new knowledge in real-time. During these two separate two-week timeframes that the concierge is in the live environment, they will have the support of their trainers for feedback and mentoring. This allows our training team to begin building rapport while directing the concierge down the path to success. Many members still prefer person-to-person phone contact to resolve their inquiries and issues, as such, our concierge are trained to answer questions and resolve issues on the first call, thereby delivering high levels of first call resolution. We give them the tools they need to find answers and access the relevant resources and information that will address individual member needs.

Concierge training has an added emphasis on soft-skills that supports a consultative approach to members with additional focus on understanding unasked questions and implicit needs. This ensures that concierges are aware of underlying opportunities to guide, educate, and empower members through the teachable moments. This comprehensive training builds on the designated staffing model to provide a truly differentiated member service experience that is customized for each plan sponsor, and personalized for each individual member using a simplified, seamless approach.

Lastly, a robust certification and performance assessment process ensures that each Aetna Concierge representative is equipped with the necessary skills to deliver concierge-level service to Aetna members upon completion of their training program.

Member Experience

The concierge is able to provide a differentiated member service experience through the use of the First Impression Treatment (FIT), which uses an ASD system alert to notify a concierge when a member calls in for the first time. Concierges are able to discuss key topics, as identified by the Plan Sponsor, with a first-time caller to ensure that members are maximizing their available benefits, and promote awareness on topics that are key from the perspective of the plan sponsor.

Concierges connect members more seamlessly through the use of internal warm transfers to Aetna clinicians, and programs that are available to them. They also serve as a single point of contact by transferring members to external 3rd party vendors and service providers. Outbound text messaging is an added capability that allows concierges an additional way to personalize the experience by following-up with members via the communication channel they prefer, whether it is by phone, email, or text.

Customer Service Training

In addition to our in-depth Aetna Concierge training program, our concierges are placed in a 12 to 14 week foundational customer service training program. The training is delivered through classroom lecture and computer-assisted instruction. The training program covers:

- Benefit determination
- Claim review
- Eligibility information
- System navigation and documentation
- Communications and soft skills

Additionally, 4 weeks of in-depth product and integration training, as well as consultative soft-skills training builds upon the foundational customer service training to ensure that the concierges have an

elevated level of expertise and skill in delivering concierge-level service. Ongoing management oversight and mentoring focuses on skills refinement and proficiency to support continuous skills development and improvement.

We review all new hire training content weekly and incorporate changes to policy, product or systems within 5 working days.

Trainees study previously recorded calls and mock-up call scenarios. They also meet with seasoned customer service representatives (CSRs) to listen to and watch real calls.

Trainees only graduate when they can demonstrate they can consistently handle calls with a quality level that meets or exceeds our standards.

State of Alaska Specific Training

We want our team to know that the State members are important to us and we address this through cultural training. When a member calls with a question or concern, our service center staff will be trained and well educated on not just your plans and other vendors, but on your culture.

We will take the State of Alaska through an elaborate implementation process to ensure collection of all relevant information to support the Concierge team. We will use our experience and both collect the critical information from the State of Alaska as well as our network and clinical teams to populate both the tools as well as determine critical culture training.

We will work with the State of Alaska to define your role in the cultural training process. We see tremendous value in the State of Alaska delivering the cultural training to support a clear understanding of the State of Alaska's culture program goals, vendor partners and other key features.

The service center staff will review your benefit program, special administrative issues and other unique requirements. We will provide copies of the State's employee benefit booklets, announcements, other communications and any materials that you recommend, to provide our staff with a clear understanding of your program. This provides a smooth transition for responding to employee inquiries, as well as claim settlement.

Attachments:

4.2.1.6 Explain any incentive programs you employ to retain competent customer service employees.

Answer: ActiveHealth monitors success, provides continued education credits at no cost to our customer service employees. Pay increases are based on performance and our philosophy is to promote our best employees within a large dynamic organization.

INTEGRATED MEDICAL AND HEALTHCARE MANAGEMENT OFFERING

We conduct performance reviews for our customer service staff and determine pay increases annually. We recognize and reward them for their performance and team outcomes.

These outcomes include:

- Customer focus
- Contact documentation adherence
- Quality call/correspondence review results
- Teamwork

- Schedule adherence
- Service excellence innovation (Keeping the Commitment)
- Telephone service factor
- Attendance

Managers consider these elements in the annual performance merit review.

In addition to their base salary, eligible customer service representatives (CSRs) take part in an incentive program that permits them to earn more monies on a quarterly basis.

We designed the Customer Service Incentive Program to keep and motivate CSRs. It also encourages a higher level of performance by providing meaningful financial rewards to those who excel in specific quality, productivity and teamwork goals.

We subject final bonus eligibility and bonus amounts to plan maximums and managers' discretion.

Attachments:

4.2.1.7 What is the average years of experience for your customer service staff?

Answer: The average years of experience for our customer service staff exceeds three years with ActiveHealth and over 5 years work experience.

INTEGRATED MEDICAL AND HEALTHCARE MANAGEMENT OFFERING

The average years of experience of our customer service staff in the Fresno Service Center is 7.13 years.

Attachments:

4.2.1.8 What is the average length of employment for your customer service staff?

Answer: The average years of experience for our customer service staff exceeds three years with ActiveHealth and over 5 years work experience.

INTEGRATED MEDICAL AND HEALTHCARE MANAGEMENT OFFERING

The average length of employment for our customer service staff in the Fresno Service Center is 10 years.

Attachments:

4.2.1.9 How many dedicated toll-free phone lines will be made available to answer member and provider inquiries?

Answer: One dedicated toll-free phone line will be made available to answer member and provider inquiries.

INTEGRATED MEDICAL AND HEALTHCARE MANAGEMENT OFFERING

For an integrated medical and healthcare management offering, the State will have one dedicated 800 number with prompting for members and providers. When a State employee uses the member prompt on the 800 number, their call is handled by the My AlaskaCare Single Point of Contact team which handles member calls exclusively. When providers use the provider prompt 800 number, their call is geographically routed to be handled by representatives in our Provider Service Center which handles

providers' calls exclusively.

Members can also reach the Concierge via live Aetna Navigator-based web chat. In the event a Concierge needs additional detail from a member during a chat, they will call the member at a number that is convenient for the member in order to continue the conversation.

Provider services are geographically aligned to one of eight Provider Service Centers. All work (e.g. calls, claims, correspondence) is systematically routed from central addresses/phone numbers to provider's local service center. Provider Service Center locations are:

- Allentown, PA
- Arlington, TX
- Bismarck, ND
- Blue Bell, PA
- High Point, NC
- Jacksonville, FL
- New Albany, OH
- Walnut Creek, CA

Attachments:

4.2.1.10 How many dedicated toll free phone lines for the hearing impaired will be made available to answer member and provider inquiries?

Answer: One dedicated toll free phone line for the hearing impaired will be made available to answer member and provider inquiries.

Attachments:

4.2.1.11 During what hours/days of week will toll free phone lines be staffed?

Answer: Instate staff will work regular business hours, to be determined but typically 9 am AKST to 6 pm AKST. ActiveHealth program operations center in Greenwood Village, CO is open from 4:30 am. to 7:00 pm. AKST, Monday through Friday; 5:00 am. to 10:00 am. AKST, Saturday. If the State elects to purchase our Nurse Advice Line, toll free lines would be staffed 24x7, 365 days per year.

INTEGRATED MEDICAL AND HEALTHCARE MANAGEMENT OFFERING

For an integrated medical and healthcare management offering, the State's members will have access to their My AlaskaCare Single Point of Contact team from 8:00 a.m. to 6:00 p.m., in their local time zones. The dedicated My AlaskaCare team will handle all of the State of Alaska member calls from 8:00 a.m. to 7:00 p.m. pacific standard time with support team handling call for members in eastern, central and mountain times prior to 8:00 a.m. pacific.

Members may also obtain customer service information through Aetna Voice Advantage, our self-service telephone system, and Aetna Navigator, our secure member website, which are both available 24 hours a day, 7 days a week.

Attachments:

4.2.1.12 Provide an explanation of how you define “after-hours.” Explain your process for delivery of services on nights, weekends, and holidays.

Answer: On holidays, Sundays and after hours, the dedicated State line will be answered by a voicemail system, which directs callers to leave a message and informs them that their calls will be returned the next business day. The message is time and date stamped so those callers are registered in our system to meet member pre-certification or incentive timeliness guidelines, if applicable. If the State purchases our nurse advice line, all callers have the option to call 24/7.

If members call the nurse advice line during operating hours for other Care Management programs their call will be managed by our staff.

If members call the nurse advice line after hours, and they either want to be engaged or are already engaged in one of our programs, Nurse Line staff would log follow up requests for the following business day. The system then automatically logs the request to their personal coach or customer service to follow up during business hours. Coaches and nurses can also request the after hours nurses to follow up with members evenings, weekends and holidays to support the members when they are available and require assistance.

Attachments:

4.2.1.13 Describe how emergency after-hours calls will be handled.

Answer: The State's dedicated line will suggest members call 911 with any medical emergency, both during operating hours and after-hours. Your line will also direct callers to call our optional 24/7 nurse advice line, which provides live support to all callers and could help callers with emergency situations 24 hours per day.

Attachments:

4.2.1.14 Is there a voice mail system or capability for callers to leave messages after normal business hours? During hours?

Answer: Yes; members who call the dedicated State line can leave a voice mail both during and after business hours, but typically during business hours they speak to a live person is less than 30 seconds. Should a caller attempt to reach a nurse, coach or physician for whom they have their direct line - and that person is unavailable - they have the option to leave a message which is returned within one business day. Each employee has a voice mail system that can receive confidential time-stamped messages after and during normal business hours.

Attachments:

4.2.1.15 Do members reach a live representative or an interactive voice response unit (IVR) when calling customer service?

Answer: Members reach a live representative when calling customer service after a brief recorded response letting them know they've connected with the State line. Member's will be presented several optional connections depending on why they are calling.

INTEGRATED MEDICAL AND HEALTHCARE MANAGEMENT OFFERING

For an integrated medical and healthcare management offering, when members call customer service, they are first greeted by Aetna Voice Advantage, our telephone self-service system.

Members are able to request to speak to their My AlaskaCare Single Point of Contact at any time during the call by speaking 1 of the more than 150 synonyms for concierge that the system is programmed to recognize. When a member requests to speak to a concierge, their validated member information automatically presents to the concierge receiving the call.

Our state of the art IVR system, Aetna Voice Advantage (AVA), fully supports our service model with complex call routing designed to support the multi-product customer. Only one toll-free-number is required and the AVA integrated product menu, along with the speech recognition technology, will get the member to the right area.

All information provided by the member to the AVA system will be available to the concierge, eliminating the need to repeat information.

Attachments:

4.2.1.16 Please describe how you would handle a call from a member who does not speak English.

Answer: The first step in our assessment process is to evaluate the member's language preference, including any barriers such as hearing impairment. We then evaluate literacy, educational levels, and overall cultural ideals by listening to the patient to understand their beliefs, values and practices. By acknowledging and showing respect for differences, and incorporating culturally relevant strategies for achieving health goals, Nurses are more likely to effectively engage the member, thus driving improved clinical and financial outcomes.

For non-English speaking members, we have in-house staff available through our customer service and nursing teams for the following languages: Bamba, Cantonese, Creole, Chinese (Mandarin), English, Farsi, French, Hindi, Nepali, Punjabi, Russian, Spanish, Tagalog, and Urdu. Additionally, we utilize Language Line translation services for telephonic translation provided in over 140 languages.

All of the member outreach materials sent to the member population will be written at a sixth grade reading level. ActiveHealth's member portal and all it's content is converted to Spanish with one quick click.

All of our member reminders and program materials are written in English and in Spanish. ActiveHealth also provides a toll free 800 number on all of our reminders that a member can use to call one of our nurses. Through our care management system, our nurses have online access to all reminders mailed to each member in the program and can read the reminder to the member over the phone, or connect the member to a translator. Additionally, we also have TTD capabilities for hearing impaired members.

Once the member engages with a nurse, the process is structured to build rapport. The coach becomes the member's trusted advisor who educates and supports the member in developing strategies to reach their health care goals. Our staff are trained in coaching, health literacy and cultural competency, and work with members to motivate them to define SMART goals, which are specific and realistic goals, the plan to achieve the goals and to begin to take culturally appropriate action steps to reach those goals.

Attachments:

4.2.1.17 Are all calls logged into your tracking system?

Answer: Yes; all calls are time and date stamped and logged in read-only format into our tracking system where they are permanently stored.

INTEGRATED MEDICAL AND HEALTHCARE MANAGEMENT OFFERING

For an integrated medical and healthcare management offering, we use an online tracking and documentation system called Aetna Strategic Desktop (ASD) for member and provider contacts

including telephone calls, written correspondence, Internet e-mail and walk-in visitors We track events in the system from the moment a member contacts us. The system tracks any tasks or activities performed to resolve the service request from beginning to end.

Attachments:

4.2.1.18 If no, what percentage of calls are logged into your tracking system?

Answer: Not applicable: all calls are logged in read-only format into our tracking system where they are permanently stored.

Attachments:

4.2.1.19 Please check all items below which pertain to calls handled by the customer service representatives:

Answer: 1: All calls are recorded,
2: Customer service representatives document all calls,
5: Calls are documented in summarization

Detail: Our system was designed to create an optimal experience for the caller. The system allows for quick but thorough documentation of each call.

Options:

1. All calls are recorded
2. Customer service representatives document all calls
3. Customer service representatives can make adjustments to claims during a call
4. Calls are documented verbatim
5. Calls are documented in summarization

Attachments:

4.2.1.20 If your customer service unit uses a dedicated on-line call tracking and documentation system, identify whether the following characteristics are tracked:

Answer: 1: Date of initial call,
2: Date inquiry closed,
3: Representative who handled the call,
4: Call status,
5: If and where issue was referred for handling,
6: Reason for call,
7: What was communicated to member

Detail:

Options:

1. Date of initial call
2. Date inquiry closed
3. Representative who handled the call
4. Call status
5. If and where issue was referred for handling
6. Reason for call
7. What was communicated to member

Attachments:

4.2.1.21 What other methods of contacting customer service representatives, besides telephone, are available for members to use?

Answer: Besides telephone, members can contact customer service by email and mail.

INTEGRATED MEDICAL AND HEALTHCARE MANAGEMENT OFFERING

For an integrated medical and healthcare management offering, members can contact My AlaskaCare Single Point of Contact via live Aetna Navigator-based web chat. This capability allows Concierges an additional way to personalize members experience by following-up with members via the communication channel they prefer, whether it is by phone, email, or text.

If the concierge needs additional detail from a member during the web chat, the concierge will call the member directly at the member's convenience to continue their conversation.

Members may also use Aetna Navigator, to send a written inquiry to member services. Every page on the Aetna Navigator site has a "Contact Us" link, making it simple to send a secure message to member services whenever they have a question or concern. Our goal is to respond to e-mail inquiries within one business day.

The representatives in Juneau and Anchorage will have access to the same systems and information as the concierge team and will be able to assist members who visit those locations.

Attachments:

4.2.1.22 Do customer service representatives handle both member calls and provider calls?

Answer: A pool of trained intake customer service representatives handle both member calls and provider calls. This team transfers calls to appropriate the clinical staff group. For example, some providers call into the program to speak to a personal disease management nurse, while others may want to talk to one of our medical directors regarding a gap in care notification, or CareConsideration.

INTEGRATED MEDICAL AND HEALTHCARE MANAGEMENT OFFERING

For an integrated medical and healthcare management offering customer service representative do not handle provider calls.

Providers and their staffs have a unique phone number separate from the phone number members would call. Our Provider Service Centers are available between 8 a.m. and 5 p.m. local time to answer their questions. Our automatic call distribution system quickly directs each call to a local service center based on the area code from which the call is placed.

Attachments:

4.2.1.23 Identify the typical work and training experience required of your customer service supervisors and/or managers.

Answer: ActiveHealth's Customer Service Associates have the following qualifications:

Two to three years combined experience in medical and/or customer service environment

Screening Process:

* As the initial contact point for members and providers, ActiveHealth conducts a thorough screening process for CSAs. We screen for candidates with high emotional intelligence, excellent problem

solving skills, and the ability to adapt to a range of psycho-social factors and pressures.

Education:

- * High School Diploma, required
- * Advanced technical or Associate Degree or higher, preferred
- * Experience/Skills:

Training:

- * Our CSAs participate in continuing educational activities, attend all relevant ActiveHealth training programs, and participate in onsite client meetings and demonstrations

Customer service training focuses upon a comprehensive learning model predominantly aimed at skills development, program content knowledge, and mastery of backend and electronic coaching record systems. The initial training program is completed prior to a staff member taking on a case load of active members. The initial training program is a 120-hour course using interactive and didactic formats both in the classroom and online. The initial training program ends with an 8 hour practicum to demonstrate skill level. Topics covered in the initial training include an overview of company mission and values, systems, risk management, educational content review, principles of health coaching models, behavior change tools and techniques, and call documentation. An integral part of the training curriculum includes hands-on practice of skills using role playing, call monitoring, and other teaching media.

In addition, we supplement the initial training of staff with focused training and information about the special populations that may be enrolled in the program. Coaches also receive corporate training in cultural and senior sensitivity.

Coaches are trained in motivational interviewing, stages of change, and other evidence-based coaching techniques to help members recognize their behavior discrepancies, take responsibility for bringing their behavior back in alignment with health goals, and design an actionable and practical plan in support of healthier living behaviors. ActiveHealth Management provides a five part training series to new clinicians on the practical application of coaching techniques and how to implement behavioral change.

Each session introduces and highlights a series of skills that will allow the individual to better develop member rapport, enhance member relationships, and further develop new relationships by introducing them to coaching concepts that will help them to create goals and facilitate behavior change to help improve members' health. A summary of the program is outlined below.

- * Part 1-Introduction to Coaching and Behavior Change
- * Part 2-Developing your Client Relationship Skills
- * Part 3-Setting Client Goals
- * Part 4-Helping Members to Overcome Obstacles
- * Part 5-Conducting Assessments while Utilizing Coaching

The material incorporates the Transtheoretical Model as developed by James Prochaska and Motivational Interviewing as developed Stephen Rollnick, Ph.D., & William R. Miller, Ph.D. The

training takes place over a five week period with role plays, home work, and case reviews as some of the tools to help participants take these theories from the abstract to everyday practical application.

In addition, at this point in time over 80 ActiveHealth clinical staff have completed either the Real Balance Health Coach Certification program, provided by Dr. Michael Arloski, or the Wellness Coach Certification program provided by Wellcoaches.

INTEGRATED MEDICAL AND HEALTHCARE MANAGEMENT OFFERING

We provide extensive training to both our Aetna Concierge teams and our claims processing teams.

Division Managers

Division managers are responsible for coordinating the team activities that support our customer's benefit plans. The call teams are led by customer service supervisors who report to the division managers. Call supervisors have total responsibility and accountability for the prompt and proper response to members' questions and problems. Their roles and responsibilities are:

Call or Claim Managers

These managers are assigned three to five teams of either claims administration or customer service staff. They are also responsible for the day-to-day operations of their team within the service center. Other responsibilities include maintaining working relationships with assigned customers and oversee training and promote continuous learning for the customer service representatives and claim processors.

Supervisors

A supervisor oversees a team of 20 employees, either claim processors or customer service representatives and manages the assigned accounts assigned to their team. They have the responsibility to develop and monitor performance of their team. The most important role for the supervisor is our customers. Keeping costs down by explaining and promoting cost management programs to members.

The Fresno Service Center has a career path established leading to supervisory positions. They identify individuals interested in supervision and provide them with opportunities to learn these functions in their current positions by such assignment as working with trainees, filling in for supervisor during absences, etc. They work with them during the course of the temporary assignment to provide guidance, feedback, etc.

There is ongoing training for supervisory and management staff. This training consists of seminars, direct broadcast, and mandatory attendance at Home Office leadership schools. Each supervisor/manager is required to participate yearly to update their skills.

Health Concierge Training

Concierges receive a much broader training that provides a thorough understanding of all products, services and clinical programs. We include information about the State's culture, preferences and benefit offerings, even if offered through another carrier, in our training curriculum.

We hire a different caliber of people for the concierge role because they'll be expected to know more and actively listen for triggers to unearth the unasked questions on every call. Training is also done differently to ensure that the concierge can realistically apply their knowledge and actively listen throughout. There is one on one support offered by the trainer throughout the comprehensive training.

The training is structured in such a manner that the concierge will learn their materials in two sections. Once one section is learned, the concierge is placed in a live phone environment for two weeks to allow them to use their new knowledge in real time. During these two separate two week timeframes that the concierge is in the live environment, they will have the support of their trainer as well as our Aetna One Quality team. This allows our Quality team to begin building rapport while directing the concierge down the path to success.

Attachments:

4.2.1.24 What is the current ratio of customer service representatives to supervisors and managers.

Answer: The current ratio of customer service representatives to supervisors and managers averages 5:1.

INTEGRATED MEDICAL AND HEALTHCARE MANAGEMENT OFFERING

The State of Alaska will have 1 dedicated supervisor and 23 dedicated Customer Service Representatives in their team.

Typically, a supervisor may have approximately 18-20 CSRs in their team. A manager may have approximately 6-7 supervisors reporting to them.

Attachments:

4.2.1.25 What is the ratio of customer service representatives to covered lives in your organization's programs?

Answer: The ratio of customer service representatives to covered lives is approximately 1:20,000.

INTEGRATED MEDICAL AND HEALTHCARE MANAGEMENT OFFERING

The ratio of concierges to members is about 1:4,500. For the State of Alaska, My AlaskaCare Single Point of Contact concierges will be a team of 23.

A number of factors affect actual staffing levels. These include both the complexity and number of plans available to employees, and the service level requirements of the customer.

We use workforce management tools to forecast call volume and to schedule appropriate customer service representative coverage. Service center managers continually monitor staffing and call volume to maintain quality standards and service targets.

Attachments:

4.2.1.26 Describe when and how a caller's recurring or unresolved issue is elevated to a supervisor/manager for resolution. Explain how you measure the success of this process over time.

Answer: Any caller with a recurring or unresolved issue is offered the attention of a supervisor or manager for further resolution.

Please see our Customer service complaint procedure below: Documentation and Measuring Success

1. Every attempt should be made to resolve the complaint on the initial call. Document any attempts to resolve the issue.
2. Document explanations given to the member/provider.
3. If the complaint requires more research prior to resolution, document to whom the complaint was referred, when it was referred, and how it was referred.

4. Refer complaint to supervisor for research and resolution and document this action.
 - a. Inform complainant that you will refer the issue to your supervisor.
5. If supervisor also cannot resolve the complaint, the supervisor will seek assistance from appropriate resources.
6. Supervisor and/or other resources will document actions taken on the complaint.
7. Write notes in ActiveAdvice as an addendum to initial complaint note to keep the notes regarding the complaint together.
8. Consider referring members to their insurer for issues related to their benefits.
9. Sometimes there are no resolutions other than an apology.
10. The Quality team will monitor progress and make suggestions if all avenues toward a resolution have not been considered.

General Complaints:

Employees document unresolved issues and complaints, then forward to the manager responsible for the functions addressed in the complaint. The manager first evaluates if the complaint is within the scope of responsibility for ActiveHealth or if it is related to a client or a vendor's area of responsibility. If the complaint is within the scope of responsibility of the client or vendor, the account manager will forward the complaint to the pre-designated contact with the responsible entity. All complaints regarding clinical issues (e.g. Care Considerations) are referred to a Medical Director for review and input. The manager also informs the account manager and Executive Director of all complaints, which are analyzed in our program review meetings with the goal of identifying areas for improvement.

Complaints requiring escalation are escalated the same day. The manager will research the complaint, document findings and the resolution on the complaint form. Our standard is to resolve complaints within five working days. When areas for improvement are identified, a corrective action plan is developed to include communication of the plan to the personnel involved. Complaints are submitted to the Quality Improvement team, which tracks them to identify trends and areas for improvement. The complaint summary report is presented to the Quality Improvement Committee on a quarterly basis with the primary goal of identifying areas for improvement.

INTEGRATED MEDICAL AND HEALTHCARE MANAGEMENT OFFERING

Our goal is to provide our concierge staff with the optimum level of training, system access and online information to promptly and accurately respond to virtually any type of inquiry. In addition, we empower the concierges to take all actions to resolve the issue and support the member.

We recognize that there will be situations, due to the nature of the inquiry, when it will be appropriate for another department to resolve a member's concern. One example of this would be a patient management inquiry, when we would connect the member to a nurse consultant for assistance.

Where an inquiry requires additional research, the concierge will document the information concerning the outstanding inquiry. Our systems will then electronically direct the request to the appropriate department for review and resolution. Once resolved, we will reach out to the member to advise them of the resolution.

If an answer lies in a different department, the concierge introduces the member to the new representative, explains the circumstances and gets everyone involved on the same page immediately. The concierge will point out benefits your employee might not even know they had and explain the

way the benefit works.

If a caller would like to speak to a member of management, the concierge will gather all relevant information and transfer the caller to a team leader. When the team leader is not available, the concierge will try to locate another member of management. If the caller is unable to hold, the concierge offers to take the pertinent information and have a member of management return the call. Management's goal is to return the call within one business day.

Attachments:

4.2.1.27 Provide the turnover rate of your call center representatives for the past three calendar years.

Answer: Across the past three years, turnover averaged 14% for customer service representatives.

INTEGRATED MEDICAL AND HEALTHCARE MANAGEMENT OFFERING

The call staff turnover rate for our Fresno Service Center for the past three calendar years is:

- 2010: 13.60%
- 2011: 10.20%
- 2012: 10.48% (as of 9/30/2012)

Attachments:

4.2.1.28 Using current calendar year data, please provide the following information for each customer service office that will have responsibility for this account:

	Standard Target	Average Statistics
Answer speed (xx seconds)	Less than 30 seconds	Under 11 seconds
Wait time (xx seconds)	Less than 30 seconds	Under 11 seconds
Abandonment rate (xx.xx%)	Under 5%	2.2%

Detail:

Attachments:

4.2.1.29 Provide your standard wait times for triage and assessment, crisis counseling, urgent care, and routine care:

	Standard Wait Time
Triage and Assessment	Less than 30 seconds
Crisis Counseling	Less than 30 seconds
Urgent Care	Less than 30 seconds
Routine Care	Less than 30 seconds

Detail:

Attachments:

4.2.2 Establishing Population Needs

4.2.2.1 Identification

4.2.2.1.1 Please describe how your organization will identify population specific health issues and design or modify existing healthcare management programs to meet the specific needs of the State. Include the type of data you will be relying on to make determinations of population health, and what type of data you expect to collect from the population once the program is underway.

Answer: ActiveHealth's approach incorporates an integrated suite of population health management services designed to improve clinical outcomes by detecting and closing gaps in care; promoting member-specific health practices across the continuum of healthcare; enhancing the doctor-patient relationship; promoting more effective use of health care resources; and by incorporating feedback (from patients and providers, as well as in the data). All of these activities will drive continuous outcomes and clinical program improvement.

We thrive in client partnerships where data is available and drives the strategy and design for healthcare management programs. Data provides a rudder as we initiate programs and transparent reporting and data management are imperative to create a true and sustainable partnership. Our predictive modeling differs from most due to the breadth of the data and the sophistication of our clinical and financial algorithms we use to identify members, stratify their risk, and provide specific health actions and messages to members and providers.

Our client partners agree that one of our greatest strengths is our flexibility and willingness to design programs that are laser focused on their data, goals and culture.

We begin by assembling 2-3 years of historical claims, pharmacy, lab (incl lab values), bio-metrics, HRA, clinical outcomes and previous program participation data. We ingest and analyze the data and report back to the State the current disease and lifestyle risk status of the population and how they have stratified across our risk and program methodology. We would compare this to any other analytics and population metrics available to the State as well as our Book of Business benchmarks. Together, we would analyze the data regularly and adjust our programs and outreach accordingly.

We would continuously build on the data provided by the State, incorporating financial, clinical, HRA, bio-metrics, clinical outcomes, health risk mitigation, incentive and program participation data. We will also continuously use our benchmarking and large data base of over 20 million members to slice/dice data to better analyze the impact of all programs and strategize to maximize the State's budget and lower health care costs.

In summary we would look forward to customizing our program suite of best in class services while staying focused on our previous success in deploying programs designed to improve quality of care and outcomes by:

- * Using a shared, standardized set of member, services, and clinical data.
- * Powered by the CareEngine clinical logic system.
- * Thorough and ongoing design and updating by a large team of dedicated clinicians, with external expert content review where appropriate.
- * Provider-facing components favoring high specificity (low false positivity for messages and alerts).
- * Member-facing components geared toward health literacy, interaction preference, and their precise clinical scenario, which is more likely to promote action than general health messaging alone.
- * Customization to fit into and guide existing workflows.
- * Incorporating member and provider feedback for system improvement.
- * Using actual data subsequent to the "intervention" to determine compliance.

Attachments:

4.2.2.1.2 Describe how you will identify participants from the population for healthcare management services and indicate if you use any of the resources listed below:

**Answer: 1: Behavioral health referrals,
2: Biometric data,
3: Case management referrals,
4: EAP referrals,
5: External vendor partner referrals,
6: Health advocacy referrals,
7: Health Risk Assessments,
8: Lab data,
9: Medical claims,
10: Nurse line referrals,
11: On site clinic referrals,
12: Physician/Provider referrals,
13: Rx claims,
14: Self referrals,
15: Utilization management referrals,
16: Other, please specify: [We will identify members eligible for Care Management programs by ingesting historical and current data, creating a longitudinal medical record for each member and running the records through our clinical algorithms and predictive modeling tool. Besides the data sources above, we also add other self reported information through the portal as well as data collected during Lifestyle and Disease Management coaching calls.]**

Detail:

Options:

1. Behavioral health referrals
2. Biometric data
3. Case management referrals
4. EAP referrals
5. External vendor partner referrals
6. Health advocacy referrals
7. Health Risk Assessments
8. Lab data
9. Medical claims
10. Nurse line referrals
11. On site clinic referrals
12. Physician/Provider referrals
13. Rx claims
14. Self referrals
15. Utilization management referrals
16. Other, please specify: [Text]

Attachments:

4.2.2.1.3 Does your organization utilize predictive modeling technology to identify participants?

Answer: Yes; ActiveHealth programs identify candidates by utilizing a clinical predictive model through our CareEngine system. Our analysis of client data begins with the member identification process that is carried out through our clinical stratification and identification algorithms. This is a clinical predictive model that has been continuously developed and refined by the ActiveHealth

Clinical Program & Product Management team over the past 14 years. Our real-time analytics analyze HRA, claims, pharmacy, laboratory, patient-reported (from telephonic and online coaching sessions) and physician-reported data to generate an internal "Member Health State". The member health state is comprised of hundreds of "Monitored Events" representing gaps-in-care as well as care patterns and markers of disease and pre-disease risks.

Our stratification process and predictive models also look for patterns of care indicative of future risk, e.g. care patterns indicating the need for Preference-Sensitive Decision Support. This applies to conditions and procedures such as knee or hip replacement, spine surgery, hysterectomy, and prostate cancer. Other types of care patterns are programmed into the rule sets to identify imminent need for care coordination, such as cancer workups, where sequential symptom, imaging, and biopsy data are detected that suggests a patient may need additional care coordination as well as psychosocial support in an Enhanced Case Management capability. Note that this identification, rather than triggering from a hospitalization event, tries to identify a pattern prior to the actual hospitalization, so that care patterns can still be influenced to improve the health and economic outcome for the member.

Particular emphasis is placed upon "impactable", actionable items identified during the course of stratification. Members are identified and then hierarchically stratified by "opportunity score" into high, medium and low risk categories. This allows their efficient and cost-effective assignment to the most appropriate set of wellness & disease management interventions. This is relevant to cost avoidance since it allows us to direct our efforts at the population with the highest risk for incurring costs and the population with the highest degrees of impactable risk. Opportunity score shows a high degree of correlation with current and future costs as well as external measures of cost risk such as Symmetry's "Episode Risk Groups".

Our predictive model promotes cost avoidance in several ways. The most prominent way is through the closure of evidence-based gaps-in-care. The CareEngine is ever vigilant in identifying opportunities where patients are at risk for an adverse event that leads to utilization and consequent costs. By messaging the gap-in-care to the provider and patient there is an opportunity to close the gap thereby reducing or eliminating the possibility of the adverse event and avoiding the utilization and its attendant costs.

A simple example of this is the patient with a history of stroke and an irregular heart beat (atrial fibrillation) who is not on a blood thinning medication (anticoagulant). We know from medical research that untreated, 6.84% of these patients will suffer a stroke. However, if they are started on an anticoagulant, only 2.19% will suffer a stroke. This is a prevention rate of 4.65%. Put another way, if we identify 100 members with atrial fibrillation who are not taking a blood thinner and through the action of the CareEngine we are able to start all of them on a blood thinner, this will prevent 4.65 strokes. It will also avoid the costs of 4.65 hospitalizations for stroke and the cost of post-hospitalization care of a stroke patient (estimated total 2012 costs = \$211,000). This is how our predictive model identifies opportunities to intervene and promote cost avoidance. Our predictive model has approximately 1,300 of these predictive algorithms operating to identify gaps-in-care.

Another way we employ predictive modeling to promote cost avoidance is through identification of lifestyle risks. Using claims, HRA and biometric data, our predictive model can identify the presence of 13 lifestyle risk factors (e.g., tobacco, stress, obesity, etc.) modeled by Edington in his work at the University of Michigan. Using this data we can intervene to reduce these lifestyle risks through lifestyle coaching, disease management advice or directing members to educational materials on the MyActiveHealth portal. Published studies (HERO) have demonstrated that there is cost avoidance associated with the reduction of lifestyle risks.

Predictive models that identify high-risk pregnancy allow for referral to our maternity programs which have been demonstrated to reduce antepartum complications, preterm births, and NICU admissions. There is a substantial cost avoidance associated with reduction in these events.

It is important to note that the output of our predictive model is clinically-driven. Rather than identification strictly based on predicted future cost, there is both a summary numeric score as well as a narrative output that describes the member's conditions, comorbidities, at-risk conditions, and specific actions they must take to pursue to mitigate future risk. This actionable data set is available to all providers and staff providing care through the Care Team platform. The profile is also made available to the member themselves in a user-friendly format on the MyActiveHealth portal so that they, too, can act upon this information to improve their health and mitigate costs.

Finally, work is in progress through data mining, neural networks, regression techniques and other state-of-the-art methods to develop next-generation capabilities to predict risk for events such as complications, hospitalizations and readmissions, in order to identify members who may require prophylactic outreach, engagement and intervention. As our future modeling exercises are developed to an effective level of performance they will be incorporated into our identification rules.

Attachments:

4.2.2.1.4 Does your organization stratify the total population by risk level?

Answer: Yes; all members of the population are stratified by risk level. ActiveHealth develops an Overall Opportunity Score which represents the degree to which lifestyle coaching or disease management has the opportunity to impact patients' clinical outcomes. The Overall Opportunity Score is the accumulation of Stratification Scores for each CSID matrix (Condition and Utilization) and points that are assigned to CareEngine Care Considerations. Selected Care Considerations are also assigned points dependent on the clinical issue and contributes to the Overall Opportunity Score.

Attachments:

4.2.2.1.5 In the most recent calendar year and of those eligible for the program at each risk level (high, moderate, low) indicate the percent of members in each category for your book of business (with an incentive and without an incentive).

	Percent of Members	Comments
Identified	10%	Placeholder - Please refer to the attached exhibit 4.2.2.1.5 for detailed actual information in the format requested.
Outreached To	10%	Placeholder - Please refer to the attached exhibit 4.2.2.1.5 for detailed actual information in the format requested.
Reached	10%	Placeholder - Please refer to the attached exhibit 4.2.2.1.5 for detailed actual information in the format requested.
Opted Out	10%	Placeholder - Please refer to the attached exhibit 4.2.2.1.5 for detailed actual information in the format requested.
Enrolled	10%	Placeholder - Please refer to the attached exhibit 4.2.2.1.5 for detailed actual information in the format requested.
Dropped Out	10%	Placeholder - Please refer to the attached exhibit 4.2.2.1.5 for detailed actual information in the format requested.
Completed program – goals met	10%	Placeholder - Please refer to the attached exhibit 4.2.2.1.5 for detailed actual information in the format requested.

Detail: Please refer to the attached exhibit 4.2.2.1.5 for detailed actual information in the format requested.

Attachments: [4.2.2.1.5 Engagement Table.docx](#)

4.2.2.1.6 Does your organization stratify only the Health Risk Assessment (HRA) participants by risk level?

Answer: No; ActiveHealth stratifies participants using ALL available data, not just HRA.

Attachments:

4.2.2.1.7 Do you stratify participants in a client group with your book of business or is it client specific?

Answer: ActiveHealth conducts client-specific stratification.

Attachments:

4.2.2.1.8 Are intervention services linked to HRA results?

Answer: Yes; intervention services are linked to HRA results.

A differentiator of our portal is the ability to provide members with a personalized and actionable list of action items, referred to as Health Actions, after they complete their HRA, but based on the compilation of their entire data set. The Health Actions are derived via the complex clinical algorithms in ActiveHealth's CareEngine system. The list may include discussing Care Consideration alerts with their physician, participating in other programs such as health coaching, making lifestyle changes or other actions. Members see a completion score of their progress toward completing the Health Actions, along with an image of a 'running person' which signifies action and health. If an incentive is offered for the completion of the Health Assessment, a message may be shown on the member's home page that provides details about the incentive. We will pre-load external websites based on a member's clinical profile. Members also have the ability to add links to their favorite health websites.

After the member completes the HRA, immediate feedback in the form of an electronic Health Report is presented to the member. The report summarizes the results of the HRA and provides information to educate and spur action. If the biometric screening has already taken place prior to the member completing the HRA, the biometric screening results will have already been pre-populated into their PHR and will be reflected within the member's electronic Health Report. Conversely, if the member's biometric screening results are fed into our data vault subsequent to their HRA completion, they will update the member's electronic Health Report. The member would need to log into the web portal to access their updated Health Report.

Attachments:

4.2.2.1.9 Are intervention services linked to biometrics results?

Answer: Yes; intervention services are linked to biometric results. After biometric data is formatted, it is included in our aggregated member medical records along with medical and pharmacy claims data, lab and test results, HRA and other data sources. Biometric screenings facilitated through a vendor partner are fed into ActiveHealth's data vault, processed by the CareEngine and populated into the member's personal PHR/HRA via the web portal. We receive data values from biometric screenings as well as eligibility files, medical claims, pharmacy data, lab data, and other self-reported information on a predetermined basis (typically daily, weekly or monthly). Each of these data sources are integrated into our data vault and CareEngine algorithms are applied to identify errors or gaps in care, as well as potential high risk members to whom we would reach out and offer wellness strategies.

Attachments:

4.2.2.1.10 Describe how healthcare management program managers have access to the claims payment information either internally or by data feed from the claims payer to view member activity and costs?

Answer: When Aetna is the payer and ActiveHealth is providing healthcare management programs, the Aetna UM/CM nurses can see all healthcare management data and the healthcare management nurses and coaches can see the utilization and claims payment data. When ActiveHealth works with other payers our ability to see their claims payment and cost data varies by their policies. We have "firewalls" and nondisclosure agreements in place with all payers we work with, however some still do not share claims payment and cost data. That said, our predictive modeling tool is so sophisticated that we don't find the lack of access to claims or cost experience affects our ability to target high risk and high costs members with great accuracy.

When ActiveHealth deploys our program with payers other than Aetna, we are willing to share data. ActiveHealth's call center nurse workflow software, ActiveAdvice, provides nurses with outcomes dashboards. These workflow dashboards are driven by CareEngine and other program data, to identify the current status of clinical outcomes for each participant based on their conditions, gaps in cares, and risks. For example, diabetic dashboard metrics include the following: a) member has had an annual eye exam, b) member's HbA1C value < 7, c) member has had 2 HbA1c tests in 12 months, etc. The dashboard view is available at a member specific level as well as the nurse can view the metrics across all the members he or she is managing. This is an important outcomes-improvement feature because it guides nurses to prioritize members for engagement as well as the specific metrics to focus on with members that will positively impact the overall health of that member and the population.

Attachments:

4.2.2.2 Health Risk Assessment

4.2.2.2.1 Confirm you offer a Health Risk Assessment (HRA).

Answer: 1: Confirmed

Detail: ActiveHealth provides an online HRA through our member web portal, MyActiveHealth. ActiveHealth can also provide telephonic HRAs.

Options:

1. Confirmed
2. Not Confirmed

Attachments:

4.2.2.2.2 Can your HRA be purchased independent of other programs?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

4.2.2.2.3 How long have you offered this HRA?

Answer: 4: 7 to 10 years

Detail:

Options:

1. 2 years or less
2. 2 to 5 years
3. 5 to 7 years
4. 7 to 10 years
5. 10 years or more

Attachments:

4.2.2.2.4 Is your HRA proprietary or was it created externally (i.e. University of Michigan)?

Answer: ActiveHealth's HRA is proprietary, developed by our internal research and development team comprised of over 30 practitioners including physicians, nurses, pharmacists and health educators.

Attachments:

4.2.2.2.5 Confirm you have attached a copy of your HRA.

Answer: 1: Confirmed

Detail:

Options:

1. Confirmed
2. Not confirmed

Attachments: [HRA Sample 12-08.pdf](#)

4.2.2.2.6 Is your HRA administered internally or do you use an outside vendor?

Answer: 1: Internally

Detail:

Options:

1. Internally
2. External vendor, (specify)
3. Combination of internally and outside vendor

Attachments:

4.2.2.2.7 To how many clients do you provide HRA services?

Answer: 56

Detail:

Attachments:

4.2.2.2.8 How is information about the HRA delivered to participants?

Answer: 1: Brochures,
2: Email,
3: Face to face,
4: Mail,
5: Payroll stuffers,
6: Posters,
7: Website,
8: Other, please specify: [text messages, phone campaign]

Detail:

Options:

1. Brochures
2. Email
3. Face to face
4. Mail
5. Payroll stuffers
6. Posters
7. Website
8. Other, please specify: [Text]

Attachments:

4.2.2.2.9 Are standard communications materials regarding the HRA included in your base fee? Provide samples.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments: [4.2.2.2.9 MyActiveHealth Email HRAv2\[1\].docx](#)

4.2.2.2.10 What types of risk factors are included in your HRA? (Check all that apply)

Answer: 1: Age,
2: Blood glucose,
3: Blood pressure,
4: Cholesterol, including LDL and HDL,
5: Chronic illnesses,
7: Gender,
8: Health perception,
9: Life and job satisfaction,
10: Nutrition,
11: Patient disease history,
12: Physical activity,
13: Safety,
14: Sleep,
15: Stress,
16: Substance abuse,

17: Tobacco use,
18: Triglycerides,
19: Waist circumference measurement,
20: Other, please specify: [Our HRA assesses the following risks:

- Biometrics
- BMI
- Waist circumference
- Blood pressure

- Lifestyle
- Safety (e.g. seatbelt use, home environment and fall risk)
- Tobacco use
- Alcohol (potential misuse/abuse/alcoholism)
- Physical activity
- Unhealthy diet (includes condition-specific diet)

- Mental Health
- Depression screen
- Stress level

- Routine healthcare needs
- Routine health evaluations (medical, dental, blood pressure, eye exams, etc.)
- Routine screening tests

- Future health conditions
- Obesity (based on biometrics above)
- Heart disease
- Diabetes
- Breast cancer
- Lung cancer
- Colon cancer
- Prostate cancer
- Skin cancer

- Current health conditions
- Exacerbations / complications of conditions
- Condition specific monitoring needs (e.g. lab or other evaluation for conditions like diabetes, cholesterol, anemia or bone disease)

- Medication Use
- Condition-specific adverse effects
- Polypharmacy
- Medication interactions (e.g. herbal / prescription)]

Detail:

Options:

1. Age
2. Blood glucose
3. Blood pressure

4. Cholesterol, including LDL and HDL
5. Chronic illnesses
6. Family disease history
7. Gender
8. Health perception
9. Life and job satisfaction
10. Nutrition
11. Patient disease history
12. Physical activity
13. Safety
14. Sleep
15. Stress
16. Substance abuse
17. Tobacco use
18. Triglycerides
19. Waist circumference measurement
20. Other, please specify: [Text]

Attachments:

4.2.2.2.11 Is there an extra fee for customization? If there is an additional cost, please indicate the cost on the rate sheet.

Answer: 2: No

Detail: Clients are able to add up to 10 additional questions to our HRA at no additional charge. Our HRA questionnaire is extensive and incorporates branch logic to assure members are only asked relevant questions based on their responses. Co-branding and customization of messaging is also included at no additional charge.

Options:

1. Yes (indicated on rate sheet)
2. No

Attachments:

4.2.2.2.12 What categories of information does the HRA evaluate? (Check all that apply)

Answer: 1: Biometric measurements, e.g. BMI, blood pressure,
2: Health risk and behaviors,
3: Job satisfaction,
4: Personal medical conditions,
5: Preventive services,
6: Quality of life,
7: Safety

Detail:

Options:

1. Biometric measurements, e.g. BMI, blood pressure
2. Health risk and behaviors
3. Job satisfaction
4. Personal medical conditions

5. Preventive services
6. Quality of life
7. Safety

Attachments:

4.2.2.2.13 Does the HRA evaluate member readiness to change?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

4.2.2.2.14 How long does it typically take to complete your HRA?

Answer: 1: 10 minutes or less

Detail:

Options:

1. 10 minutes or less
2. 10 to 15 minutes
3. 15 to 30 minutes
4. 30 to 45 minutes
5. 45 minutes or more

Attachments:

4.2.2.2.15 What is the range of the number of questions in your HRA?

Answer: 4: 100+ questions

Detail: The short form of the HRA has approximately 30 questions, although members with more risks will trigger branching logic to ask more questions. There are several hundred potential questions based around the list of risks outlined in response to question 4.2.2.2.10.

Options:

1. 0 - 25 questions
2. 26 - 50 questions
3. 50+ questions
4. 100+ questions

Attachments:

4.2.2.2.16 Is your HRA available in paper and/or electronically?

Answer: 3: Both

Detail: ActiveHealth also offers telephonic HRAs, which our clients have found extremely effective with certain populations.

Options:

1. Paper
2. Electronic
3. Both

Attachments:

4.2.2.2.17 Do you have the capability to upload biophysical metrics automatically into your HRA?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

4.2.2.2.18 How often is your HRA revised?

Answer: 5: Quarterly

Detail:

Options:

1. Every 2 plus years
2. Every 2 years
3. Annually
4. Semi-annually
5. Quarterly
6. As needed
7. Other, please specify: [Text]

Attachments:

4.2.2.2.19 In the most recent calendar year, what percent of your total eligible membership completed the HRA?

Answer: 16%

Detail: Of those that have registered for the HRA, over 79 percent have completed the assessment. Across our entire book of business in the most recent year, approximately 16 percent of those eligible for the HRA completed the assessment.

Attachments:

4.2.2.2.20 On average, what percentage of your covered population participates in a HRA?

Answer: 3: 10 to 20 percent

Detail: On average, across our entire book of business, approximately 16-20 percent of those eligible for the HRA completed the assessment. For clients with incentives, participation is dramatically higher.

Options:

1. 5 percent or less
2. 5 to 10 percent
3. 10 to 20 percent
4. 20 to 30 percent
5. 30 to 40 percent
6. 40 to 50 percent
7. 50 to 75 percent
8. 75 to 95 percent
9. Greater than 95 percent

Attachments:

4.2.2.2.21 Which of the following services do you integrate your HRA program with? (Check all that apply)

Answer: 1: Case Management,
2: Disease Management,
3: EAP/Behavioral Health,
4: Fitness,
5: Health advocates,
6: Health coaches,
7: Health plan/administrator,
8: Incentives,
9: Nurse Line,
10: Onsite clinics,
11: Wellness/ Lifestyle Management,
12: Biometric Screening,
13: Other, please specify: [Clinical decision support messaging]

Detail:

Options:

1. Case Management
2. Disease Management
3. EAP/Behavioral Health
4. Fitness
5. Health advocates
6. Health coaches
7. Health plan/administrator
8. Incentives
9. Nurse Line
10. Onsite clinics
11. Wellness/ Lifestyle Management
12. Biometric Screening
13. Other, please specify: [Text]
14. No integration

Attachments:

4.2.2.2.22 Does the HRA evaluate the predictability of the following: (Check all that apply)

Answer: 1: Disease morbidity - potential for progression of disease,
2: Cost - individuals most likely to incur the highest costs,
3: Other, please specify: [Health risk levels] ,
4: Absenteeism,
5: Presenteeism

Detail:

Options:

1. Disease morbidity - potential for progression of disease
2. Cost - individuals most likely to incur the highest costs
3. Other, please specify: [Text]
4. Absenteeism
5. Presenteeism
6. No integration

Attachments:

4.2.2.2.23 Please indicate the type of feedback employees receive upon completion of the HRA. (Check all that apply)

Answer: 1: Individual written paper report to all respondents,
3: Individual electronic report to all respondents,
5: Customized plan of action for all respondents

Detail:

Options:

1. Individual written paper report to all respondents
2. Individual written paper report to high-risk respondents only
3. Individual electronic report to all respondents
4. Individual electronic report to high-risk respondents only
5. Customized plan of action for all respondents
6. Customized plan of action for high-risk respondents only

Attachments:

4.2.2.2.24 Please indicate the type of feedback that is received by the State. (Check all that apply)

Answer: 1: Number of respondents,
2: Number of respondents by risk level,
3: Aggregate report indicating areas of risk within the population,
4: Website access/usage,
5: Website maintenance and availability

Detail:

Options:

1. Number of respondents
2. Number of respondents by risk level
3. Aggregate report indicating areas of risk within the population
4. Website access/usage
5. Website maintenance and availability

Attachments:

4.2.2.2.25 Does the State receive aggregated and de-identified reporting on overall HRA results? If there is an additional cost, please indicate the cost on the rate sheet.

Answer: 1: Yes, included in fees

Detail:

Options:

1. Yes, included in fees
2. Yes, at an additional fee (indicated on rate sheet),

Attachments:

4.2.2.2.26 Are you able to electronically transfer HRA results in the event of a vendor change?

Answer: 1: Yes, included in pricing

Detail:

Options:

1. Yes, included in pricing
2. Yes, at an extra charge
3. No

Attachments:

4.2.2.2.27 Describe other dedicated or customized customer services you are prepared to offer the State.

Answer: Non clinical resources dedicated to the HRA include 1 Business Manager, 1 Business analyst, 3 QA resources, and 1 IT analyst. Our proprietary Health Risk Assessment has been developed, and is periodically reviewed and updated, by our 30 member clinical research and development team (over 20 Physicians and 5 PharmD). The review and update cycle for the entire content is annual, and updates are batched in quarterly releases. The core clinical team of 2 medical directors is responsible for organizing and updating the HRA content. The HRA is integrated with our evidenced based medicine algorithms, Care Engine analytics, and can prepopulate data via our ODS system from historical data or 3rd party biometrics. It can be offered in a Full, Short/Update or Wizard form of the assessment. Required questions fall in the 30 - 40 range and average time to complete is 10 minutes.

Attachments:

4.2.2.3 Biometrics

4.2.2.3.1 Confirm you offer a medical (biometric) screening program.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

4.2.2.3.2 Can your medical (biometric) screenings be purchased independent of other programs?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

4.2.2.3.3 How long have you provided this service?

Answer: 2: 2 to 5 years

Detail:

Options:

1. 2 years or less
2. 2 to 5 years
3. 5 to 7 years
4. 7 to 10 years
5. 10 years or more

Attachments:

4.2.2.3.4 Are your medical (biometric) screening programs administered internally or do you use an outside vendor?

Answer: 2: External vendor, (specify)

Detail: ActiveHealth will partner with our existing long term partner Summit Health because of their market expertise and extensive experience providing biometric screenings across the State of Alaska. Summit Health completed 200 health screening and flu shot clinics in Alaska during 2012 across the state including Anchorage, Fairbanks, Juneau, Ketchikan, Sitka, Kodiak, and the Kenai Peninsula. Summit Health also supplies home test kits, which will be important to reach all of the State's members while maintaining a cost effective solution. In 2012, Summit Health processed approximately 2,000 home test kits from Alaska residents.

Options:

1. Internally
2. External vendor, (specify)
3. Combination of internally and outside vendor

Attachments:

4.2.2.3.5 How many total covered lives do your medical (biometric) screening programs support?

Answer: 2,010,000

Detail:

Attachments:

4.2.2.3.6 To how many clients do you provide medical (biometric) screening services?

Answer: 21

Detail:

Attachments:

4.2.2.3.7 In which capacities do you offer medical (biometric) screening programs? (Check all that apply)

Answer: 1: Mail,

2: On-site client locations,

3: Off-site

Detail:

Options:

1. Mail

2. On-site client locations

3. Off-site

Attachments:

4.2.2.3.8 How is information about the medical (biometric) screenings delivered to participants?

Answer: 1: Brochures,

2: Email,

3: Face to face,

4: Mail,

5: Payroll stuffers,

6: Posters,

7: Website,

8: Other, please specify: [Telephone]

Detail:

Options:

1. Brochures

2. Email

3. Face to face

4. Mail

5. Payroll stuffers

6. Posters

7. Website

8. Other, please specify: [Text]

Attachments:

4.2.2.3.9 How do you collect biometric data?

Answer: 1: Mail / home-kits,

2: Onsite,

3: Off-site / lab vendor partner,

4: Venipuncture,

5: Finger-stick,

6: Mouth swab,

7: Urine,

8: Other, please specify: [Other: provider forms can also be entered into our system directly. Self-reported biometrics can be added to the member's HRA if so desired by the State. We are also able to ingest biometric data from other vendors other than Summit Health, if requested by the State.]

Detail: Other: provider forms can also be entered into our system directly. Self-reported biometrics can be added to the member's HRA if so desired by the State. We are also able to ingest biometric data from other vendors other than Summit Health, if requested by the State.

Options:

1. Mail / home-kits
2. Onsite
3. Off-site / lab vendor partner
4. Venipuncture
5. Finger-stick
6. Mouth swab
7. Urine
8. Other, please specify: [Text]

Attachments:

4.2.2.3.10 How can a member's healthcare provider obtain results?

Answer: Providers are able to access the members personal health record by gaining consent from the patient and then logging into their online member web health portal. Providers are also able to call into our clinical operations center to obtain results. For our ACO partners, providers can also see biometrics at the point of care through our Population Health Management tool called CareTeam. ActiveHealth would also be interested in other methods of dissemination to providers requested by the State.

Attachments:

4.2.2.3.11 How do you receive biometric results?

**Answer: 1: Data entry of physician reported info via fax,
2: Self reported,
3: File upload from lab data or from screening event,
4: Other, please specify: [Lab data]**

Detail:

Options:

1. Data entry of physician reported info via fax
2. Self reported
3. File upload from lab data or from screening event
4. Other, please specify: [Text]

Attachments:

4.2.2.3.12 Do you provide standard communications materials regarding the medical screening as part of the fees? Please describe what is provided.

Answer: 1: Yes

Detail: Our account management and communications team will work with the State to determine the best communication strategy, materials and schedule for biometric screenings depending on how the program will be deployed.

Options:

1. Yes
2. No

Attachments:

4.2.2.3.13 What measurements are available in your medical (biometric) screenings programs?

Answer: 1: Blood glucose,
2: Blood pressure,
3: Body fat percentage,
4: Breast Cancer-Mammogram,
5: Cervical Cancer-PAP Test,
6: Cholesterol-Total, LDL, HDL,
7: Height/Weight/Body Mass Index,
8: Lung Cancer,
10: Prostate Cancer-PSA Test,
11: Tuberculosis testing,
12: Tobacco Use-Saliva, Blood, Breath Analyzer,
13: Triglycerides,
14: Waist circumference

Detail:

Options:

1. Blood glucose
2. Blood pressure
3. Body fat percentage
4. Breast Cancer-Mammogram
5. Cervical Cancer-PAP Test
6. Cholesterol-Total, LDL, HDL
7. Height/Weight/Body Mass Index
8. Lung Cancer
9. Other, please specify: [Text]
10. Prostate Cancer-PSA Test
11. Tuberculosis testing
12. Tobacco Use-Saliva, Blood, Breath Analyzer
13. Triglycerides
14. Waist circumference
15. Other Conditions, please specify: [Text]

Attachments:

4.2.2.3.14 Is there an extra fee for customization? If there is an additional cost, please indicate it on the rate sheet.

Answer: 2: No

Detail:

Options:

1. Yes
2. No

Attachments:

4.2.2.3.15 On average, what percentage of your covered population participates in medical (biometric) screenings?

Answer: 7: 50 to 75 percent

Detail:

Options:

1. 5 percent or less
2. 5 to 10 percent
3. 10 to 20 percent
4. 20 to 30 percent
5. 30 to 40 percent
6. 40 to 50 percent
7. 50 to 75 percent
8. 75 to 95 percent
9. Greater than 95 percent

Attachments:

4.2.2.3.16 Does the biometric screening program evaluate the predictability of the following: (Check all that apply)

Answer: 1: Disease morbidity - potential for progression of disease,

2: Cost - individuals most likely to incur the highest costs,

3: Other, please specify: [Wellness/Lifestyle coaching elements] ,

4: Absenteeism,

5: Presenteeism

Detail:

Options:

1. Disease morbidity - potential for progression of disease
2. Cost - individuals most likely to incur the highest costs
3. Other, please specify: [Text]
4. Absenteeism
5. Presenteeism
6. No integration

Attachments:

4.2.2.3.17 Are you able to electronically transfer biometrics results in the event of a vendor change?

Answer: 1: Yes, included in pricing

Detail:

Options:

1. Yes, included in pricing
2. Yes, at an extra charge
3. No

Attachments:

4.2.3 Outreach

For **EACH** of the healthcare management programs you are proposing for the State, please provide the following information:

4.2.3.1 Please describe how you communicate and provide outreach to plan members. Specifically include the type of communications used to target specific portions of the population and the frequency of those communications.

Answer: We provide a holistic approach in our member engagement strategies so they feel less like "program" recipients and more like individuals with specific goals and support needs to reach their health and wellness optimal status.

We look at each member's data and status and identify the best support and educational offering that will best mitigate their risk and that they will likely engage. While we do target members for specific programs, we listen to their goals and preferences and meet them "where they are". For example we may outreach to a member with out of control diabetes who is not interested in working with one of our nurses but are interested in working with a Registered Dietician or a Certified Diabetes Educator or an Exercise Physiologist.

Our flexibility in our enrollment strategy will ensure the members experience these as a seamless continuum of health services, ranging in intensity from lifestyle management (least intensive), disease management (more intensive), and maternity management or referral to Case Management Vendor (most intensive).

Our communication focus on "what's in it for you" and taking action. Members require efficient, direct and inviting communications to peak their interest. Once we have live discussions, our staff are very skilled at engaging members.

Before we can enroll, we identify members for Lifestyle, Maternity and Disease Management interventions by applying our CareEngine-powered identification and stratification rules (clinical predictive model) for the entire spectrum of health care services. Members are identified using all available data for the population, including Health Risk Assessment responses, biometric data, claims data (medical, procedural, pharmacy and lab) and member supplied data entered in the online personal health record or documented by one our coaches in our coaching sessions. The result of the scoring process is a clinical profile for each member that identifies issues across the continuum - ranging from lifestyle, at risk, to chronic and acute. Because members may have multiple issues and issues across the continuum, they are encouraged to participate and receive outreach for one program only, based on the following program hierarchy from highest to lowest priority: Maternity Management, Disease Management and Lifestyle Management.

Using our primary nurse coaching model, once the member is engaged for any issue, the same nurse or health coach will address other issues or will offer to co-manage with another specialty coach according to criteria (based on member status) and the member preference. By applying our program hierarchy logic to the results of our clinical predictive model we are able to manage outreach and engagement so that members receive outreach for one program only. If there are other issues to be addressed across the continuum, the primary nurse or health coach will address all of them or bring in

other members of the care team to support the engagement process as described above. Using this approach, engagement is simplified and the concept of separate programs is transparent to the member as they navigate the health care continuum.

We also accept members into the program based on self or other referral, such as from their treating provider, as well as other vendor program referrals, such as utilization management or EAP. In addition, we ask for daily utilization management files that are loaded into the CareEngine system. We will also integrate our program with external vendor programs and do so by adding vendor programs to our program hierarchy process. We recommend receiving daily data files from the vendors so we will know which members are participating in each vendor program. In addition, we are able to send ActiveHealth program participation data to the external vendors.

During the implementation process ActiveHealth will work with <<CLIENT>> and their vendors to establish the hierarchy and "rules of the road" that determine which organization will provide outreach and engagement for various issues.

Outreach Across the Entire Continuum of Care

Members are encouraged to participate and receive outreach for one program only, based on the following program hierarchy from highest to lowest priority: third party Case Management, Maternity Management, Disease Management and Lifestyle Management. Using our primary nurse coaching model, once the member is engaged for any issue, the same nurse or health coach will address other issues or will offer to co-manage with another specialty coach according to criteria (based on member status) and the member preference. If there are other issues to be addressed across the continuum, the primary nurse or health coach will address all of them or bring in other members of the care team to support the engagement process as described above. Using this approach, engagement is simplified and the concept of separate programs is transparent to the member as they navigate the health care continuum.

Maternity Management

Members identified by our predictive model rules or referrals from other programs receive outreach calls in an attempt to engage the member in the maternity program. ActiveHealth's maternity management program has the most impact when participants engage early - within the first 16-20 weeks of pregnancy. However, members may enroll at any point during their pregnancy.

Disease Management

Member identified for Disease Management are stratified across low, moderate and high risk opportunity levels. Members stratified as low opportunity are targeted for online engagement and can opt into telephonic coaching by self referring via calling our toll free line. Low opportunity members receive messaging in the member portal, MyActiveHealth, as well as an outreach letter promoting online and telephonic engagement.

Members identified as moderate and high opportunity are targeted for telephonic engagement and are supported by various online tools. Moderate and high opportunity members receive messaging in the online member portal, MyActiveHealth, as well as up to five outreach phone calls and four outreach letters. The outreach process includes the following elements:

- * Introductory call and letter: The objective of the first automated introductory call and introductory letter are to introduce the program, build program awareness and encourage coach engagement.

- * Invitation call and letter: Moderate and high risk members are then selected for additional outreach with the objective of promoting coach to member engagement. These members receive a second

automated invitation telephone call followed by an invitation letter.

- * Reminder calls and letter: Moderate and high risk members who have not yet engaged then receive up to two additional outreach telephone calls made by Customer Service Agents interspersed with one additional outreach letter.

- * Unable to reach call and letter: If the member has not engaged after the outreach campaign, they receive one additional automated phone call and an "unable to reach" letter.

At any point in the outreach process members may opt to engage with a coach, which completes the outreach process, and the engagement process begins.

Lifestyle Management

Member identified for Lifestyle Management are stratified across low, moderate and high risk opportunity levels. Members stratified as low opportunity are targeted for online engagement and can opt into telephonic coaching by self referring via calling out toll free line. Low opportunity members receive messaging in the online member portal, MyActiveHealth, as well as an outreach phone call and letter promoting online and telephonic engagement.

Members identified as moderate and high opportunity are targeted for telephonic engagement supported by the online program. Moderate and high opportunity members receive messaging in the member portal, MyActiveHealth, as well as up to five outreach phone calls and three outreach letters. The outreach process includes the following elements:

- * Invitation call and letter: The objective of the first automated introductory call and introductory letter are to introduce the program, build program awareness and encourage coach engagement.

- * Reminder calls and letter: Moderate and high risk members who have not yet engaged then receive a second automated phone call, followed by up to two additional outreach telephone calls made by Customer Service Agents interspersed with one additional outreach letter.

- * Unable to reach call and letter: If the member has not engaged after the outreach campaign, they receive one additional automated phone call and an "unable to reach" letter.

At any point in the outreach process members may opt to engage with a coach, which completes the outreach process, and the engagement process begins.

We also promote our programs from our member portal, MyActiveHealth, through messages posted to the portal as well as messaging generated from the member portal to the member's email. For example, MyActiveHealth provides members with a personalized list of action items, referred to as Health Actions. The Health Actions are derived via the clinical algorithms in ActiveHealth's CareEngine system. This ensures that a member is presented with appropriate, member-specific and actionable tasks to improve his or her health and to maximize savings. For example, Health Actions include recommendations to participate in one of our coaching programs, if the member has been identified as someone who will benefit from the program.

Engagement Across the Entire Continuum of Care

Maternity Management:

An expectant mother is enrolled in the program when she agrees to participate and completes a telephonic engagement session with one of our maternity nurses. Using the ActiveAdvice application

and embedded maternity assessment tools, the nurse evaluates the member's current health status, obstetrical history, and medical history including the presence of any co-morbid conditions such as diabetes, hypertension, asthma, or HIV. Our assessment process evaluates members for complications of previous pregnancies or deliveries that may place expecting mothers at a higher risk, or require increased surveillance during this pregnancy.

Additionally, the initial interaction facilitates member education regarding regular pre-natal care. Nurses identify any gaps in pre-natal care and encourage adherence to the member's medical treatment plan. Examples of information collected and reviewed include:

- * Estimated date of confinement (EDC).
- * Pre-natal visits with their physician to date.
- * Nutritional needs of a pregnant woman (e.g., a balanced diet).
- * Member's current medications and supplements.
- * Vaccinations, genetic testing and appropriate trimester screenings.
- * Promoting a healthy pregnancy and lifestyle including educating member on the potential harm of smoking, drugs and alcohol use during pregnancy.
- * Plan for follow-up visits.
- * Diagnostic studies to date.
- * Social and family issues or concerns, etc.

While our predictive model does assign an initial risk level based on analysis of available claims data, the initial assessment provides key information that might otherwise not be available via claims. Based on the results of the initial screening, our tool recalculates and updates the member's risk level assignment.

Once a risk level is determined, follow-up calls are scheduled at appropriate intervals. If the member is determined to be high-risk, the interactions with the member will occur monthly unless the member circumstances warrant more frequent contact. High risk members also receive a post partum call 2- 4 weeks following delivery. Moderate risk members received calls every 6-8 weeks and post partum. Low risk members receive follow-up calls at 28 weeks, 36 weeks, and post partum. After each interaction, a follow up letter including nurse coach contact information and educational materials are sent to the member.

Disease Management:

The frequency of contact for engaged members is guided by their opportunity level as well as results of the assessment. Nurses use clinical judgment along with a flexible care plan development process, so they are able to schedule coaching sessions as often as needed. ActiveHealth encourages members to make unscheduled inbound calls, in between scheduled appointments, should the member have a new concern or question they would like to discuss with their assigned nurse. In addition, we will outreach to the member in between scheduled appointments, should we learn a new issue about the member that requires communication earlier than the next scheduled appointment. The average high opportunity member schedules nine to twelve engagement sessions per year. The average moderate opportunity member schedules six to nine engagement sessions each year. The average low opportunity member schedules four to six engagement sessions per year.

Lifestyle Management

The frequency of contact for members engaged in the lifestyle management and coaching program is

guided by their opportunity level, as well as the results of the assessment. Similar to the disease management program, lifestyle management coaches use clinical judgment along with a flexible care plan development process, so they are able to schedule coaching sessions as often as needed.

ActiveHealth encourages members to make unscheduled inbound calls, in between scheduled appointments, should the member have a new concern or question they would like to discuss with their assigned nurse.

In addition, ActiveHealth will outreach to the member in between scheduled appointments, should we learn a new issue about the member that requires communication earlier than the next scheduled appointment. Low, moderate and high opportunity members may schedule coaching sessions as frequently as weekly. Moderate and high opportunity members are offered unlimited weekly coaching sessions with the expected average number of sessions for moderate opportunity members at six and for high opportunity members at eight. Low opportunity members who self refer may engage in up to four sessions.

Attachments: [4.2.3.1 outreach engagement process diagram.pdf](#)

4.2.3.2 Do you incorporate social networking into your program? If there is an additional cost, please indicate the cost on the rate sheet.

Answer: 1: Yes, included in base pricing

Detail: As part of our wellness enhancement strategy for 2013, we are working on enhancing our engagement strategy by deploying a multi-modal engagement approach, as part of our wellness programs available to members. Our enhanced platforms contains online social wellness communities and an innovative group coaching platform that we will use to engage members in a way meaningful to them, driving increased program engagement and reportable outcomes.

- Online Coach Moderated Communities

- Leveraging the power of social / peer-to-peer support in aiding member engagement and behavior change, members will have the ability to communicate with each other via an online community approach.
- These communities will allow members to hold each other accountable, communicate with others who are struggling with the same barriers, and hear success tips and stories from people who are “just like them.”
- A Clinical Coach Moderator will help guide discussions, provide / integrate valuable resources and ensure conversations benefit participating members.

- Group Coaching Model

- Also leveraging the power of peer-to-peer support, we have developed a one-to-many model for health coaching.
- Group coaching is different from standard onsite health education programs, as it moves away from an instructor lecturing a class and progresses to leveraging core coaching principles in eliciting members participation and accountability.
- Group coaching sessions can be held virtually or onsite and will leverage the online communities for additional support.
- The group coaching sessions are designed to drive increased proactive engagement and personal goal setting.

Options:

1. Yes, included in base pricing
2. Yes, for an additional fee (indicated on rate sheet)
3. No

Attachments: [4.2.3.2 communication assets.pdf](#)

4.2.3.3 Are reminders sent on a routine schedule to members and/or participants to motivate appropriate health actions (e.g., obtain certain tests, schedule follow-up exams, etc)?

Answer: 1: Yes, to all members

Detail: Members will receive e-mail reminders periodically to encourage regular use of online and telephonic resources. For example, a member might be emailed to come back to the site to complete the HRA, review applicable preventive care guidelines, complete disease management or lifestyle coaching courses identified for them, or review their PHR. Members that provide their mobile phone number may also receive text message reminders.

Options:

1. Yes, to all members
2. Yes, to participants only
3. No reminders sent

Attachments:

4.2.3.4 Do you participate in on-site health events, such as health fairs, as part of your healthcare management programs? If there is an additional cost, please indicate the cost on the rate sheet.

Answer: 1: Yes, included in base pricing

Detail: During implementation we would schedule special meetings to focus on the State's scheduled on-site health events and also discuss where you'd like our assistance in taking a leadership role to organize and facilitate health fairs, lunch and learns, bio-metric screening sessions, etc. We anticipate supporting most health fairs within our base pricing by our in state staff. Should the State desire special guest speakers or experts on site there may be additional fees discussed prior to any decisions to move forward.

Options:

1. Yes, included in base pricing
2. Yes, for an additional fee (indicated on rate sheet)
3. No

Attachments:

4.2.3.5 Which of the following do you consider your program to be?

Answer: 2: Opt-out - patients are assumed to be participating unless they actively declare that they are opting out

Detail: Our most prominent program model is an opt-out model, however we are able to offer opt-in and hybrid models. We carefully track member engagement levels and will report ongoing status to the State. Reports feature information for differentiating between actively engaged members and members unable to reach, lost to outreach, engagement status by risk level, etc.

Options:

1. Opt-in -patients must sign up to participate
2. Opt-out - patients are assumed to be participating unless they actively declare that they are opting out
3. A combination of opt-in and opt-out

Attachments:

4.2.3.6 If a participant opts out of the program, how long will it be until they are contacted again?

Answer: 3: 6 months

Detail: All members in the program are continuously monitored by the CareEngine regardless of level of engagement. If a member opts out, we continue to monitor their claims and would send an alert to their provider if we discovered a gap in care.

Whether or not members receive communications after they have opted out - and frequency -is customized by each client. Some clients prefer zero contact after a member opts out. Other clients like to deploy our "reconnect campaigns" where we can reintroduce members to engage after 3, 6, 9 or 12 months. Other clients want us to attempt engagement again if a members stays in a high risk status for more than 3 months while many clients put the accountability to contact us in the hands of the member.

In our standard programs, opt-outs are typically members who are targeted for telephonic engagement and when contacted tell us they do not want to participate in the program in any manner, meaning they decline telephonic, mail and online engagement. Low risk members can contact us and request to be opted out as well.

Non-responders include members who are targeted for engagement but do not respond to our progressive outreach campaign of awareness and outreach calls and letters. These members receive program materials, including Care Consideration communications and newsletters via mail, in addition to having access to our on line tools. They may elect to step up to engagement at any time. On a periodic basis, we will also attempt to re-activate those members who did not respond to previous outreach attempts.

Once members are identified for the program, member stratification may change based on new administrative data, member-derived information, and member progress. Additionally, members are stratified against a range of 36 adult and 6 pediatric conditions and co-morbidities, so the level of engagement and customization of the program is specific to each member and may change over time. As such, levels of outreach, monitoring and tracking are highly-specific to each member.

Options:

1. 1 month
2. 3 months
3. 6 months
4. 1 year
5. Never

Attachments:

4.2.4 Incentives

For **EACH** of the healthcare management programs you are proposing for the State, please provide the following information:

4.2.4.1 Describe any incentive awards you provide or administer to increase enrollment. Identify any additional costs associated with this on the rate sheet.

Answer: Across all of our programs we can measure compliance and or participation in a variety of ways to help facilitate appropriate use of incentives, awards or reporting requirements. ActiveHealth administers an array of incentives, including but not limited to the following:

- * Incentives for HRA completion, biometric screening completion, participation in wellness/disease management/maternity assessment completion.

- * Another common incentive is to reward ongoing program participation for moderate and/or high risk participants. For example, engaged with a nurse at least four times a year. If they meet this goal, they qualify for a client-defined incentive.

- * We track members that are invited and engaged in our program, and who qualify for the client defined incentive. Each month we track this data and provide the appropriate information back to the State or the organization fulfilling the incentive.

Each activity or program participation requirement can be tracked and incentivized on various levels, which the member can view through our online member web portal (Rewards Center) as they progress through their program. Points, dollars and other ways to incent the member for each activity can be tracked and displayed on the tool to ensure each member is aware of their goals and their progress on a daily basis. Members will also be notified when they complete all their required activities and meet their goals to receive the full incentive.

Although we do not fulfill the incentives for our program directly, we can, on behalf of the client contract with a fulfillment company such as Hallmark or IncentOne if the State wanted to issue gift cards. If the State wants to set up an HSA credit or some sort of premium differential we can work with Aetna or another payor to administer directly. Regardless of the incentive, we will track whether the member meets the criteria for the incentive, communicate to the member and coordinate with the organization fulfilling the incentive.

In addition, some incentives are built into our standard programs and do not require client involvement for fulfillment. With respect to our wellness programs, members can receive additional incentives and rewards in the form of discounted items they can purchase on their own such as vitamins, fitness club memberships, etc. For example, in our smoking cessation program, participants are provided with patches, nicotine gum and other aids to help them quit smoking.

Attachments:

4.2.4.2 Can you administer client-specific (custom) incentives? If there is an additional cost, please indicate the cost on the rate sheet.

Answer: Yes; ActiveHealth can administer client-specific (custom) incentives. Client-specific incentives can be tracked through the Rewards Center within our online member web portal. Although we do not fulfill the incentive for our program, we can contract with a vendor that does and we will track whether the member meets the criteria for the incentive and coordinate with the organization fulfilling the incentive. Each activity or program participation requirement can be tracked and incentivized on various levels. Points, dollars and other ways to incent the member for each activity can be tracked and displayed for both the member and the nurse/coach.

Attachments:

4.2.4.3 Are you able to provide incentive administration for members with more than one condition? For example: Member in weight management and stress management can receive 2 incentives for coaching received on both conditions.

Answer: Yes; we have flexibility and capabilities to administer incentives for members with multiple conditions. We can also track participation in programs run by other vendors or the State and ingest that data into our reports and Rewards Center on line.

Attachments:

4.2.4.4 Please describe the incentive program you would propose for the State? (8 sentences or less).

Answer: Typically, we advise clients to phase in their incentive program with at least a 3 year strategy. We would encourage a program that initially builds awareness by requiring all members to complete the Health Assessment and either Biometric Screening or a well visit or annual screening with their provider. (faxing the biometrics to us for data ingest) Once the Health Assessment is completed, the members with risk should also be required to complete some level of sustained telephonic or online coaching to improve chances of clinical outcome improvement. To ensure all members are actively participating throughout the year, it is important to provide options, such as a physical activity program or challenges to engage members in different ways. Rewarding members for healthy behaviors, such as a health club membership, is also recommended. Once members have adjusted to an annual HRA, including biometric screening, we would suggest the State move to an outcomes based incentive program where you are rewarding members to either maintain their health or improve their metabolic numbers.

Attachments:

4.2.5 Participation

For **EACH** of the healthcare management programs you are proposing for the State, please provide the following information:

4.2.5.1 How do you define participation for your current clients?

Answer: 5: Participation is defined as working with a manager on a routine basis

Detail: A participant will have completed the initial assessment and (at least) have scheduled the second assessment call. Ongoing participation is defined as on-going completed coaching sessions.

Options:

1. Identified members are considered participants unless they have actively communicated that they do not want further contact
2. Participation is defined as anyone identified as being eligible
3. Participation is defined as anyone receiving educational information and/or working with a manager
4. Participation is defined as anyone who has a condition covered by the program
5. Participation is defined as working with a manager on a routine basis
6. Other: [Text]

Attachments:

4.2.5.2 In the most recent calendar year, what percentage of those members that were referred to or identified for services were actively engaged to participate based on your definition above?

Answer: 6: 30 to 50 percent

Detail: Engagement is calculated as those members who are successfully contacted (denominator) who agree to engage with a nurse (numerator) and have completed the initial assessment and have scheduled the second assessment call.

Options:

1. 5 percent or less
2. 5 to 10 percent
3. 10 to 15 percent
4. 15 to 20 percent
5. 20 to 30 percent
6. 30 to 50 percent
7. 50 to 70 percent
8. 70 to 90 percent
9. 90 to 100 percent

Attachments:

4.2.5.3 What is the average frequency or length of participation?

Answer: Average length of participation ranges between 6 and 12 months based on risk status, incentives, program type and other factors.

Attachments:

4.2.5.4 What is the typical drop-out disenrollment rate for enrollees?

Percent of active disenrollment: Please specify	The decline rate (defined as the number of members who decline of those successfully contacted) for our DM clients with incentives in place was 12% over the last 12 months. Top reasons for decline were: 1. Uninterested in program 2. M.D. manages chronic illnesses 3. Currently too busy - try later
Percent of passive disenrollment: Please specify	The Unable to Reach rate for our DM clients with incentives in place was 56% over the last 12 months. UTR is defined as members unable to reach among those outreached.
We do not track this: Please specify	Not applicable, We track a variety of disenrollment metrics and definitions based on our client specifications.

Detail: Please see the attached document for details

Attachments: [4.2.2.1.5 Engagement Table.docx](#)

4.2.5.5 How often do you report participation rates to the client?

Answer: Participation is reported at an executive summary level through monthly dashboard reports and in detail with quarterly operational reports.

Attachments:

4.2.5.6 If you provide tobacco cessation services, please provide your tobacco cessation program's quit rate:

6 month:	Our six month quit rate is 31 percent.
12 month:	We do not currently measure the 12 month quit rate.

Detail: Validation of tobacco use is based upon ICD-9 claims for tobacco use as well as positive responses to our health assessment questions about tobacco use.

Attachments:

4.2.5.7 Does your tobacco cessation program include nicotine replacement therapy?

Answer: Yes; once enrolled into the smoking cessation program, a member becomes eligible for an eight-week supply of Nicotine Replacement Therapy (NRT). The NRT is provided as long as long as no contraindications are present. NRT is included in our base pricing of our LifeStyle Coaching program.

If contraindications are present, members will be provided our reward box. The reward box includes an exercise band, pedometer, healthy cookbook and tape measure. This box is used both as a reward for members who are engaging in the program and as a tool to continue to facilitate the members engagement in the program. Coaches will use items from the box in subsequent coaching sessions, when applicable, to help members reach their goals.

Attachments:

4.2.5.8 Please describe any methods or efforts specific to the State's population that your organization would recommend to increase participation.

Answer: The most critical element that drives success in a wellness program is member engagement. We work with our clients to design an effective incentive and relevant program promotional package and continuously monitor the results and revise the program to maximize engagement of the at risk population. Incentives or disincentive strategies are essential for successful engagement. Engagement, whether incented or not, needs to include a variety of communication methodologies such as regular mail, telephonic outreach and web-based communications. Additionally, members should be encouraged to seek out their treating providers for necessary screenings through incentives. On-site health seminars on client specific issues and biometric screening events can also greatly increase visibility, risk identification and engagement.

As noted in the incentives section, ActiveHealth would encourage a program that builds awareness by requiring all members to complete the Health Assessment and Biometric Screening. Once the Health Assessment is completed, the members with risk should also be eligible for some level of incentive for completing some level of sustained telephonic or online coaching to improve chances of clinical outcome improvement. To ensure all members are actively participating throughout the year, it is important to provide options, such as a physical activity program or challenges to engage members in different ways. Rewarding members for healthy behaviors, such as a health club membership, is also recommended.

Recently, another ActiveHealth client asked us to create an incentive strategy that would drive more activity in their Wellness program. We responded with a combination of formulary based participation incentives and HRA completion incentives resulting in a significant increase in participation and outcomes. This required customized communications and data strategies across a broad spectrum of population demographics, including non-English speaking membership. Using these types of engagement strategies across our portfolio has led to double and triple the typical non-incented engagement rates and resulted in significant increases in ROI and clinical outcomes.

Attachments:

4.2.6 Effectiveness

For **EACH** of the healthcare management programs you are proposing for the State, please provide the following information:

4.2.6.1 Describe how you will evaluate the effectiveness and efficiency of each program in the following areas:

Clinical outcomes
Costs avoided
Behavior Change
Improved health knowledge
Reduced risk
Appropriate utilization
Member satisfaction
Return on investment
Other, please specify

Answer: We measure program utilization, clinical, operational, and financial performance using the following ActiveHealth Outcome Metrics:

- * Utilization (assuming appropriate data are received) - hospitalizations for CAD, Diabetes, Asthma, COPD, CHF, Stroke; ER visits for Asthma, COPD, CHF
- * Financial (assuming appropriate data are received) - CareEngine (resolved care considerations)
- * Return on investment calculation information
- * Clinical Indicators: Across 42 (36 adult and 6 pediatric) chronic conditions, the clinical indicators we select are those shown by evidence-based medical literature to have a compelling relationship to significant morbidity or mortality for the relevant conditions, representing modifiable risk.
- * Functional status - e.g., asthma score, NYHA coronary artery disease functional status; GERD quality of life; MIDAS functional status for migraine.
- * Behavioral - smoking cessation rates; changes in body-mass index.

Clinical outcomes for the CareEngine program are primarily measured in terms of the number of Care Considerations successfully resolved. We only report success when we actually receive claims evidence of compliance, e.g., that a recommended prescription was not only written by the physician, but was filled by the member. The quarterly reports show Care Consideration success rates by:

- * Severity level
- * Specific type of CC
- * Major diagnostic category

Clinical outcomes for the program are specific to each clinical condition in disease management. Many are based on medical or pharmacy claims evidence (e.g., use of recommended medications for high cholesterol or cardiovascular risk factors, etc.) and some are based on self-reported information given to nurses such as achieving blood pressure or cholesterol target levels, stopping smoking, etc.

Behavior Change

Active Lifestyle Coaching captures behavior change associated with the following lifestyle topics: Tobacco use, elevated BMI, and nutrition, exercise and stress issues. Across all programs, behavior change outcome metrics include improvement in risk profile

For all programs, including disease management, lifestyle coaching and maternity management, ActiveHealth effects, tracks and reports behavior change. Highly customized assessments embedded in our ActiveAdvice care management workflow platform measure behavior change, SMART goals, and are based on a member's individual clinical profile created by the CareEngine clinical stratification and identification algorithms. By generating very specific questions relative to identified conditions, the assessments support the acquisition of additional clinical information for use by the CareEngine System. Based on the answers to questions and utilizing branching logic, the assessments

generate customized care plans which support individual SMART goal setting, interventions, and ongoing follow-up. The assessment tools also enable the primary nurse to provide member education and communication specific to the member's condition(s) and potential opportunities to improve their care. Communicating Care Considerations that have been converted from medical jargon to language easily understood by patients fully leverages our ability to achieve greater levels of compliance in correcting issues we identify for the specific member, as well as fostering behavior change. Additionally, the customized tools support the assessment of readiness to change, individualized educational opportunities and behavioral modification support so efforts can be directed at those issues most relevant to the patient. Members are coached on how to effectively interact with their physicians in a highly specific manner, further enhancing the information exchange between patient and physician. The overall result is a comprehensive patient-centric holistic approach to care management not limited to individual disease states.

Member-derived clinical data from the targeted assessments, such as blood pressure, weight, medications (including over-the-counter and herbal preparations), are quickly integrated into the CareEngine, providing an important source of new information. As new patient data enters the system, new clinical interventions can be defined instantaneously and communicated immediately if needed to physicians and patients that will inform and support the care plan as well as ensure the safety and optimal health of covered members.

Improved health knowledge

Improved health knowledge occurs across the population as participation increases in the online and telephonic coaching and education modules available. Educational intervention and brochures are sent to members at the end of each engagement session, including ways to effectively communicate with their physician. Lifestyle coaching, disease management and maternity management all provide ongoing measurement of online and telephonic engagement. For example, the program tracks when a member accesses an online self care modules, such as our diabetes program, which includes a score of educational content making it easy to improve health knowledge. When engagement and ongoing participations increases, we see improved clinical outcomes, which have led to improved financial outcomes for our clients.

Reduced risk

Please refer to the attached exhibits (4.2.6.1 Clinical Outcomes overview & 4.2.8.3 Savings Methodology) for detailed overviews describing ways in which our programs have reduced risks across populations similar to the State's.

Appropriate utilization

* Utilization (assuming appropriate data are received) - hospitalizations for CAD, Diabetes, Asthma, COPD, CHF, Stroke; ER visits for Asthma, COPD, CHF

Member satisfaction

We conduct a satisfaction survey for all members who enrolled in our program and who have been enrolled for 50 days and have conducted at least one follow-up assessment. Members are surveyed through an automated telephonic survey conducted by an independent third party vendor. A survey is administered after a member has been enrolled for 50 days with their Nurse Care Manager or wellness coach. The member satisfaction survey methodology is based on a five point Likert scale, which is the most widely used scale in survey research. When responding to a Likert questionnaire, members specify their level of agreement to a given statement. The objective of the survey is to measure member satisfaction with the disease management program, measure member's benefit from the disease management program, rate member satisfaction with their Nurse Care Manager, and identify any areas of concern or opportunities for improvement based on member satisfaction survey results.

Survey results include response rate and percentage of respondents' answers for each possible response. A sample survey, including survey results is included with our proposal.

Return on investment

Please refer to our savings methodology overview (4.2.8.3 Savings Methodology)

Attachments: [4.2.6.1 Clinical Outcomes Overview.docx](#)
[4.2.8.3 Savings Methodology.docx](#)

4.2.6.2 Please list the average annual ROI for clients of similar size for the following years:

2009	ROI is difficult to compare across clients due to the wide variation in program type, however, we have included typical three year ROI projections for a program of similar size and scope in the attached exhibit (4.2.6.2 ROI). ActiveHealth would agree to place fees at risk against a similar ROI.
2010	ROI is difficult to compare across clients due to the wide variation in program type, however, we have included typical three year ROI projections for a program of similar size and scope in the attached exhibit (4.2.6.2 ROI). ActiveHealth would agree to place fees at risk against a similar ROI.
2011	ROI is difficult to compare across clients due to the wide variation in program type, however, we have included typical three year ROI projections for a program of similar size and scope in the attached exhibit (4.2.6.2 ROI). ActiveHealth would agree to place fees at risk against a similar ROI.

Detail: Please see attached document

Attachments: [4.2.6.2 Book of Busines ROI table.docx](#)

4.2.6.3 Are you able to measure ROI for each health care management program?

Answer: Yes; We are able to measure ROI for each health care management program. Please refer to our attached savings methodology for potential ways for measuring ROI for each program, including Active Disease Management, Active Lifestyle Coaching and Maternity Management.

Attachments: [4.2.8.3 Savings Methodology.docx](#)

4.2.6.4 If yes to the previous question, on average, what range (%) of ROI is each program producing and what is the process to develop the ROI?

Answer: Please refer to the attached ROI exhibit (4.2.6.2 Book of Busines ROI) for the type of ROI projected for a program similar to the State's, based on the methodology described in exhibit 4.2.8.3 Savings Methodology.

Attachments: [4.2.6.2 Book of Busines ROI table.docx](#)

4.2.6.5 Are any of your ROI guaranteed savings dependent on an incentive, client-offered or otherwise? Please provide details.

Answer: We are able to provide ROI with and without an incentive (client-offered or otherwise). Because the incentive would theoretically improve ROI, ActiveHealth would work with the State to estimate the probable and expected improvement and the develop an appropriate mutually agreed upon performance guarantee.

Attachments:

4.2.6.6 How often do you solicit program participants' feedback and satisfaction?

Answer: 5: Continuously

Detail: We conduct a satisfaction survey for all members who enrolled in our program and who have been enrolled for 50 days and have conducted at least one follow-up assessment. Members are surveyed through an automated telephonic survey conducted by an independent third party vendor. A survey is administered after a member has been enrolled for 50 days with their health coach.

Our member satisfaction survey methodology is based on a five point Likert scale, which is the most widely used scale in survey research. When responding to a Likert questionnaire, members specify their level of agreement to a given statement. The objective of the survey is to measure member satisfaction with the lifestyle coaching program, measure member's benefit from the coaching program, rate member satisfaction with the health coaches, and identify any areas of concern or opportunities for improvement based on member satisfaction survey results. Survey results include response rate and percentage of respondents' answers for each possible response. A sample survey, including survey results is included with our proposal.

Options:

1. Annually
2. Semiannually
3. Quarterly
4. Monthly
5. Continuously
6. Randomly
7. Other. Please specify: [Text]
8. Do not survey satisfaction

Attachments:

4.2.6.7 Please describe the results of your most recent member satisfaction surveys.

Answer: Member satisfaction continually exceeds our goal of 85% or higher.

Attachments:

4.2.6.8 How often do you conduct client satisfaction surveys?

Answer: 5: Annually

Detail: The State will be able to provide feedback as it relates to the level of satisfaction with its overall program as well as account management team's performance through our Client Satisfaction Survey tool. This tool will measure account management services in the following categories: technical knowledge, accessibility of personnel, responsiveness of personnel, interpersonal skills, communication skills (written and oral) and overall assessment of the services provided to the State. In addition, the State's feedback will be solicited regarding the full team supporting your program. The account management team will be responsible for working with the State to ensure the appropriate team members are assigned.

Options:

1. Ongoing
2. Monthly
3. Quarterly
4. Semi-Annually
5. Annually
6. We do not conduct Client satisfaction surveys

Attachments:

4.2.6.9 Please describe the results of your most recent client satisfaction surveys.

Answer: Client satisfaction continually exceeds our goal of 85% or higher. ActiveHealth places fees at risk for many clients based on a five point scale covering pertinent topics.

Attachments:

4.2.6.10 Explain how your organization will determine whether the program produces cost savings for the State. Describe the types of annual program evaluations you will prepare.

Answer: We are confident in our ability to produce cost savings for the State. We are flexible in our measurement approach and have provided a methodology template used with clients of similar size and scope (see the attached exhibit, 4.2.8.3 Savings Methodology) which could be modified to meet the State's needs.

Attachments: [4.2.8.3 Savings Methodology.docx](#)

4.2.7 Healthcare Management Services

4.2.7.1 Wellness Services

For **EACH** of the wellness programs you are proposing for the State, please provide the following information:

4.2.7.1.1 Please identify and describe in detail each service you provide through your wellness program.

Answer: Our wellness program provides something for all members regardless if they are healthy and interested in maintaining their health, or if they have multiple health risks and have not yet found their intrinsic motivation to work toward a healthier status. We have a combination of modalities in our wellness programs as we understand that different members appreciate different approaches and strategies.

Our program for the State can include on-site forums and group coaching, HRA, social wellness programs, biometrics, extensive on-line programs and individual and telephonic coaching, and promotion and integration with local and regional programs.

In other sections of this RFP we have provided detail regarding our extensive online offerings so in this section we will provide more detail about our lifestyle coaching program.

Active Lifestyle Coaching is our dedicated lifestyle coaching program, emphasizing wellness components that are integral to all of our solutions. The purpose of the program is to identify the at-risk members in a population and impact them before they develop costly chronic conditions or other health issues. The program empowers individuals to quit tobacco, achieve their target weight, adopt healthier diets, develop healthy exercise habits and cope with stress. Health coaches establish an ongoing, telephonic relationship with each member and use various methods to encourage members to incorporate healthy behaviors and to achieve their lifestyle goals.

Our Active Lifestyle Coaching program fully integrates with other ActiveHealth programs to deliver a refined member experience. Active Lifestyle Coaching focuses on the following lifestyle issues:

- Weight Management
- Tobacco Cessation
- Healthy Nutritional Choices
- Physical Activity
- Stress Management

Identification

All member data including claims, health assessment, lab/test results, biometric data, etc., is analyzed

by our predictive model to identify and stratify members who will benefit from Lifestyle Coaching. Similar to Disease Management, members are stratified as low, moderate or high risk based on their Clinical Risk Assessment (CRA) score.

Factors that drive the CRA score and assignment to various risk categories include at-risk elements such as at-risk for diabetes, pre-diabetes or cardiovascular disease; negative lifestyle behaviors such as tobacco use or elevated BMI; and presence of chronic conditions and co-morbidities. The combination and weighting of these factors drive the CRA score, which is mapped to the three risk categories.

Outreach and Engagement

Once the member has been identified, our outreach process starts. Moderate and high risk members are targeted for telephonic engagement with one of our Lifestyle Coaches. Low risk members receive mailed materials and can opt into telephonic engagement by calling the program. ActiveHealth introduced an online Wellness/Lifestyle module in our member portal, which is available for all risk groups. Our plan includes targeting low risk members for web based engagement while moderate and high risk members are targeted for coach engagement supported by the online program. At any point in the outreach process members may opt to engage with a coach, which completes the outreach process, and the engagement process begins.

Engaged members are individuals who have been identified for the lifestyle management program, have been invited to engage with a coach due to being moderate or high risk, and have elected to work with a dedicated coach on an ongoing basis. Low risk members may also self refer for telephonic engagement with a coach. The engagement process includes targeted member assessment and supportive coaching to assist the member in establishing goals and a personalized plan of care to achieve the goals.

Care plan development through a primary coach model

Active Lifestyle Coaching applies motivational interviewing and other coaching techniques to facilitate healthy behavior changes across the continuum of health related life choices including weight, tobacco use, stress mitigation, nutrition and activity. Active Lifestyle Coaching uses a primary coach model where the same coach supports the member throughout the course of their engagement in the program. Member interaction with the coach may include discussion of Care Considerations, identification of base motivation, goal setting using SMART goals, and review of and support of strategies to achieve goals. Members also receive personalized follow up letters along with topic-specific brochures from their coach to reinforce information discussed during the telephone call. The coach will also suggest the member participate in various online educational follow-up activities at MyActiveHealth, such as picking up brochures, reading articles, documenting biometrics such as weight and blood pressure, and participating in other interactive programs.

At the end of each call, the coach will set up the next appointment. We make appointment reminder calls, and if the appointment is missed, we make another outreach attempt to reschedule the missed appointment. All members in the program are continuously monitored by the CareEngine regardless of level of engagement. Once members are identified for the program, member stratification may change based on new administrative data, member-derived information, and member progress.

The core philosophy of our lifestyle management program is to use motivational coaching and education tools to facilitate and integrate healthy behavior changes across the continuum of health-related life choices, including relaxation and stress mitigation, healthy nutrition choices, and maintenance of consistent activity levels. Coaches are trained to understand how to incorporate the Transtheoretical Model as developed by James Prochaska and Motivational Interviewing as developed by Stephen Rollnick, Ph.D., & William R. Miller, Ph.D. The training takes place over a five week period with role plays, home work, and case reviews as some of the tools to help participants take these theories from the abstract to everyday practical application.

Regardless of whether we are coaching the member about chronic conditions or lifestyle issues, we utilize a personalized goal oriented approach to address where the member is on the health continuum.

We incorporate cultural competency in our coaching, in order to make our discussions and recommendation more relevant and meaningful to the member. Our materials are in English and Spanish and we incorporate health literacy standards to make our materials more effective tools for our members.

Online lifestyle coaching features

Online components that members access through the MyActiveHealth web portal are a standard component of Active Lifestyle Coaching. Available by smart phone or web browser, the online program serves as both a supplement to a member who is working with a health coach as well as an additional engagement avenue for members who are low risk, who have not responded to our outreach efforts, or who prefer to work at their own pace rather than telephonically with a coach.

The online features include:

- Condition- and topic-specific pages that present general and member-specific health education information.
- Access to an incentives reward center
- Ability for the member to insert notes and provide other feedback and information
- Display of assigned Nurse Coach's name, toll-free number and direct extension
- The ability to email with your Nurse Coach (if currently working with a nurse)
- The ability to chat in real-time with a Nurse Coach
- Nurse Coach-recommended activities (i.e., homework assignments) in the member's website, including health-related articles, podcasts, videos and other online tools.
- Appointments scheduled with your Nurse Coach will display on the website
- Access to a robust online “Digital Coaching” program that provides members with support and information to make necessary lifestyle and behavioral changes
- “Call Me” form on specific Health Actions and Health Report
- Data persistency between MyActiveHealth and our coaching platform, ActiveAdvice
- Ability to complete form and self-refer into program

Additionally, system integration points exist between the MyActiveHealth website and ActiveAdvice, the system platform ActiveHealth coaches use when working telephonically with members. Although this system integration is not visible to members, it is important in terms of overall care management. It prevents a member from having to provide the same information twice (one in MyActiveHealth and then a second time to the nurse) and ensure that the nurse is current on all important information. For example, if a member enters over the counter medications in the Personal Health Record within MyActiveHealth, that data is exported to ActiveAdvice so the nurse is aware. Another example is when a member provides information in order to complete a nurse-assigned homework item, that information is displayed to the nurse in ActiveAdvice.

An ActiveHealth nurse can, with a single click, open a member's MyActiveHealth site through the ActiveAdvice system. With the member's permission, the nurse will have a read-only view to assist the member with any questions.

Attachments:

4.2.7.1.2 Please indicate whether your wellness program is available only in its entirety or whether the State can select which aspects of the wellness program it wishes to implement (customization). If customization is allowed, please identify how customization is priced.

Answer: The State can select which aspects of the wellness program it wishes to implement (customization). Modules of the program in our pricing model are our wellness portal, the Rewards Center, and telephonic coaching. Extensive on-site coaching may also require additional fees. If customization is desired, we welcome the discussion surrounding pricing based on the program elements of most benefit to the State.

Attachments:

4.2.7.1.3 How is information about each program delivered to participants?

Answer: We provide members information about our programs through structured promotional campaigns developed in partnership with the State. We have materials ready for review by the State that can be deployed by mail, on-line, e-mails, text, on-site promotional activities such as health fairs and meetings. We also appreciate the opportunity to provide State HR personnel, unit managers, wellness champions, physicians, local programs, information about our programs and to learn about their specific offerings and services. We can visit on-site and we can also provide information through webinars and phone conferences. Our on-site staff in Juneau and Anchorage will look forward to being closely involved in program promotion.

We deliver interventions using onsite coaching supported by phone, mail, and our online member web portal. Member identified for Lifestyle Management are stratified across low, moderate and high risk opportunity levels. Members stratified as low opportunity are targeted for online engagement and can opt into telephonic coaching by self referring via calling out toll free line. Low opportunity members receive messaging in the online member portal, MyActiveHealth, as well as an outreach phone call and letter promoting online and telephonic engagement.

Members identified as moderate and high opportunity are targeted for telephonic engagement supported by the online program. Moderate and high opportunity members receive messaging in the member portal, MyActiveHealth, as well as up to five outreach phone calls and three outreach letters. The outreach process includes the following elements:

- * Invitation call and letter: The objective of the first automated introductory call and introductory letter are to introduce the program, build program awareness and encourage coach engagement.
- * Reminder calls and letter: Moderate and high risk members who have not yet engaged then receive a second automated phone call, followed by up to two additional outreach telephone calls made by Customer Service Agents interspersed with one additional outreach letter.
- * Unable to reach call and letter: If the member has not engaged after the outreach campaign, they receive one additional automated phone call and an "unable to reach" letter.

At any point in the outreach process members may opt to engage with a coach, which completes the outreach process, and the engagement process begins.

We also promote our programs from our member portal, MyActiveHealth, through messages posted to the portal as well as messaging generated from the member portal to the member's email. For example, MyActiveHealth provides members with a personalized list of action items, referred to as Health Actions. The Health Actions are derived via the clinical algorithms in ActiveHealth's CareEngine system. This ensures that a member is presented with appropriate, member-specific and actionable tasks to improve his or her health and to maximize savings. For example, Health Actions include recommendations to participate in one of our coaching programs, if the member has been identified as someone who will benefit from the program.

Please refer to exhibit 4.2.3.1 for Outreach & Engagement flow charts.

Ongoing Engagement in Lifestyle Management/Wellness Coaching

The frequency of contact for members engaged in the lifestyle management and coaching program is guided by their opportunity level, as well as the results of the assessment. Similar to the disease management program, lifestyle management coaches use clinical judgment along with a flexible care plan development process, so they are able to schedule coaching sessions as often as needed.

ActiveHealth encourages members to make unscheduled inbound calls, in between scheduled appointments, should the member have a new concern or question they would like to discuss with their assigned nurse.

In addition, ActiveHealth will outreach to the member in between scheduled appointments, should we

learn a new issue about the member that requires communication earlier than the next scheduled appointment. Low, moderate and high opportunity members may schedule coaching sessions as frequently as weekly. Moderate and high opportunity members are offered unlimited weekly coaching sessions with the expected average number of sessions for moderate opportunity members at six and for high opportunity members at eight. Low opportunity members who self refer may engage in up to four sessions.

Attachments: [4.2.3.1 outreach engagement process diagram.pdf](#)

4.2.7.1.4 Are standard communication materials regarding each program included in your base fee? Provide samples.

Answer: Yes; standard communication materials regarding each program are included in our base fee. Please refer to the attached lifestyle coaching communication index with embedded letter and notification templates. Other promotional materials are also available for review by the State.

Attachments: [4.2.7.1.4 Lifestyle Coaching Communication Index.docx](#)

4.2.7.1.5 Describe where offices(s) for each program will be located and the specific services managed at each location.

Answer: ActiveHealth will provide staffing for the State's wellness program by Alaska residents who will work at Aetna offices located in Anchorage and Juneau, as well as from home offices located across the state in suburban or rural areas (once a new employee passes our stringent work at home audit). Our Alaska-based team will be further supported by clinical and operational staff in our Greenwood Village, Colorado clinical operations center. Greenwood Village is approximately a 20 minute drive from Denver and the Denver airport.

Attachments:

4.2.7.1.6 Describe how wellness employees utilize member claims payment and utilization management information either internally or by data feed from the claims payer to initiate and provide services under each program.

Answer: Similar to Disease Management, all member data including medical & pharmacy claims, health assessment, biometric data, UM/CM vendor referrals, etc. is analyzed by our predictive model to identify and stratify members who will benefit from Lifestyle Coaching. Members are stratified as low, moderate or high opportunity based upon the following lifestyle risk factors:

- Dietary Issues
- Exercise Issues
- Stress Issues
- Overweight
- At Risk for CAD
- Prehypertension
- Prediabetes
- At risk for Prediabetes
- Cholesterol Primary
- Borderline Hyperlipidemia
- Obesity
- Cholesterol Secondary
- Tobacco Use

Individual and combinations of lifestyle factors drive assignment to the three opportunity levels. For example, obesity or tobacco use alone drive assignment to the high opportunity category.

Attachments:

4.2.7.1.7 How many years has your organization provided each wellness program?

Answer: ActiveHealth has provided wellness programs for over nine years, since 2003. ActiveHealth launched our internal standalone Active Lifestyle Coaching program in 2010. We have delivered integrated wellness education modules through disease management, case management and health advocacy since 2003.

Attachments:

4.2.7.1.8 How many clients do you currently serve within each wellness program?

Answer: Active Lifestyle Coaching serves 34 clients within each wellness program, totaling over 1.9 Million lives within our employer group book of business.

Attachments:

4.2.7.1.9 What is the size of the target client for each wellness program?

Answer: The target client for all our Wellness programs is 10,000 members.

Attachments:

4.2.7.1.10 How many total covered lives does each wellness program support?

Answer: Active Lifestyle Coaching and Wellness programs support over 1.9 Million employer group lives.

Attachments:

4.2.7.1.11 List how many staff members will be dedicated to each wellness program.

Answer: We recommend a designated staff model because it provides flexibility in meeting staffing needs, resulting in better service. Designated means there is a defined number of staff members whose primary responsibility is to support a particular account. This team would, as needed, have secondary and tertiary responsibility for other accounts within the group. We continually monitor volume and staffing.

Attachments:

4.2.7.1.12 Describe which wellness programs (if any) are available for children under 18 years of age?

Answer: Wellness content is built into the following pediatric conditions through our Disease Management program.

- Weight Management (Obesity) - Adult and Pediatric
- Hypertension - Adult and Pediatric
- Asthma - Adult and Pediatric
- Diabetes - Adult and Pediatric
- Cystic Fibrosis - Adult and Pediatric
- Sickle Cell Disease - Adult and Pediatric

Attachments:

4.2.7.1.13 What is the average caseload for each wellness manager within each program?

Answer: The average coach to case load ratio for lifestyle management is approximately 1:200-250 based on risk/opportunity.

Attachments:

4.2.7.1.14 Will services under each program be available to members for at least 8 hours each day during Alaska Standard Time? Indicate the hours of operation for each service.

Answer: Yes; should Aetna be awarded both the Medical and HCM contracts, we will be establishing a Health Concierge model for customer service. Our team will also comprise State of Alaska residents for both Lifestyle and Disease Management Coaching, Hours will cover 8-12 hours Alaska Standard Time. Services will also be supported by our ActiveHealth customer service program operations center in Greenwood Village, CO are open from 4:30 am. to 7:00 pm. AKST, Monday through Friday; 5:00 am. to 10:00 am. AKST, Saturday. We also offer an optional 24x7 Nurseline for an additional fee.

Attachments:

4.2.7.1.15 Which days of the week will each services under each program be available?

Answer: Services are available Monday through Saturday. Our clinical operations are closed on Sunday. An optional Nurseline service would allow 24x7 access to nurse triage and program referrals.

Attachments:

4.2.7.1.16 Is there a ceiling on the number of telephonic coaching cases per program you will manage for the State? If yes, what is that limit (per program)?

Answer: There is no ceiling on the number of telephonic coaching cases per program ActiveHealth will manage for the State.

Attachments:

4.2.7.1.17 Indicate any accreditations you currently hold SPECIFIC to your wellness programs.

Answer: Active Lifestyle Coaching is currently pursuing NCQA wellness accreditation. As of this year we will have satisfactory data for NCQA to measure the success of our standalone data.

Attachments:

4.2.7.1.18 Describe the minimum required credentials for employees providing services in each program.

Answer: All coaches hold a minimum of a bachelor's degree in a health-related field (e.g., psychology, health education, exercise science, nutrition). Senior-level coaches are registered dietitians, registered nurses, or other professional staff who hold a minimum of a master's degree in a health-related field (e.g., nutrition, exercise, psychology, social work, counseling, etc.).

Experience Requirements

All coaches must have proven organizational skills and demonstrated ability to create and sustain a supportive client-focused environment for behavior change, with past coaching, counseling, or teaching experience desirable. Coaches must also have excellent oral and written communication skills, the ability to manage a heavy caseload and maintain thorough and confidential records of client progress, excellent telephone manners, and basic computer skills.

Preferred candidates for senior-level coaching positions have health education or health coaching experience in nutrition, weight management, physical fitness/exercise, tobacco cessation, and/or relaxation skills (mind-body techniques), as well as experience with routine medical care systems and working with medical personnel and in active referral systems.

All coaches are thoroughly assessed and their education is verified to ensure that they are qualified to provide the services for which they are hired. For example, only formally trained and CDR-registered dietitians are employed to provide general nutrition education to those members who have high-acuity comorbid medical concerns. Coaches are required to understand the clinical literature related to their

area of expertise, and they are provided ongoing access to new evidence. All staff members have routine documentation and data capture requirements. Participant files are audited, and calls are monitored to evaluate compliance with program protocol. Additionally, new member cases are discussed in weekly case review meetings with medical physician oversight. Telephone sessions are randomly audited to facilitate consistency in approach of content delivery and to identify training opportunities. Onsite health coaching is delivered by our certified wellness health coaching staff. Based on the scope of desired onsite coaching, our coach can either be located onsite full-time or visit sites on a weekly or monthly basis. Our health coaches are experts in providing a variety of services. Typically, they act as the "face" of the wellness program, with services including:

- * Conducting presentations / lunch & learns
- * Attending management meetings / company meetings to promote the program
- * Collecting non-invasive biometrics
- * Assisting with HRA completion
- * Instructing members how to utilize all tools available on our MyActiveHealth portal
- * Conducting face-to-face coaching sessions

Additionally, our coaches can provide onsite wellness consulting services - assisting in leading health fairs, leading wellness committees, assisting in aligning vendor programs with existing onsite wellness initiatives, and assisting in policy development to build a cohesive culture of wellness. Additionally, they can partner with national or local community organizations to ensure a comprehensive approach to wellness.

Attachments:

4.2.7.1.19 Describe your training program for employees in each program.

Answer: Training Overview

The health coach training is a comprehensive learning model predominantly aimed at coaching skills development, program content knowledge, and mastery of backend and electronic coaching record systems. The initial training program is completed prior to a health coach taking on a case load of active members. The initial training program is 120-hour course using interactive and didactic formats both in the classroom and online. The initial training program ends with an 8 hour practicum to demonstrate skill level. Topics covered in the initial training include an overview of company mission and values, systems, risk management, educational content review, principles of health coaching models, behavior change tools and techniques, and call documentation. An integral part of the training curriculum includes hands-on practice of coaching skills using role playing, call monitoring, and other teaching media. Coaches are trained in motivational interviewing, stages of change, and other evidence-based coaching techniques to help members recognize their behavior discrepancies, take responsibility for bringing their behavior back in alignment with health goals, and design an actionable and practical plan in support of healthier living behaviors.

In addition, we supplement the initial training of staff with focused training and information about the special populations that may be enrolled in the program. Coaches also receive corporate training in cultural and senior sensitivity.

Attachments:

4.2.7.1.20 Please indicate, for each program, what percent of staff members have a clinical degree by type (i.e., Registered Nurse, Physical Therapist, Dietician, Exercise Physiologist, Nutritionist, Personal Trainer).

Answer: Our coaching staff includes individuals with the following types of disciplines.

* Exercise Physiologists, Nutritionists, and Health Educators: Provides support for general weight management, tobacco cessation, nutrition, exercise and stress management. - 65 percent.

* Registered Nurse requires RN license - 10 percent.

* Registered Dietitian and Weight Loss Therapist. Registered Dietitian (RD) requires RD license or certification based on state requirements, whereby Weight Loss Therapist has preferred background of Licensed Clinical Social Worker - 35 percent.

We encourage staff to obtain coaching certification. We developed an internal coaching certification training program modeled on WellCoaches and Real Balance 360(r) training programs which many of our Lifestyle Coaches and Disease Management staff have obtained.

Attachments:

4.2.7.1.21 Is your organization willing to modify aspects of the wellness program per direction from the Project Director?

Answer: Yes; We are willing to modify and customize aspects of the wellness program per direction from the Project Director.

Attachments:

4.2.7.1.22 Do you include gym memberships as part of your wellness offering?

Answer: No; however, Aetna could promote gym memberships and could potentially help the State arrange an incentive for gym memberships, then track and report upon that incentive through our online web portal tools.

Attachments:

4.2.7.1.23 Can you provide onsite fitness programs?

Answer: Yes; We can provide onsite fitness programs which most commonly are social networking campaigns prominently featuring fitness challenges. Other onsite fitness and educational programs can also be developed in partnership with the State.

Our optional ActiveChallenge program includes a total of six top-down organizational challenge options, of which clients can choose three to offer their members per year, typically lasting six to 12 weeks each. The program also includes year-round access to the site with the ability for employees to challenge themselves and co-workers on an on-going basis. The program has both online and off-line reporting capabilities so that everyone can participate. Additional information about the challenges is provided below:

Member Teams and Challenges

- Members form teams to compete in friendly wellness challenges.
- Programs generally kick off with a 12-week weight loss, exercise and walking challenge called "Ready, Set, Go".
- Peer-to-peer challenges can also be issued, as well as over 50 "Bonus Challenges" which run weekly.

Online Tracking and Networking Tools

- Teams and individuals have their own website to set goals, track progress and communicate with each other.
- Multiple options for reporting progress allow members to participate whether or not they have a

computer

- A central reporting dashboard shows you aggregate member participation, progress, and outcomes in the program.

Attachments:

4.2.7.2 Nurse Call Line

4.2.7.2.1 Please identify and describe each service you provide through your nurse call line program.

Answer: Overview: ActiveHealth has partnered with SironaHealth for over 6 years to deliver a best in class Nurse Advice Line - or Nurseline - available 24 hours a day, 7 days a week, 365 days per year.

SironaHealth's service goal is to ensure member safety and satisfaction by facilitating the most appropriate level of care with compassion and speed. We know that better healthcare decisions are made, and healthcare dollars are saved, when a member has convenient and timely access to a clinician. This may be especially important for Alaska members who are in remote locations with limited access to medical support.

SironaHealth's team of Registered Nurses educates your member on their health, treatment options, and available healthcare resources specific to where they reside — enabling them to make the correct healthcare choices for themselves and their families. Based on presenting symptoms or specific health questions, our Nurses follow physician authored clinical guidelines to provide:

General health information

Self-care instructions, when appropriate

Guidance on whether to see a doctor

Physician and/or service referral

Escalation to Emergency Services

SironaHealth's programs also include automated fulfillment services. At the end of a call, follow-up educational materials can be sent to consumers via mail or email.

Rapid Triage Screening Model

SironaHealth primarily utilizes the Rapid Triage Screening (RTS) model, in which a non-clinician initially answers calls. Incoming calls are routed to a dedicated toll-free number and are processed through an automated menu system that includes appropriate disclaimer language as well as client-specific pick options. SironaHealth's Rapid Triage Screening (RTS) model has received URAC accreditation and meets all applicable standards.

Advantages of the RTS callback model include the following:

Improved risk management: callers who have urgent medical symptoms are triaged first, rather than “waiting their turn” in the RN queue.

Appropriate use of specialty resources: front-end screening enables the MSR to route calls to the most appropriate available RN. For example, a caller with a question about diabetes could receive a call back from a Certified Diabetic Educator rather than be transferred into the generalist pool.

Improved customer service: most callers with non-urgent questions would rather receive a timely callback than hold for an RN.

SironaHealth and ActiveHealth have developed seamless processes of service delivery by providing

SironaHealthnurses access to the integrated ActiveHealth clinical platform, ActiveAdvice. SironaHealthprovides ActiveHealth a file each morning which automatically downloads summary data from the calls the previous evening or weekend and facilitates a call back by an ActiveHealth RN. ActiveHealth nurses can also request an evening or weekend call by a SironaHealthRN to check on less stable patients requiring additional support.

Attachments:

4.2.7.2.2 Do you provide nurse call line services as a stand-alone program?

Answer: No; ActiveHealth does not provide nurse advice/call line services as a stand-alone program, but our partner SironaHealth does provide nurse call line services as a stand-alone program.

Attachments:

4.2.7.2.3 Describe where all functions associated with this unit are located.

Answer: SironaHealth's physical contact center is located in South Portland, Maine. In addition to their brick-and-mortar facility, SironaHealth manages a remote network of Registered Nurses who work from HIPAA-compliant home offices across the nation.

Attachments:

4.2.7.2.4 Do you provide all nurse line services internally or are any services subcontracted?

Answer: ActiveHealth partners with SironaHealth to deliver best in class nurseline services available 24 hours a day, 7 days a week, 365 days per year.

Attachments:

4.2.7.2.5 How many years has your organization provided nurse call line services?

Answer: The SironaHealth management and operation teams have provided Nurse Advice Line services since 1997 under the brand names of SironaHealth and IntelliCare. ActiveHealth has partnered with SironaHealth/IntelliCare for over six years.

Attachments:

4.2.7.2.6 How many total covered lives does your nurse call line program support?

Answer: ActiveHealth extends Nurseline services to over 1,250,000 lives across our care management book of business.

Attachments:

4.2.7.2.7 How many clients do you currently service in your nurse call line program?

Answer: 15

Attachments:

4.2.7.2.8 Indicate any accreditations you currently hold SPECIFIC to the nurse call line program.

Answer: SironaHealth has received URAC accreditation and meets all applicable standards.

Attachments:

4.2.7.2.9 Is your organization willing to modify aspects of the nurse call line program per direction from the Project Director?

Answer: Yes; ActiveHealth is willing to modify aspects of the nurse call line program per direction from the Project Director.

Attachments:

4.2.7.2.10 List how many staff members will be dedicated to the State's nurse call line.

Answer: We recommend a designated staff model because it provides flexibility in meeting staffing needs, resulting in better service.

Designated means there is a defined number of staff members whose primary responsibility is to support a particular account. This team would, as needed, have secondary and tertiary responsibility for other accounts within the group. We continually monitor volume and staffing.

Attachments:

4.2.7.2.11 Describe the minimum required credentials of a nurse call line employee.

Answer: With respect to nurse qualifications, Nurses must have at least one of the following:

- BS, Nursing, 2 yrs managed care experience
- Diploma from accredited nursing program, 2 yrs managed care experience
- Associate Degree, Nursing, 2 years managed care experience

Experience /skills:

- 3-5 yrs in clinical nursing-(Required)
- Prior post acute care planning
- Prior disease management experience
- Holds current Registered Nurse (RN) License to practice in the United States

Attachments:

4.2.7.2.12 Please indicate what percentage of the staff members in the nurse call line unit have a clinical degree.

Answer: All (100%) of the SironaHealth nursing staff has a clinical degree.

Attachments:

4.2.7.2.13 During what hours/days of week will toll free phone lines be staffed?

Answer: ActiveHealth's optional nurseline service is staffed with Registered Nurses 24x7x365.

Attachments:

4.2.7.2.14 How are calls "after-hours" of operation handled?

Answer: Members who call into the 24/7 nurse support line after hours seeking their Disease Management Nurse or Lifestyle Coach will receive follow up from their regular nurse/coach within 24 to 48 hours of their call. Members also have access to an audio library on a wide range of health topics through this service.

We have established data sharing protocols so that members may be referred between the Nurse Advice Line program and the other ActiveHealth programs. Calls to the Nurse Advice Line program from the previous night automatically flow back to ActiveHealth medical management applications and will automatically trigger RN follow-up based logic such as the call reason, resolution and member status in another program. A summary of the member's Nurse Advice Line call would be provided to our disease management program. This allows the disease management nurse to proactively outreach to the member based on information collected in a Nurse Line encounter.

Attachments:

4.2.7.2.15 On average, how many calls per week does the nurse call line receive in a typical population?

Answer: The annual average utilization rate for SironaHealth's health plan book of business ranges from 2% to 10%. Nurse Advice Line utilization is directly related to continuous program promotion so members have the toll free line available at the point in time they reach for support.

Attachments:

4.2.7.2.16 What is the average length of time for a call?

Answer: Average length of time for a call is approximately eight minutes.

Attachments:

4.2.7.2.17 What percentage of members access the nurse call line annually in a typical population?

Answer: 2: 5 to 10 percent

Detail: The annual average utilization rate for SironaHealth's health plan book of business ranges from 2% to 10%. Our Medicare book of business has utilization rates in the range of 3-6%. Based on our experience, the utilization of the service is a direct result of the investment made to promote and communicate the availability of the Nurse Advice Line.

Options:

1. 5 percent or less
2. 5 to 10 percent
3. 10 to 15 percent
4. 15 to 20 percent
5. 20 to 30 percent
6. 30 to 50 percent
7. 50 to 70 percent
8. 70 to 90 percent
9. 90 to 100 percent

Attachments:

4.2.7.2.18 What percentage of calls result in an emergency room visit?

Answer: In the last year, 11% of calls resulted in an emergency room visit.

Attachments:

4.2.7.2.19 What percentage of calls result in avoidance of an emergency room visit?

Answer: These numbers are based on actual results for a Medicaid health plan client with approximately 150,000 members.

Over the course of a year, 8,238 health plan members utilized the Nurse Advice Line service. Of those, 2,032 stated that they planned to visit an emergency room if the Nurse Advice Line were not available, and were subsequently directed to a lower level of care:

- 1,192 (59%) were directed to call their primary care physician
- 802 (39%) were directed to stay home and administer home care instructions
- 38 (2%) were advised to seek miscellaneous care (poison control, crisis line, etc.)

Attachments:

4.2.7.2.20 Does your nurse call line have access to see which programs members are currently participating in and can they make referrals to these programs as appropriate?

Answer: Yes; Nurse Advice Line staff have access to our ActiveAdvice nurse workflow software portal, which shows the programs members are currently participating in and allows referrals to these programs as appropriate.

Attachments:

4.2.7.2.21 Do you report on diversion of care?

Answer: Yes, we report on diversion of care and can provide a cost-savings analysis when callers are directed to a lower level of care than they would have otherwise sought had the Nurse Advice Line not been available.

Attachments:

4.2.7.2.22 Please explain how you evaluate the ROI for this program.

Answer: Providers of Nurse Advice Line services, including health plans, hospitals and other healthcare organizations typically measure the value of a Nurse advice line service by comparing the caller's original intent with the advice given by the Nurse. For example, a caller might state that if the Nurse Advice Line service were not available, they would have visited a local emergency department to be evaluated. If that caller then speaks with the Nurse and the Nurse determines that the appropriate level of care for the caller's concern is home care advice, then a savings can be derived in terms of total healthcare spending.

Below is a more detailed example of how dollar amounts can be associated with these savings to determine an estimated return for the Nurse Advice Line service. These numbers are based on actual results for a Medicaid health plan with approximately 150,000 members.

Over the course of a year, 8,238 health plan members utilized the Nurse Advice Line service. Of those, 2,032 stated that they planned to visit an emergency room if the Nurse Advice Line were not available, and were subsequently directed to a lower level of care:

1,192 (59%) were directed to call their primary care physician

802 (39%) were directed to stay home and administer home care instructions

38 (2%) were advised to seek miscellaneous care (poison control, crisis line, etc.)

The average total cost of an emergency room visit in the United States is estimated to be approximately \$1,000. The average for a visit to a physician is \$65. Given these numbers, the potential costs savings associated with redirecting the 2,032 members away from the emergency room is:

Avoided ER Use (2,032 x \$1,000) - PCP Visit Costs (1,192 x \$65) = \$1,954,520

The cost of providing the Nurse Advice Line service for all 8,238 calls was approximately \$200,000 for the year. The projected return for the Nurse Advice Line service is:

$\$1,954,520 - \$200,000 = \$1,754,520$, or \$8.77 saved for every \$1.00 invested in the service.

Even discounting this return, there is clearly a financial value associated with the service. Equally important is the “soft “value of the Nurse Advice Line service. We hear again and again from our callers that having access to the Nurse Advice Line service brings peace of mind. Recent Gallop surveys have shown that Nurses are the most trusted health professionals in America, as they are seen as having a high degree of ethical integrity and honesty. Callers also tell us that there is no substitution

for a conversation with a health professional when a child has a fever in the middle of the night, or an aging parent is feeling dizzy. Callers can reach a Nurse from the comfort and privacy of their home, office, car or hotel room. For the caller, there is also financial value as calling the Nurse advice line is typically a free call, when a physician visit or emergency room visit can cost significant out of pocket dollars.

Attachments:

4.2.7.3 Disease Management Programs

4.2.7.3.1 Please identify and describe each service provided through your disease management program.

Answer: We provide an NCQA accredited disease management program to clients who understand that population-wide health improvement initiatives will lead to a cascade of benefits. Our clients are more productive and profitable; employees feel better and work better; health plans save money; and physicians are empowered to make better decisions.

Active Disease Management earnestly engages all parties in the decision making process. Targeted, member-specific information is communicated to both the member and the physician to help make smarter, more informed decisions about clinical care - one member at a time. Our unique approach and clinical technology foundation allows for better healthcare at lower costs. Active Disease

Management:

- Focuses equally on physicians and patients in effecting behavior changes leading to improved clinical and financial outcomes;
- Identifies and targets impactable clinical issues that are communicated to physicians and patients with specific actions that can be taken to improve patient care;
- Customizes member engagement and education activities and intensity according to the member's specific clinical issues and medical needs;
- Targets resources to those members most likely to benefit from disease management interventions;
- Designs interventions and a plan of care around the member's complete set of conditions and co-morbidities;
- Maximizes multiple condition care by anticipating potentially harmful interactions between disease states;
- Integrates seamlessly with other internal and external care management programs, such as ActiveHealth's online web portal, HRA, lifestyle coaching, case management, UM, maternity, and incentive/reward programs;
- Savings over the first year of implementation exceed \$3.10 per member per month, based upon a study involving a large-scale commercial population of 200,000 members.

Pinpointing members that need help managing their conditions

Our disease management program is “powered” by our proprietary CareEngine, which applies thousands of evidence-based clinical rules to aggregated member medical, pharmacy, and lab results along with self-reported data to uncover potential errors and instances of sub-optimal care.

The clinical predictive modeling rules are applied on a continuous basis to all members of a covered population, not just those with chronic illness, to find clinical improvement opportunities. The CareEngine also provides clinical decision support. For each opportunity identified, a “Care Consideration” is generated that identifies the clinical issue(s) found, and suggests a change in treatment that evidence-based literature and treatment guidelines indicate would improve the patient's care. These Care Considerations are communicated to treating physicians, our disease management nurses and members, each time a care improvement opportunity is identified by the CareEngine System®.

Primary Nurse Model

At the onset of engagement, members are assigned a Care Manager who will work with them to

manage their condition and support them in meeting their healthcare goals. Care Managers are registered nurses who act as the member's primary personal health coach, motivating behavior changes, providing one-on-one education for the member's individual health care needs. Member interaction with the Care Manager may include discussion of Care Considerations, education on key clinical targets related to all of the member's condition(s), warning signs for condition-related complications, and other individualized educational and goal-setting interventions. Members also receive personalized follow-up letters along with condition-specific health brochures from their Care Manager to reinforce issues discussed during the phone calls.

Our coaches are trained to monitor cues while conducting the initial interviews with the members and during the course of management to discern the member's "decisional balance" (Janis & Mann, 1977) as they progress through the process of change. It is critical, particularly during the Maintenance phase (typically after the first six months of the program) to keep the decisional balance securely weighted in favor of the pros associated with the behavior change, otherwise the risk of relapse increases. Our nurses look for these cues, particularly after a sustained period of action and commitment, to guard against relapse and provide additional encouragement and reinforcement to the member's actions and success. Our nurses also work with members to motivate them to define SMART goals, which are specific and realistic goals, the plan to achieve the goals and to begin to take culturally appropriate action steps to reach those goals.

Another important role of the Care Manager is to coach and advocate member communication with his/her physician(s). This helps to reinforce the importance of the member actively participating in their health care. The overall result is a comprehensive patient-centric approach to care management not limited to individual disease states.

Online Disease Management tools available through MyActiveHealth

Active Disease Management includes online components that members access through the MyActiveHealth website. The online program serves as both a supplement to a member who is working with a health coach as well as an additional engagement avenue for members who are low risk, who have not responded to our outreach efforts, or who prefer to work at their own pace rather than telephonically with a coach.

The online features include:

- Condition- and topic-specific pages that present general and member-specific health education information.
- Ability for the member to insert notes and provide other feedback and information
- Display of assigned Nurse Coach's name, toll-free number and direct extension
- The ability to email with your Nurse Coach (if currently working with a nurse)
- The ability to chat in real-time with a Nurse Coach
- Nurse Coach-recommended activities (i.e., homework assignments) in the member's website, including health-related articles, podcasts, videos and other online tools.
- Appointments scheduled with your Nurse Coach will display on the website
- Access to a robust online "Digital Coaching" program that provides members with support and information to make necessary lifestyle and behavioral changes
- "Call Me" form on specific Health Actions and Health Report
- Data persistency between MyActiveHealth and ActiveAdvice applications
- Ability to complete form and self-refer into program

Additionally, system integration points exist between the MyActiveHealth website and ActiveAdvice, the system platform ActiveHealth coaches use when working telephonically with members. Although this system integration is not visible to members, it is important in terms of overall care management. It prevents a member from having to provide the same information twice (one in MyActiveHealth and then a second time to the nurse) and ensure that the nurse is current on all important information. For example, if a member enters over the counter medications in the Personal Health Record within MyActiveHealth, that data is exported to ActiveAdvice so the nurse is aware. Another example is when a member provides information in order to complete a nurse-assigned homework item, that

information is displayed to the nurse in ActiveAdvice.

Lastly, an ActiveHealth nurse can, with a single click, open a member's MyActiveHealth site through the ActiveAdvice system. With the member's permission, the nurse will have a read-only view to assist the member with any questions.

Attachments:

4.2.7.3.2 How many years has your organization provided a disease management program?

Answer: ActiveHealth has provided a disease management program since 2003, for over nine years. Our response to 4.2.7.3.7 shows the year each condition-specific module went live.

Attachments:

4.2.7.3.3 How many total covered lives does your disease management program support?

Answer: ActiveHealth's Disease Management program supports over 13 million members: over four million lives as a result of our direct employer group book of business and an additional nine million lives as a result of our relationship with health plans.

Attachments:

4.2.7.3.4 What percentage of members is managed in your disease management program in a typical population?

Answer: Please refer to 4.2.2.1.5 for our book of business information. In a typical employer group population, ActiveHealth identifies 18 percent to 20 percent as candidates for management in one of our disease management programs. Of the identified group nurses are able to telephonically engage approximately 37% when incentives are in place - 24% for a typical employer group population without incentives. Identification percentages can vary significantly based on the demographic makeup of the book of business as well as promotional efforts, provider strategies and plan design.

Attachments: [4.2.2.1.5 Engagement Table.docx](#)

4.2.7.3.5 How many clients do you currently service in your disease management program?

Answer: Active Disease Management covers 69 direct employer groups. Across all services (health care management, clinical decision support and data warehouse), the total population covered by ActiveHealth exceeds 21 million members with 77 direct employer clients, 19 health plan clients, six state health plan employer groups, three Medicaid clients, five TPAs, one multi-specialty IPA provider group, three large hospital health systems, and a regional health information organization. ActiveHealth's success is demonstrated by our growing health plan employer group membership, which includes:

- North Carolina State Health Plan
- Mississippi State and School Employees' Health Insurance Plan
- State of South Carolina
- State of West Virginia
- Alabama State Employees' Insurance Board
- Pending mid-Atlantic State Health Plan agreement exceeding 200,000 members going live in 2013
- Growing base of Medicaid clients
- Several local and city government employee groups
- U.S. Military - ActiveHealth improves quality of care for over 600,000 lives through health plan partnerships.

ActiveHealth's State Health Plan Employer Group clientele is rapidly expanding because our population health management approach is focused upon gathering all medical data for an individual, creating a longitudinal medical record, applying evidence based guidelines, and providing a single clinical platform which engages all members of the care team for the individual in a variety of settings

or modalities. Service delivery is uniquely customized to meet the high expectations of public-private initiatives.

Attachments:

4.2.7.3.6 Indicate any accreditations you currently hold SPECIFIC to your disease management program.

Answer: Active Disease Management maintains NCQA accreditation and meets or exceeds all NCQA requirements.

Attachments:

4.2.7.3.7 Indicate which conditions/diseases are routinely managed in your disease management program.

Answer: Active Disease Management covers 36 adult and six pediatric conditions, listed by cluster below. Our member facing telephonic and online coaching program is supplemented by direct contact with the treating provider.

Vascular Cluster

Coronary Artery Disease (CAD) 2003

Diabetes - Adult and Pediatric 2003

Congestive Heart Failure (CHF) 2003

Hypertension - Adult and Pediatric 2003

Hyperlipidemia (High Cholesterol) 2003

Peripheral Artery Disease (PAD) 2003

Cerebrovascular Disease (CVA)/Stroke 2003

Pulmonary Cluster

Asthma - Adult and Pediatric 2003

Chronic Obstructive Pulmonary Disease (COPD) 2003

Orthopedic/Rheumatologic Cluster

Chronic Lower Back Pain 2004

Rheumatoid Arthritis 2003

Osteoporosis 2003

Osteoarthritis 2003

Gastrointestinal Cluster

Gastro Esophageal Reflux Disease (GERD) 2003

Peptic Ulcer Disease 2003

Inflammatory Bowel Disease (Crohn's Disease and Ulcerative Colitis) 2003

Chronic Hepatitis 2003

Neuro-Geriatric Cluster

Migraines 2003

Parkinson's Disease 2003

Seizure Disorders 2003

Geriatrics 2003

Cancer Cluster

Breast Cancer 2004

Prostate Cancer 2004

Colorectal Cancer 2004

Lung Cancer 2004

Lymphoma/Leukemia 2004
Cancer (General) 2004

Renal Cluster
Chronic Kidney Disease 2003
End Stage Renal Disease 2005

Other
Systemic Lupus Erythematosus 2010
Weight Management (Obesity) - Adult and Pediatric 2006
Depression* 2003
Cystic Fibrosis - Adult and Pediatric 2004
HIV 2004
Hypercoagulable State (Blood Clots) 2003
Sickle Cell Disease - Adult and Pediatric 2003

*Managed as a co-morbid condition

Attachments:

4.2.7.3.8 Describe which conditions and associated program services (if any) are available for children under 18 years of age ?

Answer: Active Disease Management manages six pediatric conditions:

Asthma - Adult and Pediatric
Diabetes - Adult and Pediatric
Hypertension - Adult and Pediatric
Weight Management (Obesity) - Adult and Pediatric
Cystic Fibrosis - Adult and Pediatric
Sickle Cell Disease - Adult and Pediatric

Attachments:

4.2.7.3.9 Indicate whether all conditions must be included in disease management or whether the State can customize the list of conditions to suit its population?

Answer: The State can customize the list of conditions to suit its population however this may affect our ability to reach guaranteed ROI.

Attachments:

4.2.7.3.10 Is your organization willing to modify aspects of the disease management program per direction from the Project Director?

Answer: Yes; We are willing to modify aspects of the disease management program, per direction from the Project Director.

Attachments:

4.2.7.3.11 Describe where the dedicated offices(s) will be located and the specific services managed at each location. Please indicate if you would be willing to locate offices in Juneau, Anchorage or Fairbanks.

Answer: We will provide staffing for the State's Disease Management program by both Alaska residents who will work in the Aetna office in Anchorage and Juneau as well as from their home office (once they pass our stringent work at home audit). Our instate staff will be further supported by

clinical and operational staff in our Greenwood Village, Colorado office. Near Denver, Greenwood Village is approximately 20 minutes from the Denver airport.

Attachments:

4.2.7.3.12 List how many staff members will be dedicated to the disease management program.

Answer: We recommend a designated staff model because it provides flexibility in meeting staffing needs, resulting in better service.

Designated means there is a defined number of staff members whose primary responsibility is to support a particular account. This team would, as needed, have secondary and tertiary responsibility for other accounts within the group. We continually monitor volume and staffing.

Attachments:

4.2.7.3.13 What is the average caseload for disease management nurses/coaches?

Answer: The average nurse caseload ratio for disease management is approximately 1:250, varying by nurse experience and acuity of the cases.

Attachments:

4.2.7.3.14 Describe the minimum required credentials of a disease management nurse.

Answer: With respect to nurse qualifications, Nurse Care Managers must have at least one of the following:

- BS, Nursing, 2 yrs managed care experience
- Diploma from accredited nursing program, 2 yrs managed care experience
- Associate Degree, Nursing, 2 years managed care experience

Experience /skills:

- 3-5 yrs in clinical nursing-(Required)
- Prior post acute care planning
- Prior disease management experience
- Holds current Registered Nurse (RN) License to practice in the United States

Attachments:

4.2.7.3.15 What percentage of disease management staff has a disease management certification such as CDE?

Answer: All of our disease management nurses hold an active nursing license and have experience in the delivery of disease management programs. Our nurses have either an external certification or internal certificate of training in Behavior Change, Goal setting and Motivational Interviewing. External certifications are from Well Coaches and Real Balance 360.

Attachments:

4.2.7.3.16 Describe your training program for disease management employees.

Answer: The initial training program is 120-hour course using interactive and didactic formats both in the classroom and online. The initial training program ends with an 8 hour practicum to demonstrate skill level. Topics covered in the initial training of our coaches and nurses includes an overview of systems, risk management, educational content review, principles of health coaching models, behavior change tools and techniques, call documentation, company mission and values. ActiveHealth provides

ongoing training in each condition covered by our program, and rewards the pursuit of internal or external certification. We also establish client-specific training so nurses and customer service staff are familiar with key program features, workflow customizations and plan documentation.

All Registered Nurses working for our disease management program start with three participant interaction audits per month. The number of monthly audits will increase to five per month when a staff member fails to exceed 90 percent of the performance measures associated with inbound and outbound calls.

Calls are constantly monitored for quality using a variety of methods to meet the developing needs of the staff. ActiveHealth Management has the ability to record and retrieve calls through its Centricity Product, provided by Envision Telephony, Inc. Centricity allows our calls to be recorded and saved 24/7 through a web-based product platform called Envision Centricity. This system also allows recording of the data entry by the staff into our medical management tool and standardized templates used to evaluate the quality of the call. Centricity provides: workforce optimization, including analytics, performance management, workforce management, quality monitoring and e-learning.

Centricity allows supervisors to listen to calls, save calls and send coaching packages to staff for learning purposes. Supervisors meet with their staff to review opportunities for development. In addition, we have one way silent monitoring for telephone calls, preceptor programs that utilize side by side reviews and management side by side reviews of the staff.

Attachments:

4.2.7.3.17 Explain any incentive programs you employ to retain competent disease management employees?

Answer: ActiveHealth monitors success, provides continued education credits at no cost to our nurses, provide pay increases based on performance and promotes our best nurses within a large dynamic organization.

Attachments:

4.2.7.3.18 During what hours/days of is the disease management program available to members?

Answer: Should Aetna be awarded both the Medical and HCM contracts, we will be establishing a Health Concierge model for customer service. Our team will also comprise State of Alaska residents for both Lifestyle and Disease Management Coaching, Hours will cover 8-12 hours Alaska Standard Time. Services will also be supported by our ActiveHealth customer service program operations center in Greenwood Village, CO are open from 4:30 am. to 7:00 pm. AKST, Monday through Friday; 5:00 am. to 10:00 am. AKST, Saturday. We also offer an optional 24x7 nurse advice line for an additional fee.

Attachments:

4.2.7.3.19 How are calls “after-hours” of operation handled?

Answer: When a 24x7 nurse advice/triage line is not in place, calls made after hours are referred to a voicemail system that allows for a time-stamped message directly to the nurse care manager. Nurses respond to messages within one business day.

ActiveHealth offers an optional 24x7 nurse advice line for after hours triage, education, support and referrals to our regular disease management program. Members who call into the 24/7 nurse advice line after hours seeking their Disease Management Nurse or Lifestyle Coach will receive follow up from their regular nurse/coach within 24 to 48 hours of their call. Members also have access to an

audio library on a wide range of health topics through this service.

We have established data sharing protocols so that members may be referred between the Nurse Advice Line program and the other ActiveHealth programs. Calls to the Nurse Advice Line program from the previous night automatically flow back to ActiveHealth medical management applications and will automatically trigger RN follow-up based logic such as the call reason, resolution and member status in another program. A summary of the member's Nurse Advice Line call would be provided to our disease management program. This allows the disease management nurse to proactively outreach to the member based on information collected in a Nurse Line encounter.

Attachments:

4.2.7.3.20 Is there a voice mail system or capability for callers to leave messages after normal business hours?

Answer: Yes; when a 24x7 nurse triage line is not in place, calls made after hours are referred to a voicemail system that allows for a time-stamped message directly to the nurse care manager. Nurses respond to messages within one business day.

Attachments:

4.2.7.3.21 In the most recent calendar year and of those eligible for the program at each risk level (high, moderate, low) indicate the percent of members in each category for your book of business (with an incentive and without an incentive).

	Percent of Members	Comments
Identified	19%	Placeholder! Please see attached exhibit 4.2.7.3.21 for actual results in the format requested.
Outreached To	19%	Placeholder! Please see attached exhibit 4.2.7.3.21 for actual results in the format requested.
Reached	44%	Placeholder! Please see attached exhibit 4.2.7.3.21 for actual results in the format requested.
Opted Out	5%	Placeholder! Please see attached exhibit 4.2.7.3.21 for actual results in the format requested.
Enrolled	37%	Placeholder! Please see attached exhibit 4.2.7.3.21 for actual results in the format requested.
Dropped Out	12%	Placeholder! Please see attached exhibit 4.2.7.3.21 for actual results in the format requested.
Completed program – goals met	100%	Placeholder! Please see attached exhibit 4.2.7.3.21 for actual results in the format requested.

Detail: please see attached form for details

Attachments: [4.2.7.3.21 DM Engagement Table.docx](#)

4.2.7.3.22 What is the average length of time a case stays open?

Answer: An average case stays open for 12 months.

Attachments:

4.2.7.3.23 Are you able to warm transfer members to other vendors? If there is an additional cost, please indicate the cost on the rate sheet.

Answer: Yes; ActiveHealth is able to warm transfer members to other vendors for no additional charge.

Attachments:

4.2.7.3.24 Describe your procedures for transition of ongoing management cases to a new vendor.

Answer: At the time of termination, the assigned account manager will work with the client and the new vendor to provide them with transition information for members that are engaged in the disease management program.

The data will be provided approximately two weeks prior to the effective termination date, in report format, and will contain the following fields:

Patient ID
Patient Last Name
Patient First Name
Date of Birth
Gender
Enrollment Date
Phase
Status
Case Start Date
Conditions (Total of 9 Reported Fields)
First Assessment Date
First Assessment Description
Last Assessment Date
Last Assessment Description
Address 1
Address 2
City
State
Zip
Organization Name.

Attachments:

4.2.7.3.25 Is there a ceiling on the number of telephonic coaching cases you will manage for this client? If yes, what is that limit?

Answer: No; there is no ceiling on the number of telephonic coaching cases ActiveHealth will manage.

Attachments:

4.2.7.3.26 Is there a limit on the number of RN engaged cases?

Answer: No; there is no limit on the number of RN engaged cases.

Attachments:

4.2.7.3.27 Does your program include an Electronic Medical Record/Personal Health Record? If there is an additional cost, please indicate the cost on the rate sheet.

Answer: Yes; we include an online Personal Health Record (PHR), through our member web portal, which is seamlessly integrated with all our clinical programs. The PHR is included in the member portal fees at no additional charge. Members can also access their PHR through our mobile enabled

capabilities.

Online Disease Management tools available through MyActiveHealth

Active Disease Management includes online components that members access through the MyActiveHealth website. The online program serves as both a supplement to a member who is working with a health coach as well as an additional engagement avenue for members who are low risk, who have not responded to our outreach efforts, or who prefer to work at their own pace rather than telephonically with a coach.

The online features include:

- Condition- and topic-specific pages that present general and member-specific health education information.
- Ability for the member to insert notes and provide other feedback and information
- Display of assigned Nurse Coach's name, toll-free number and direct extension
- The ability to email with your Nurse Coach (if currently working with a nurse)
- The ability to chat in real-time with a Nurse Coach
- Nurse Coach-recommended activities (i.e., homework assignments) in the member's website, including health-related articles, podcasts, videos and other online tools.
- Appointments scheduled with your Nurse Coach will display on the website
- Access to a robust online “Digital Coaching” program that provides members with support and information to make necessary lifestyle and behavioral changes
- “Call Me” form on specific Health Actions and Health Report
- Data persistency between MyActiveHealth and ActiveAdvice applications
- Ability to complete form and self-refer into program

Additionally, system integration points exist between the MyActiveHealth website and ActiveAdvice, the system platform ActiveHealth coaches use when working telephonically with members. Although this system integration is not visible to members, it is important in terms of overall care management. It prevents a member from having to provide the same information twice (one in MyActiveHealth and then a second time to the nurse) and ensure that the nurse is current on all important information. For example, if a member enters over the counter medications in the Personal Health Record within MyActiveHealth, that data is exported to ActiveAdvice so the nurse is aware. Another example is when a member provides information in order to complete a nurse-assigned homework item, that information is displayed to the nurse in ActiveAdvice.

Attachments:

4.2.7.4 Maternity Management

4.2.7.4.1 Please identify and describe the services you provide through your maternity management program.

Answer: * Program Overview

One of the primary tools of successful maternity management is patient education. Our maternity Program, Active Maternity Management, supported by our ActiveAdvice Care Management System, contains an extensive assessment and educational information portfolio. As our maternity management nurse interacts with the expectant mother, the system identifies level of risk and appropriate educational material to be sent to the patient based upon risk assessment, lab tests, physician input, etc. Our information portfolio contains an extensive library of educational material developed by the American College of Obstetricians and Gynecologists (ACOG).

* Process for Identifying Eligible Enrollees

Plan design typically addresses identification by providing incentives for the mother-to-be that will motivate her to enroll and participate in the program. Identification of pregnant members may also occur through the utilization review process or referral by client, provider or member. To assure optimal impact of the program, members need to be identified and enrolled in the program by the 24th week of pregnancy.

* Enrollee Outreach Procedures and Program Materials

When an expectant mother is enrolled in the program, they are sent an acknowledgement letter followed by a contact from our maternity management nurse to perform an initial assessment. As our maternity management nurse interacts with the expectant mother, our system identifies level of risk and appropriate educational material to be sent to the patient based upon risk assessment, lab tests, physician input, etc. Our information portfolio contains an extensive library of educational material developed by the American College of Obstetricians and Gynecologists (ACOG) Publishing. ACOG publishes a broad array of patient education materials on pregnancy and childbirth-related topics that are suitable for women at all stages and risk-levels of pregnancy.

* Process for Assessing Risk Status and Needs

Using High-Risk Maternity Assessment templates in ActiveHealth's ActiveAdvice system, our maternity RN case manager assesses the member's current health status, focusing on the member's understanding of the pregnancy process and evaluating the risk level for complications of pregnancy, in particular pre-term labor. ActiveHealth's embedded assessment tool assists the maternity management nurse in evaluating the patient's current history, history of previous pregnancies, presence of co-morbid conditions such as diabetes and hypertension, and current lab and test values. Based on the results of the assessment, ActiveAdvice automatically scores the level of risk and builds an appropriate plan of care.

* Provider Interface

Our care managers work closely with the patient's provider as needed during the term of the maternity management process.

* Dedicated Program Staffing

High-risk maternity management is performed by our RN Case Managers who have a minimum of two to five years of obstetrical and maternity care experience.

* Case Management Process

Depending on the level of risk, the plan of care consists of various levels of interventions geared toward the member and provider. Many of these interventions are educational in nature, support communication between the patient and provider by making sure the patient is under appropriate care, and the provider is aware of the patient's risk factors.

If at any time during the program, the member's status warrants Case Management, the member will transition to the Case Management program with the maternity nurse providing a referral and potentially a warm transfer to the Case Management vendor to trigger an intervention.

* Post- partum Assessment, Education and Support

Our maternity Program provides for a post-partum follow-up call and assessment.

* Indicate the Use of Incentives

Clients typically offer a variety of enrollment incentives to their members, such as a car seat, reimbursement for physician office co-pays, waived facility co-pays for delivery, etc.

Attachments: [4.2.7.4.1 Harvard MATE Release FINAL\[1\].pdf](#)

4.2.7.4.2 How many years has your organization provided a maternity management program?

Answer: ActiveHealth's Maternity Management program has been operational for over 17 years, since 1995.

Attachments:

4.2.7.4.3 How many total covered lives does your maternity management program support?

Answer: ActiveHealth's maternity management program covers over 2.1 Million lives.

Attachments:

4.2.7.4.4 What percentage of members is in your maternity management program in a typical population?

Answer: Typically, engagement rates range between 11 percent and 24 percent. Actual client-specific engagement levels vary based on program promotion, frequency of communication, and incentives. Based on our experience, we have seen significantly higher engagement rates when incentives are being offered.

Attachments:

4.2.7.4.5 How many clients do you currently service in your maternity management program?

Answer: ActiveHealth serves 23 clients in our Maternity Management program.

Attachments:

4.2.7.4.6 Indicate any accreditations you currently hold SPECIFIC to your maternity management program.

Answer: ActiveHealth's disease management program is NCQA accredited, but we do not hold additional certifications specific to maternity.

Attachments:

4.2.7.4.7 Indicate which of the following components are included in your maternity program? (check all that apply)?

Answer: 1: All pregnancies, regardless of risk level, routinely work with a nurse care manager,
2: All pregnancies receive multiple screenings and assessments throughout the pregnancy,
3: All pregnancies receive routine educational mailings,
4: Educational mailings are customized based on risk factors to all pregnant members,
5: Educational mailings are customized based on risk factors to high risk pregnancies,
6: High-risk pregnancies receive multiple screenings and assessments throughout the pregnancy,
7: High-risk pregnancies receive routine educational mailings,
8: High-risk pregnancies routinely work with a nurse care manger,
9: Post-partum assessment and education for all pregnancies,
10: Post-partum assessment and education for high risk pregnancies

Detail:

Options:

1. All pregnancies, regardless of risk level, routinely work with a nurse care manager
2. All pregnancies receive multiple screenings and assessments throughout the pregnancy
3. All pregnancies receive routine educational mailings
4. Educational mailings are customized based on risk factors to all pregnant members
5. Educational mailings are customized based on risk factors to high risk pregnancies
6. High-risk pregnancies receive multiple screenings and assessments throughout the pregnancy
7. High-risk pregnancies receive routine educational mailings
8. High-risk pregnancies routinely work with a nurse care manager
9. Post-partum assessment and education for all pregnancies
10. Post-partum assessment and education for high risk pregnancies

Attachments:

4.2.7.4.8 Describe where the dedicated offices(s) will be located and the specific services managed at each location. Please indicate if you would be willing to locate offices in Juneau, Anchorage or Fairbanks.

Answer: ActiveHealth will provide staffing for the State's wellness program by both Alaska residents who will work in the Aetna office in Anchorage and Juneau as well as from their home office (once they pass our stringent work at home audit). Our instate staff will be further supported by clinical and operational staff in our Greenwood Village, Colorado office.

Attachments:

4.2.7.4.9 List how many staff members will be dedicated to the maternity management program.

Answer: We recommend a designated staff model because it provides flexibility in meeting staffing needs, resulting in better service.

Designated means there is a defined number of staff members whose primary responsibility is to support a particular account. This team would, as needed, have secondary and tertiary responsibility for other accounts within the group. We continually monitor volume and staffing.

Attachments:

4.2.7.4.10 What is the average caseload for maternity management nurses/coaches?

Answer: The average nurse to case load ratio for maternity management is approximately 1:75. Maternity management case managers also manage either disease management or case management to round out their case load as volume dictates.

Attachments:

4.2.7.4.11 Describe the minimum required credentials of a maternity management nurse.

Answer: High-risk maternity management is performed by our RN Case Managers who have a minimum of two to five years of obstetrical and maternity care experience.

Attachments:

4.2.7.4.12 Describe your training program for maternity management employees.

Answer: The initial training program is 120-hour course using interactive and didactic formats both in the classroom and online. The initial training program ends with an 8 hour practicum to demonstrate skill level. Topics covered in the initial training of our coaches and nurses includes an overview of systems, risk management, educational content review, principles of health coaching models, behavior change tools and techniques, call documentation, company mission and values. ActiveHealth provides ongoing training in each condition covered by our program, and rewards the pursuit of internal or

external certification. We also establish client-specific training so nurses and customer service staff are familiar with key program features, workflow customizations and plan documentation.

All Registered Nurses working for our disease management program start with three participant interaction audits per month. The number of monthly audits will increase to five per month when a staff member fails to exceed 90 percent of the performance measures associated with inbound and outbound calls.

Calls are constantly monitored for quality using a variety of methods to meet the developing needs of the staff. ActiveHealth Management has the ability to record and retrieve calls through its Centricity Product, provided by Envision Telephony, Inc. Centricity allows our calls to be recorded and saved 24/7 through a web-based product platform called Envision Centricity. This system also allows recording of the data entry by the staff into our medical management tool and standardized templates used to evaluate the quality of the call. Centricity provides: workforce optimization, including analytics, performance management, workforce management, quality monitoring and e-learning.

Centricity allows supervisors to listen to calls, save calls and send coaching packages to staff for learning purposes. Supervisors meet with their staff to review opportunities for development. In addition, we have one way silent monitoring for telephone calls, preceptor programs that utilize side by side reviews and management side by side reviews of the staff.

Attachments:

4.2.7.4.13 Explain any incentive programs you employ to retain competent maternity management employees?

Answer: ActiveHealth monitors success, provides continued education credits, pay increases and promotes our best nurses within a large dynamic organization.

Attachments:

4.2.7.4.14 During what hours/days of is the maternity management program available to members?

Answer: ActiveHealth disease management program operations center in Greenwood Village, CO is open from 4:30 am. to 7:00 pm. AKST, Monday through Friday; 5:00 am. to 10:00 am. AKST, Saturday.

Attachments:

4.2.7.4.15 How are calls “after-hours” of operation handled?

Answer: ActiveHealth offers an optional 24x7 nurse advice line for after hours triage, education, support and referrals to our regular disease management program. When a 24x7 nurse advice line is not in place, calls made after hours are referred to a voicemail system that allows for a time-stamped message directly to the maternity management nurse. Nurses respond to messages within one business day.

Attachments:

4.2.7.4.16 Is there a voice mail system or capability for callers to leave messages after normal business hours?

Answer: Yes; when a 24x7 nurse triage line is not in place, calls made after hours are referred to a voicemail system that allows for a timestamped message directly to the maternity management nurse. Nurses respond to messages within one business day.

Attachments:

4.2.7.4.17 Is there a ceiling on the number of maternity management cases you will manage for the State? If so, what is that limit?

Answer: There is no ceiling on the number of maternity management cases ActiveHealth will manage for the State.

Attachments:

4.2.7.4.18 Does your program include an Electronic Medical Record/Personal Health Record? If there is an additional cost, please indicate the cost on the rate sheet.

Answer: Yes; participants have access to our prepopulated Personal Health Record on the MyActiveHealth member website at no additional cost. Maternity participants can grant PHR access to their treating provider.

Attachments:

4.2.7.4.19 In general, how often are pregnant participants contacted by telephone by a nurse?

Answer: 3: Once each month

Detail: Follow-up calls are scheduled at appropriate intervals based on the member's risk level. If the member is determined to be at high-risk, the interactions with the member will occur monthly unless the member circumstances warrant more frequent contact. For members with moderate risk scores, follow-up calls occur every other month. For low risk scores, follow-up calls occur between 28-32 weeks, at 36 weeks, and post-partum.

Options:

1. Once per pregnancy
2. Once each trimester
3. Once each month
4. Bi-weekly
5. Weekly
6. Other, please specify: [Text]

Attachments:

4.2.7.4.20 Describe the interventions provided for members identified as low-risk.

Answer: All pregnant mothers are encouraged to take an assessment administered by our program. Based on results, a plan of care is developed to meet the participant's needs. For low risk scores, follow-up calls occur between 28-32 weeks, at 36 weeks, and post-partum.

The goals of the program include management of pregnant members to reduce the risks and costs associated with complications of pregnancy and premature birth. The program accomplishes this by continually assessing the member's risk status, then developing a personalized plan of care with interventions geared towards the member's risk, whether low, moderate or high.

A summary of our maternity program, including structure, scope and process, is as follows:

* Program Overview

One of the primary tools of successful maternity management is patient education. Our High-Risk Maternity Program, Active Maternity Management, supported by our ActiveAdvice Care Management System, contains an extensive assessment and educational information portfolio. As our high-risk

maternity case manager interacts with the expectant mother, the system identifies level of risk and appropriate educational material to be sent to the patient based upon risk assessment, lab tests, physician input, etc. Our information portfolio contains an extensive library of educational material developed by the American College of Obstetricians and Gynecologists (ACOG).

* Process for Identifying Eligible Enrollees

Plan design typically addresses identification by providing incentives for the mother-to-be that will motivate her to enroll and participate in the program. Identification of pregnant members may also occur through the utilization review process or referral by client, provider or member. To assure optimal impact of the program, members need to be identified and enrolled in the program by the 24th week of pregnancy.

* Enrollee Outreach Procedures and Program Materials

When an expectant mother is enrolled in the program, they are sent an acknowledgement letter followed by a contact from our high-risk maternity case manager to perform an initial assessment. As our high-risk maternity case manager interacts with the expectant mother, our system identifies level of risk and appropriate educational material to be sent to the patient based upon risk assessment, lab tests, physician input, etc. Our information portfolio contains an extensive library of educational material developed by the American College of Obstetricians and Gynecologists (ACOG) Publishing. ACOG publishes a broad array of patient education materials on pregnancy and childbirth-related topics that are suitable for women at all stages and risk-levels of pregnancy.

* Process for Assessing Risk Status and Needs

Using High-Risk Maternity Assessment templates in ActiveHealth's ActiveAdvice system, our high-risk maternity RN case manager assesses the member's current health status, focusing on the member's understanding of the pregnancy process and evaluating the risk level for complications of pregnancy, in particular pre-term labor. ActiveHealth's embedded assessment tool assists the high-risk maternity case manager in evaluating the patient's current history, history of previous pregnancies, presence of co-morbid conditions such as diabetes and hypertension, and current lab and test values. Based on the results of the assessment, ActiveAdvice automatically scores the level of risk and builds an appropriate plan of care.

* Provider Interface

Our care managers work closely with the patient's provider as needed during the term of the maternity management process.

* Dedicated Program Staffing

High-risk maternity management is performed by our RN Case Managers who have a minimum of two to five years of obstetrical and maternity care experience.

* Case Management Process

Depending on the level of risk, the plan of care consists of various levels of interventions geared toward the member and provider. Many of these interventions are educational in nature, support communication between the patient and provider by making sure the patient is under appropriate care, and the provider is aware of the patient's risk factors.

If at any time during the program, the member's status warrants Case Management, the member will transition to the Case Management program with the maternity nurse providing a referral and potentially a warm transfer to the Case Management vendor to trigger an intervention.

* Post- partum Assessment, Education and Support

Our High-risk Maternity Program provides for a post-partum follow-up call and assessment.

* Indicate the Use of Incentives

Clients typically offer a variety of enrollment incentives to their members, such as a car seat, reimbursement for physician office co-pays, waived facility co-pays for delivery, etc.

Attachments:

4.2.7.4.21 Describe the interventions provided for members identified as medium-risk.

Answer: All pregnant mothers are encouraged to take an assessment administered by our program. Based on results, a plan of care is developed to meet the participant's needs. For members with moderate risk scores, follow-up calls occur every other month.

A summary of our maternity program, including structure, scope and process, is as follows:

* Program Overview

One of the primary tools of successful maternity management is patient education. Our High-Risk Maternity Program, Active Maternity Management, supported by our ActiveAdvice Care Management System, contains an extensive assessment and educational information portfolio. As our high-risk maternity case manager interacts with the expectant mother, the system identifies level of risk and appropriate educational material to be sent to the patient based upon risk assessment, lab tests, physician input, etc. Our information portfolio contains an extensive library of educational material developed by the American College of Obstetricians and Gynecologists (ACOG).

* Process for Identifying Eligible Enrollees

Plan design typically addresses identification by providing incentives for the mother-to-be that will motivate her to enroll and participate in the program. Identification of pregnant members may also occur through the utilization review process or referral by client, provider or member. To assure optimal impact of the program, members need to be identified and enrolled in the program by the 24th week of pregnancy.

* Enrollee Outreach Procedures and Program Materials

When an expectant mother is enrolled in the program, they are sent an acknowledgement letter followed by a contact from our high-risk maternity case manager to perform an initial assessment. As our high-risk maternity case manager interacts with the expectant mother, our system identifies level of risk and appropriate educational material to be sent to the patient based upon risk assessment, lab tests, physician input, etc. Our information portfolio contains an extensive library of educational material developed by the American College of Obstetricians and Gynecologists (ACOG) Publishing. ACOG publishes a broad array of patient education materials on pregnancy and childbirth-related

topics that are suitable for women at all stages and risk-levels of pregnancy.

*** Process for Assessing Risk Status and Needs**

Using High-Risk Maternity Assessment templates in ActiveHealth's ActiveAdvice system, our high-risk maternity RN case manager assesses the member's current health status, focusing on the member's understanding of the pregnancy process and evaluating the risk level for complications of pregnancy, in particular pre-term labor. ActiveHealth's embedded assessment tool assists the high-risk maternity case manager in evaluating the patient's current history, history of previous pregnancies, presence of co-morbid conditions such as diabetes and hypertension, and current lab and test values. Based on the results of the assessment, ActiveAdvice automatically scores the level of risk and builds an appropriate plan of care.

*** Provider Interface**

Our care managers work closely with the patient's provider as needed during the term of the maternity management process.

*** Dedicated Program Staffing**

High-risk maternity management is performed by our RN Case Managers who have a minimum of two to five years of obstetrical and maternity care experience.

*** Case Management Process**

Depending on the level of risk, the plan of care consists of various levels of interventions geared toward the member and provider. Many of these interventions are educational in nature, support communication between the patient and provider by making sure the patient is under appropriate care, and the provider is aware of the patient's risk factors.

If at any time during the program, the member's status warrants Case Management, the member will transition to the Case Management program with the maternity nurse providing a referral and potentially a warm transfer to the Case Management vendor to trigger an intervention.

*** Post- partum Assessment, Education and Support**

Our High-risk Maternity Program provides for a post-partum follow-up call and assessment.

*** Indicate the Use of Incentives**

Clients typically offer a variety of enrollment incentives to their members, such as a car seat, reimbursement for physician office co-pays, waived facility co-pays for delivery, etc.

Attachments:

4.2.7.4.22 Describe the interventions provided for members identified as high-risk.

Answer: All pregnant mothers are encouraged to take an assessment administered by our program. Based on results, a plan of care is developed to meet the participant's needs. If the member is determined to be at high-risk, the interactions with the member will occur monthly unless the member circumstances warrant more frequent contact.

A summary of our maternity program, including structure, scope and process, is as follows:

* Program Overview

One of the primary tools of successful maternity management is patient education. Our High-Risk Maternity Program, Active Maternity Management, supported by our ActiveAdvice Care Management System, contains an extensive assessment and educational information portfolio. As our high-risk maternity case manager interacts with the expectant mother, the system identifies level of risk and appropriate educational material to be sent to the patient based upon risk assessment, lab tests, physician input, etc. Our information portfolio contains an extensive library of educational material developed by the American College of Obstetricians and Gynecologists (ACOG).

* Process for Identifying Eligible Enrollees

Plan design typically addresses identification by providing incentives for the mother-to-be that will motivate her to enroll and participate in the program. Identification of pregnant members may also occur through the utilization review process or referral by client, provider or member. To assure optimal impact of the program, members need to be identified and enrolled in the program by the 24th week of pregnancy.

* Enrollee Outreach Procedures and Program Materials

When an expectant mother is enrolled in the program, they are sent an acknowledgement letter followed by a contact from our high-risk maternity case manager to perform an initial assessment. As our high-risk maternity case manager interacts with the expectant mother, our system identifies level of risk and appropriate educational material to be sent to the patient based upon risk assessment, lab tests, physician input, etc. Our information portfolio contains an extensive library of educational material developed by the American College of Obstetricians and Gynecologists (ACOG) Publishing. ACOG publishes a broad array of patient education materials on pregnancy and childbirth-related topics that are suitable for women at all stages and risk-levels of pregnancy.

* Process for Assessing Risk Status and Needs

Using High-Risk Maternity Assessment templates in ActiveHealth's ActiveAdvice system, our high-risk maternity RN case manager assesses the member's current health status, focusing on the member's understanding of the pregnancy process and evaluating the risk level for complications of pregnancy, in particular pre-term labor. ActiveHealth's embedded assessment tool assists the high-risk maternity case manager in evaluating the patient's current history, history of previous pregnancies, presence of co-morbid conditions such as diabetes and hypertension, and current lab and test values. Based on the results of the assessment, ActiveAdvice automatically scores the level of risk and builds an appropriate plan of care.

* Provider Interface

Our care managers work closely with the patient's provider as needed during the term of the maternity management process.

* Dedicated Program Staffing

High-risk maternity management is performed by our RN Case Managers who have a minimum of

two to five years of obstetrical and maternity care experience.

*** Case Management Process**

Depending on the level of risk, the plan of care consists of various levels of interventions geared toward the member and provider. Many of these interventions are educational in nature, support communication between the patient and provider by making sure the patient is under appropriate care, and the provider is aware of the patient's risk factors.

If at any time during the program, the member's status warrants Case Management, the member will transition to the Case Management program with the maternity nurse providing a referral and potentially a warm transfer to the Case Management vendor to trigger an intervention.

*** Post- partum Assessment, Education and Support**

Our High-risk Maternity Program provides for a post-partum follow-up call and assessment.

*** Indicate the Use of Incentives**

Clients typically offer a variety of enrollment incentives to their members, such as a car seat, reimbursement for physician office co-pays, waived facility co-pays for delivery, etc.

Attachments: [4.2.7.4.1 Harvard MATE Release FINAL\[1\].pdf](#)

4.2.7.4.23 Does your maternity management staff have ready access to a High Risk Obstetrician or Neonatologist for consults?

Answer: Yes; our maternity management staff have ready access to a High Risk Obstetrician or Neonatologist for consultation. Our clinical management team is comprised of 18 Physicians, five PharmD Pharmacists and two clinical nurses. Physicians are onsite at each clinical operations center and also use evidence based protocols to develop standardized content for the various conditions addressed in our maternity, DM, lifestyle coaching and HRA programs. We review all program content on an annual basis and make updates based on changes in evidence based medicine and standards of practice promulgated by the various specialty groups, such as the American Diabetes Association. Additionally, updates are based on general program enhancements such as the addition of new clinical modules, scripts to support nurse educational intervention and brochures, which may be sent to members at the end of each engagement session.

Attachments:

4.2.7.4.24 If a member is actively engaged in maternity management and is admitted to the hospital, does the maternity manager continue to monitor the care and provide authorizations for inpatient care?

Answer: The maternity manager is able to monitor the care but does not provide authorizations for inpatient care. Authorizations would reside with the utilization management vendor as the hospital would call and send utilization management information to the utilization management vendor, not to the ActiveHealth maternity management program.

Should Aetna be awarded both the Medical and HCM service contracts, we can deploy our integration workflow assuring very tight coordination of the Utilization Management and Maternity cases. ActiveHealth also provides HCM service integration with other carriers and has extensive experience setting up warm transfers and bi-directional referrals. We provide access to our clinical system to other vendors for the purpose of tracking program participation and ease of online referrals.

Attachments:

4.2.7.4.25 What percentage of all pregnancies are managed in your maternity program in a typical employee population?

Answer: Typically, engagement rates range between 11 percent and 24 percent. Actual client-specific engagement levels vary based on program promotion, frequency of communication, and incentives. Based on our experience, we have seen significantly higher engagement rates when incentives are being offered.

Plan design typically addresses identification by providing incentives for the mother-to-be that will motivate her to enroll and participate in the program. Identification of pregnant members may also occur through the utilization review process or referral by client, provider or member. To assure optimal impact of the program, members need to be identified and enrolled in the program by the 20th week of pregnancy.

Attachments:

4.2.7.4.26 What metrics do you report on for both pregnant participants and pregnant non-participants?

Answer: ActiveHealth's portfolio will provide reporting which will reflect transactional elements as well as the overall success of the program (quarterly and annual) elements. ActiveHealth delivers a comprehensive quarterly report showing activity volume in the maternity management program.

Metrics including but not limited to: Identification, Outreach, Outcomes, and Risk. Reports are delivered 45 days after the end of the quarter.

Attachments:

4.2.7.5 Employee Assistance Program (EAP)

4.2.7.5.1 Please identify and describe the services you provide in your EAP.

Answer: The primary purpose of the EAP is to provide confidential and timely assistance to members who experience personal problems that may affect job performance or quality of life in general. As we all know, everyday life can present us with both unforeseen challenges and crisis situations.

We must not only meet the everyday issues that life presents, but we must also provide substantive support to our members during critical and potentially overwhelming times. To do so, Aetna Resources For Living incorporates both expertise and flexibility.

We recognize that the types of services we provide cannot reasonably be limited to a list. We will provide assistance for all such issues that arise out of the course of daily living. This may include, but is not limited to:

- Family and marital discord
- Work/school/other relationship issues
- Depression and stress management
- Anxiety
- Phobias
- Legal and financial problems
- Grief and bereavement
- Substance abuse
- Gambling and other compulsive behaviors

We know that, for an EAP program to be truly effective, members should use the program to help manage work and life issues before they become unmanageable. That's why Aetna has taken the

traditional EAP one step further and put an emphasis on motivating employees to use this important benefit. Our company philosophy is to extend support to every aspect of the member's needs, including areas that may not traditionally fall within the scope of EAP services, such as guidance toward other available benefits and services.

We treat every member with dignity, confidentiality and compassion and deliver all services with the members' needs at the heart of our work. We allow our members to lead or augment care by considering other important influences in their lives that may provide valuable support. We believe the best way to manage cost and care is in the right setting, with the right provider, at the right time.

The following are among the important highlights of our proposed program for State of Alaska:

- A variety of face-to-face session models
- Telephonic and on-site Crisis Response Services
- Web-based and on-site training
- Performance guarantees, offering up to 20 percent of our fees at risk
- A three-year rate guarantee to the State of Alaska to demonstrate our focus on partnering with you to achieve long term goals
- A designated account manager
- The option of an onsite EAP provider for State employees who can provide:
 - Onsite short-term counseling
 - Lunch & Learn trainings
 - Management consultation
 - Onsite promotion at trainings and health services events
 - Assistance with making arrangements with our service center for continued counseling
- Our unparalleled ability to identify members through medical, pharmacy and other data sources, proactively engage those at risk, and facilitate the full integration of services (Information and application will vary based on the benefits package purchased by the State.)
- Standard and customized promotional and educational materials

We have provided an attachment describing the full range of EAP services we offer to the State of Alaska - State of Alaska EAP Program.

Additional attachments include EAP Performance Guarantees, EAP Sample Communications, Hurricane Sandy EAP Communications and Sample Training Catalog.

Attachments: [Sample Training Catalog.pdf](#)
[Hurricane Sandy EAP Communications.pdf](#)
[EAP Performance Guarantees.pdf](#)
[EAP Sample Communications.pdf](#)
[State of Alaska EAP Program.pdf](#)

4.2.7.5.2 How many years has your organization provided an EAP?

Answer: We have been providing EAP services for over 25 years, since 1985.

Attachments:

4.2.7.5.3 How many total covered lives does your EAP support?

Answer: 20.5 million

Attachments:

4.2.7.5.4 What percentage of members participates in your EAP in a typical population?

Answer: Aetna Resources For Living is committed to maximizing utilization in order for our customers to receive the optimum return on their EAP investment. Our underwriting assumptions include an average overall utilization rate of 5.0 - 7.0 percent. This figure includes both telephonic and face-to-face counseling services. We would expect State of Alaska's use to fall within this range, which is also the industry standard.

Attachments:

4.2.7.5.5 How many clients do you currently service in your EAP?

Answer: We currently service 2,230 clients in our EAP.

Attachments:

4.2.7.5.6 Indicate any accreditations you currently hold SPECIFIC to your EAP program.

Answer: Aetna has been providing EAP services since 1985 under the auspices of Aetna Behavioral Health. We have been continuously accredited by the appropriate industry bodies. We now offer the Aetna EAP as a standalone product and program. We are confident that our program provides the highest quality EAP services to our clients.

Attachments:

4.2.7.5.7 Is your employee assistance program included in or separate from your managed mental health program?

Answer: We can provide an EAP program as an integrated or standalone program. Benefit integration is the cornerstone of our EAP benefit offering. We believe that an EAP can serve as the gateway to improved health and productivity. Aetna Resources For Living's EAP program fully integrates all facets of health and well-being; creating true value by capitalizing on synergistic opportunities between behavioral health care and medical, disability, wellness, disease management, and other future products. We have built this capability from a total customer, program, product, and systems perspective to create an experience for the end user that encourages full utilization of services. This approach is used to implement timely and effective integration of services to ensure that members are getting the care they need at the right place and right time. We also strive to ensure that members are aware of and can take advantage of the full suite of benefits made available to them through their employer.

The primary distinguishing feature of our EAP program is our ability to offer an integrated, "total health" experience. This approach can help enhance employee health, productivity and satisfaction, while potentially impacting overall health costs. Within this total health focus, our EAP can serve as a point of early intervention for many problems and issues - the "front door" of health care services - and triage them to the resources that can best meet their needs. Members who use the EAP may achieve positive results and a beneficial experience before problems escalate. EAP utilization may potentially mitigate the need to access behavioral health or medical benefits.

Attachments:

4.2.7.5.8 Do you provide all EAP services internally or are some services subcontracted?

Answer: Aetna Resources For Living does not subcontract the delivery of our basic EAP services, including telephonic access to licensed clinicians and face-to-face access to our network of contracted providers. These services are conducted in-house.

We provide access to EAP dedicated staff 24 hours per day, 7 days per week to provide confidential

and timely assistance to employees and household members experiencing personal problems. In addition, we have successfully built a proprietary network, consisting of over 48,000 providers nationwide.

We partner with other organizations to provide specific related services to our clients. We base vendor selection on our comprehensive due diligence assessment of their ability to administer the required services.

Legal/Financial Benefits - We use a seamless warm-transfer process to provide legal and financial services through the same toll-free number used for EAP benefits. Our partner, CLC Inc. provides legal and financial services. Its national office is located in Granite Bay, CA.

The national network of more than 20,000 attorneys includes members of medium-sized law firms with a minimum of five years' experience in family law, real estate, probate, contract, consumer, and criminal legal matters. Attorneys must be fully licensed and qualified and cover the US, Canada, Puerto Rico and Virgin Islands.

The initial financial consultation is provided by one of 17 in-house specialists. Additional resources may include Consumer Credit Counseling, United Way, Catholic Charities, etc.

Backup Crisis Response Services - We provide Crisis response services through our national network and, where necessary, in partnership with Crisis Care Network (CCN). This ensures our members that these important services will be available when and where needed.

CCN is a distinguished provider of comprehensive crisis response services located in Grand Rapids, Michigan. This relationship became effective with the implementation of our program on July 1, 2004. We have aligned with this industry leader in this specialized field in order to allow our participants to have access to the most professional, contemporary and geographically diverse services available. CCN has ample national network coverage, with clinicians fully trained in the crisis response field.

We contract nationally with American Substance Abuse Professionals (ASAP) to enhance our substance abuse training network and provide Substance Abuse Professional (SAP) referrals. ASAP is continuously locating and recruiting qualified substance abuse professionals, as well as identifying areas that are in need of expanded coverage. ASAP has 1,575 counselors available nationwide (as of June 2012).

Attachments:

4.2.7.5.9 Is your organization willing to modify aspects of the EAP program per direction from the Project Director?

Answer: Yes. We provide a Designated Account Executive who will work with your Project Director during implementation to coordinate specific areas of the EAP that allow customization such as the website, communication materials and the addition of information that will make it easier to direct employees to those resources that can best serve their needs.

Attachments:

4.2.7.5.10 How many hours of training/onsite services are provided in the contract?

Answer: A pool of twenty (20) hours of on-site or web-based training is offered as an option.

Attachments:

4.2.7.5.11 Describe where the dedicated offices(s), if any, will be located and the specific services managed at each location. Please indicate if you would be willing to locate offices in Juneau, Anchorage or Fairbanks.

Answer: Our operational service strategy uses a virtual call center model which allows us to have full access to all of our counselors in all time zones. Call Center locations include San Diego, Denver, Dallas, Austin and Hartford. This model increases operational efficiencies and enhances overall member experience by providing the right call routing based on customer preferences and needs.

For our service model, we take a service/skill approach rather than a geographical approach. Our virtual call center allows us to take full advantage of the efficiencies we have to offer our customers. Instead of limiting calls to one specific location, we have counselors located across time zones that are linked through a consistent platform and technology and are available for call routing based on skill sets and functions. We have found numerous advantages including:

- Greater flexibility - The first available counselor will get the call and handle it as quickly as possible.
- Increased member experience - We route each call immediately to the first available counselor decreasing any wait time.
- Maximizing resources - We provide optimal coverage in all time zones, 24/7.
- Operational efficiencies - Our virtual call center allows us to provide consistency and increased performance.
- Business Continuity - Our virtual call center allows us to avoid any disruption from power outages or natural disasters.

We also offer as an option an on-site EAP provider (20 Hours Per Week). This Master's-level clinician familiar with Aetna and Active Health will cross promote programs and resources, providing in-person counseling sessions, training and program integration.

Aetna's ability to customize our services to meet the State's current and future needs is unmatched. Our vision for the State of Alaska's EAP program is based on our unique understanding of government programs and needs. We provide EAP services to more than 120 state, county and municipal agencies with over 328,000 covered employees. We coordinate care in many of those programs to raise the visibility of the EAP by connecting it with already recognizable and well communicated program elements such as ActiveHealth without creating another level or vendor in the employee benefits matrix. We are uniquely positioned to support an onsite EAP provider to serve at key State health services locations should the State choose this option. The on-site EAP provider, trained by Aetna and ActiveHealth Management, will cross promote programs and medical plan resources, provide in-person counseling sessions and assist with coordination of training and other services.

The onsite counselor is provided at a cost per 20 pooled hours plus travel. Travel costs are \$50 per hour within Anchorage, Fairbanks and Juneau or at cost elsewhere within the state. Costs apply per clinician. On-site providers and services are subject to availability. Hours apply per clinician. Additional travel costs may apply where overnight, extended travel or a specialist not otherwise available is required.

Attachments:

4.2.7.5.12 List how many staff members will be dedicated to the State's EAP plans.

Answer: We recommend a designated staff model because it provides flexibility in meeting staffing needs, resulting in better service.

Designated means there is a defined number of staff members whose primary responsibility is to support a particular account. This team would, as needed, have secondary and tertiary responsibility for other accounts within the group. We continually monitor volume and staffing.

Attachments:

4.2.7.5.13 Describe your training program for EAP employees.

Answer: Our call center staff members include customer service associates (CSAs) and Master's level, licensed clinicians. All staff must complete an in-depth, 240-hour training program to learn about all of our EAP processes and practices. As the calls that require the most sensitivity to detail are those involving crisis intervention or emergency assistance, particular attention is provided to this topic within the initial training program, as well as on an ongoing basis during team-specific sessions.

As part of their continuing development, all EAP staff receive annual training on handling crisis calls. We require clinicians to obtain continuing education credits (CEUs) on an annual basis in accordance with their state licensure standards. This is to ensure that our staff maintains CEUs in their area of specialty as a component of their annual individual performance expectations.

Supervision of both CMAs and clinicians begins in the initial training and continues on an ongoing basis for quality assurance and training purposes. EAP staff have one-on-one supervision for their initial few days to ensure that they are aware of, and able to, address caller needs quickly and within Aetna's quality standards. We provide staff with a mentor for the first few months of employment to assist with handling a variety of cases and issues. EAP clinicians also participate in monthly clinical case reviews with a psychiatrist when addressing complex cases and for performance measurement purposes.

This type of supervision, along with call monitoring, allows EAP management to review staff performance on a routine basis and to provide ongoing training and recommendations to enhance the delivery of services.

In addition, we generate training alerts on a weekly basis communicating process and procedure changes.

Attachments:

4.2.7.5.14 Are client specific toll-free numbers available?

Answer: Yes.

Attachments:

4.2.7.5.15 Who is the member's first point of telephone contact?

Answer: Customer Service Associates initially respond to all calls. Our EAP Master's-level clinicians provide telephonic consultative services.

Attachments:

4.2.7.5.16 What are minimum credentials of staff assigned to the 24-hour intake line?

Answer: Our clinical staff provide telephonic consultative services. They are licensed behavioral health clinicians with a minimum of three years of advanced clinical practice. A Master's degree in a social science is required, with certification in EAP services (CEAP) preferred. We train all clinicians in Motivational Interviewing, a client-centered counseling style for eliciting behavior change.

Also available are Customer Service Associates (CSAs). All CSAs must have a minimum of a high school education, as well as substantial call center experience. Those who have completed, or are currently enrolled in, a college program (or have a BSW) are preferred and are aggressively sought. Intake staff must also have an outstanding telephone voice, be customer-oriented, and demonstrate excellent listening skills. Our CSAs have extensive background in call center services and have received specialized training regarding the needs of employee assistance customers.

Attachments:

4.2.7.5.17 Describe your organization's assessment and referral services, specifically outlining the procedures used. Explain your review criteria and how they were developed.

Answer: When a member calls Aetna Resources For Living, we conduct the following services:

Intake - We provide members with a toll-free access number, which is available and staffed with clinicians, 24 hours per day, 365 days per year. After a brief screening by customer support associates, all callers are given access to licensed behavioral health professionals.

Assessment - After the initial intake, the EAP clinician conducts a comprehensive assessment that takes the member through an interview spanning a full range of clinical criteria, including a risk assessment that collects information to identify possible problems and explore the existence of the following:

- Medical co-morbidity
- Work related stressors
- Home and support system issues
- Socio-economic issues
- Legal or other stressors and issues

Rather than take the member through a rote question-and-answer tool, the clinician uses an interactive approach to cover the information needed and determine the presenting problem. The clinician will also seek to identify any underlying problems.

At each contact with an individual, our goal is to provide a personalized approach that helps resolve or address identified needs in the most efficient way possible. Our systems, tools and service delivery approach help our team proactively engage and identify targeted solutions that impact the individual's overall well-being. This approach enables us to measure the impact we are having with each contact.

One of the tools we use to assess our impact is Aetna Resources For Living's innovative SIGNAL® System (SIGNAL). SIGNAL provides statistically valid feedback to clinicians and members about their individual distress levels and improvement in global functioning. This lets each know how effective the services being provided are improving their distress levels and whether other services may be indicated. Supported by the SIGNAL System, we can also report back to the member and NNN Company that what we are doing is working.

Through SIGNAL, we measure the quality of the care as well as the quality of the relationship on a session by session basis. Four core global functioning questions (a self-assessment on the member's sense of well-being and emotional distress) are asked at the beginning of each session measure the progress the client is making with immediate feedback to the counselor - if the client is not making the expected change, or is regressing. In this way the counselor can alter, in the moment, the work being done to better accommodate the client's needs. Referrals are made within our network or to outside resources within 24 hours. All of our counselors are licensed, Masters-degree level, fully credentialed

behavioral health professionals.

We assess six primary dimensions in the first contact to identify barriers and individual client needs within each dimension. We then integrate these into a plan of care. The primary dimensions assessed in the initial contact include:

- Acute Intoxication Or Immediate Response Or Imminent Danger Risks
- Biomedical Conditions/Complications
- Emotional, Behavioral/Cognitive Impairments, Conditions Or Complications
- Emotional Distress And Global Functioning
- Readiness For Change
- Social Environment

Referral - If the participant elects, or is encouraged, to pursue treatment through face-to-face services with an EAP affiliate or provider, whenever possible, we provide the member with the option of several providers in their geographic area from which to choose.

The affiliate provider, along with the member, develops a treatment plan that includes resolution through short-term problem-focused interventions. If the problem is systemic, the plan includes services for a more prolonged period using the member's medical or behavioral health benefit plan.

All providers within our EAP network are a sub-group specialty within Aetna's behavioral health network. The EAP sub-group is made up of providers with a minimum requirement of a Master's-level education, licensure and experience in delivering short term treatment focused services that are in line with EAP industry expectations. Additionally, the EAP providers have specialties in areas such as marriage and family therapy, substance abuse counseling, adult or adolescent therapies. The referral to an affiliate provider is guided by the nature of the member's problem(s) presented.

Attachments:

4.2.7.5.18 Describe your treatment protocol for critical incidence intervention. Define the resources and treatment options that will be available to employees in the event of a crisis.

Answer: Should the State of Alaska have the unfortunate experience of a catastrophic workplace incident, such as a crime, death of an employee or other workplace trauma, the toll-free number will give you access to services for Workplace Crisis Response Programs. Unlimited telephonic assistance is provided by Management Consultants (MCs) specifically trained to assist with critical incidence intervention, substance abuse issues and management referrals.

MC Specialist Benita Rabinovich leads the Crisis Response team. Benita is Critical Incident Stress Debriefing certified and a Licensed Professional Counselor (LPC).

During a natural disaster such as Hurricane Sandy, MCs routinely meet with HR and administrative staff to review EAP benefits, consult on risk management advice related to EAP and recommend additional local, state and federal organization/agency resources. Our worklife and marketing teams worked with local, county, state and federal authorities to get materials and information to our members during Hurricane Sandy. Please see the attachment: Hurricane Sandy EAP Communications. These assisted with the most basic information: how to keep from getting scammed; how to find a gas station.

At that time, it was what our members needed, when they needed it. There is no routine disaster or crisis.

There are, however, people like Benita and her team who have dealt with these events over the years and done so with compassion and professionalism. They will be there for your employees and their dependents when you need them.

Upon receipt of such a Crisis Response Call, the EAP clinician or your assigned EAP account manager will assess the severity of the situation and advise the caller accordingly. If on-site services are necessary, the clinician or account manager will make the necessary arrangements.

If resources are necessary at a work location for the purpose of crisis debriefing and management, we partner with Crisis Care Network (CCN), a distinguished provider of comprehensive crisis response services. CCN has ample national network coverage, with clinicians fully trained in the crisis response field. CCN normally can provide onsite workplace crisis interventions within 24 to 72 hours of the incident. Conducted with individuals or groups, these interventions usually take one to three hours of onsite time and have proven highly effective in reducing the impact of trauma-related symptoms and accelerating return to work and life.

We have provided a pool of twenty (20) on-site hours of Crisis Response Services as an option.

CCN has a network of approximately 5,000 licensed or certified clinicians practicing nationally. All specialists must possess:

- Masters or Doctoral degree in a Mental Health Related Field
- Licensure or Certification to Practice-Independent Practice Privileges;
- Professional Liability Insurance
- Experience in delivering Workplace Crisis Response Services
- Specialized training consistent with Evidence Based Best Practice Standards, as supported by NIMH guidelines

CCN offers a full continuum of crisis response services and selects appropriate supportive interventions based on a variety of factors including type and severity of incident and number of affected individuals. Interventions include:

- Pre-incident training, consultation, and policy development
- Teledefusing
- Crisis Management Briefings
- Onsite Defusing
- Onsite Debriefing
- Onsite 1:1
- Onsite follow-up
- Crisis recovery handouts
- Web based resources
- Telephone follow-up/consultation and
- Referral

Aetna Resources For Living and Crisis Care Network are committed to serving as trusted partners in delivery of this important work. We understand the high impact and visibility of critical incidents and realize that services must be consistent with your established protocols.

Follow-Up

When a clinician responds to a critical incident, we will contact the client after the incident to evaluate

the services and determine if additional services are necessary.

In addition, CCN supports the employer's role in assessing the need for follow-up care and referring to its qualified affiliates by offering easy access to a widely-accepted, clinically-tested, brief, post-traumatic stress debriefing assessment.

Attachments: [Hurricane Sandy EAP Communications.pdf](#)

4.2.7.5.19 Describe how you would deliver crisis intervention services to five employees in Kotzebue, AK and the time frame for such delivery starting from the time of initial outreach

Answer: As your EAP provider, we will be familiar with your policies and procedures for handling crisis situations and committed to providing the service you need and expect.

Services would begin immediately with telephonic services provided by our Management Consultants (MCs), Master's-level clinicians specifically trained to assist with crisis response, substance abuse and management services. An MC would be available telephonically 24/7 and would begin coordinating services with our national Crisis Response partner, CCN, who has 30 Crisis providers in Alaska. None of these are currently in Kotzebue, and it would be necessary to fly a clinician to Kotzebue. Most onsite services can be provided within 24 to 72 hours.

The MC will coordinate a prompt, customized response to help your organization minimize the damage and return members to normal levels of productivity. The MC will provide assistance in assessing the type of response most appropriate for the situation and for your organization's work environment. When an onsite response is warranted, the MC will provide guidance in determining which type of onsite response would be most appropriate.

The following is a step-by-step process outlining the Critical Incident Response Service process:

- Request for Services - Following a catastrophic or traumatic event, your authorized representative(s) calls your toll free number and accesses 24/7/365 crisis management services.
- Telephone Assessment - The MC will immediately assess the situation and consult with your organization's representative focusing on calming the caller, gathering pertinent information and developing a detailed plan.
- Communication Pieces - The MC will email helpful documents from our resource library to be immediately available for supervisors and employees to help prepare for onsite services.
- Intervention Plan - The MC will coordinate the arrival of an onsite counselor as well as help structure management's approach for dealing with the situation. They will guide and support management in preparing for the arrival of our crisis response provider.
- Crisis Response Service Provider - A certified crisis response provider will be dispatched to the site. The MC usually schedules a crisis response service at the worksite with a group of employees directly impacted by a critical incident as soon as clinically necessary following the traumatic event.
- Group Debriefing - Where appropriate, the provider will speak to all of the affected individuals as a group.
- Individual Meeting/Assessment - The provider will be cognizant of any employee(s) that may need individual counseling and assure that the employee(s) receive access to the most immediate and appropriate clinical attention needed.
- Follow-Up - The MC will remain in contact with your key contacts within your organization for as long as is necessary to resolve issues related to the crisis. EAP will follow up with the provider, company contact and your onsite representative to determine if any further services are needed.
- Report - If requested, a report detailing the clinical response, outcome and any further recommendations can be written and sent to the corporate representative who requested the

intervention.

- Quality Assurance - A follow-up online accessible quality assurance survey will be emailed to the company contact.

We have offered a pool of twenty (20) hours of Crisis Response Services. Or, the State can choose to provide these services on an hourly rate.

Attachments:

4.2.7.5.20 Describe the services and training/workshops you can provide the State through local network practitioners for promotion of mental wellness and prevention of mental health problems and substance abuse. This includes but is not limited to supervisory training of State employees to identify, document, and refer substance abuse cases for proper treatment.

Answer: Aetna Resources For Living has developed a library of presentations and topics that appeal to both our plan sponsors and members which we continually update and expand. Topics include Alcohol and drug-free workplace training for employees and managers, stress, wellness, and topics as diverse as Post Traumatic Stress Disorder (PTSD) and Etiquette in the Workplace. Our goal is to take a fresh look at typical topics, such as stress and change management, and make those trainings more engaging and relevant. We have attached a copy of our 2012 Training Catalog.

We contract nationally with American Substance Abuse Professionals (ASAP) to enhance our substance abuse training network and provide Substance Abuse Professional (SAP) referrals.

Attachments: [Sample Training Catalog.pdf](#)

4.2.7.5.21 Describe how you will coordinate EAP services with Managed Mental Health services including handling transition of member care from EAP to MMH when appropriate.

Answer: At Aetna Resources For Living, the EAP can serve as the gateway to care. EAP clinicians assess members and refer them to EAP providers for urgent and routine services. Members begin the treatment process by using their EAP sessions. If a member requires services in excess of the EAP sessions, the member's behavioral well-being benefit provides those additional services. This allows members whose needs can be met through short-term solution-focused services to obtain necessary services. It also enables those members who would benefit from additional services to obtain assessment and initial treatment services from qualified providers.

Our clinical staff members thoroughly evaluate the needs of the member and craft intervention strategies accordingly. We train our staff to coordinate the use of the EAP and the behavioral health/medical benefit plan and to work closely with their counterparts in these fields to ensure the delivery of effective, integrated services. As over 97 percent of our EAP providers are also part of our behavioral health network, the process of transitioning from EAP to behavioral health benefits is transparent to the member. The member continues to receive services from the provider, while the provider simply begins to submit claims under the member's behavioral health benefits. There are no issues with transitioning from an EAP to a behavioral health provider and there are cost-efficiencies related to using EAP sessions as the initial point of assessment.

Attachments:

4.2.7.5.22 Provide the total number of Alaska contracted EAP practitioners in your current network, by location.

Answer: Anchorage, 10; Eagle River, 2; Fairbanks, 4; Homer, 1; Juneau, 3; Kenai, 1; Ketchikan, 1; Kodiak, 1; Palmer, 2; Sitka, 1; Soldotna, 4; Wasilla, 2

Attachments:

4.2.7.5.23 Explain how providers are selected and screened for proficiency in their specialty and provide the average experience level of the various mental health professionals.

Answer: Providers seeking participation in our network must submit an application and successfully complete the credentialing process. We ensure that we are in receipt of all applicable information about the provider's practice, including specialties and languages spoken. Prospective network clinicians must include primary verification of all credentials, including evidence of malpractice insurance coverage.

All network providers must be able to provide individual therapy sessions.

We begin the selection and credentialing procedures in the following situations:

- Contact of specific practitioners and/or provider groups meeting our practitioner specialty needs in a given market
- Practitioner and/or provider group contacts us or designee noting interest in joining our network
- Review of network need for the specialty is made through a standardized process to determine the pursuit of the requesting practitioner or group
- Contact of specific practitioners and/or provider groups a customer refers

Credentialing Process

The practitioner completes the standardized credentialing application to include a current practitioner signature attesting to the following:

- Reasons for any inability to perform the essential functions of the position, with or without accommodation
- Lack of present illegal drug use
- History of loss of license and felony convictions
- History of loss or limitation of privileges or disciplinary activity
- Current malpractice insurance coverage
- The correctness and completeness of the application

Primary verification of the following is submitted when applicable to the practitioner specialty:

- Educational degree
- Licensure
- Agency (DEA) and/or Controlled Dangerous Substances (CDS) registration
- Board certification (physicians only)
- Education and training specific to the specialty
- Work history
- Malpractice insurance
- Liability claims history
- License sanctions

- Medicare/Medicaid sanctions

The peer review committee reviews all completed credentialing applications and credentialing files for approval. Where credentialing results do not meet standard credentialing requirements, the committee performs focused peer review as needed.

We notify the practitioner in writing of the peer review committee decision.

The accepted practitioner completes the contracting process and, upon contract execution, we enter practitioner specific data allowing the practitioner to begin receiving referrals.

We review ongoing monitoring of participating practitioner Medicare and Medicaid sanctions on a monthly basis.

We review ongoing monitoring of participating practitioner state sanction information based on the frequency of the release of the information from the applicable state.

All EAP providers are also subject to complete review during the recredentialing process. We request, review and analyze the same data as during the initial credentialing process. Recredentialing occurs at least every three years, depending upon specific state requirements.

Attachments:

4.2.7.5.24 How much notice is a provider contractually required to give if he/she elects to terminate contract with your network?

Answer: Either party may terminate this Agreement without cause at any time by providing at least ninety (90) days advance written notice to the other party.

Attachments:

4.2.7.5.25 Provide the total number of contracted EAP practitioners in your current network in the other 49 states.

Answer: 46,885

Attachments:

4.2.7.5.26 Indicate whether the network(s) is owned by you or by another organization. Describe your relationship with that network, if it is not owned by you.

Answer: Aetna Resources For Living owns its network.

Attachments:

4.2.7.5.27 How quickly is a member informed when his/her provider has left the network?

Answer: We notify affected members at least 30 days in advance, by letter, of a practitioner's termination.

Attachments:

4.2.7.5.28 What percentage of members participate in the EAP in a typical employee population?

Answer: While we assume an average overall utilization rate of 5.0 - 7.0 percent, we know that employees use the EAP for a much wider range of resources than those telephonic and face-to-face services surrounding substance abuse, stress and other behavioral issues. Your Account Manager will review quarterly and annual reports to determine what services employees are using, and how well we are doing in providing those services. Items tracked include annualized utilization for EAP, worklife,

legal/financial and management consulting components as well as web use, crisis response services, trainings, sessions used, demographic information, satisfaction rates, call volumes, Average Speed of Answer, service levels, and abandonment rates. We also know that each population differs based on unique needs and culture. We will provide a customized communication plan that helps drive utilization. This will include a reasonable quantity of printed materials in support of implementation and/or on an annual basis at your request at no cost. Reasonable quantities are defined as up to 120% of the number of eligible employees for items such as flyers or brochures; a quantity up to 5% of the number of eligible employees for items such as posters; and a quantity of up to 20% of anticipated attendees at health fairs for other promotional items. Requests exceeding these quantities may incur an additional fee.

Attachments:

4.2.7.5.29 For the EAP benefit, please indicate the average number of face-to-face visits per unique episode of care within the last 12 months?

Answer: 2.85 (2011 - 2012 annual figures not yet available)

Attachments:

4.2.8 Quality Control (use tables provided in Attachment G3)

4.2.8.1 Please explain in detail how you will evaluate and report to the State your performance under the Contract. Specifically, identify and describe, by function, how each aspect of the work set forth in Section 1.04 of the RFP instructions relative to the HealthCare Management component will be evaluated for effectiveness and efficiency. For each function, please provide the following evaluative information:

- A detailed description of each performance standard you will utilize to evaluate each functional component for effectiveness and efficiency.
- The benchmark measurement for each identified performance standard for each functional component.
- The frequency of reporting to the State your evaluation of each identified performance standard for each functional component based on the standards and benchmarks you utilized to determine effectiveness and efficiency.
- Which standards you are willing to subject to penalty for failure to meet.
- Whether the evaluation of each standard will be conducted by your organization or will be conducted by an independent external organization.

Answer: Please refer to our response to Attachment I3 - Healthcare Management Implementation and Performance Guarantees, showing ActiveHealth's care management performance guarantees for the information requested in this question.

We will measure success by engagement, clinical outcomes, return on investment and other aspects such as client and member satisfaction. Success requires the technology, data aggregation expertise and clinical depth, converting engagement to improvement in outcomes and present the data to our clients in a usable format. We have a dedicated staff that develop and produce all reporting that include medical informaticists, analysts and members of our finance team. We are fully transparent in our reporting so the State is not left guessing about the financial, clinical and operational outcomes of the healthcare management programs.

Attachments:

4.2.8.2 Are you willing to place fees at risk for meeting certain performance standards and guarantee outcomes under the Contract?

Answer: 1: Yes

Detail: While we have a standard list of performance standards included with this RFP we have included a more focused list we recommend for the State attached here. This file includes not just what performance standards we would recommend, but we've also included a pricing and guarantee strategy that aggressively holds us accountable for optimal performance as well as stretch goals that would guarantee the State only pays for the highest level of outcomes. We would look forward to the opportunity to discuss our proposal in detail.

Options:

1. Yes
2. No

Attachments:

4.2.8.3 Are you willing to guarantee savings in this proposal? If so, please explain.

Answer: Yes; we are absolutely willing to guarantee savings in fact we have included a pricing and guarantee strategy that aggressively holds us accountable for optimal performance as well as stretch goals that would guarantee the State only pays for the highest level of outcomes. We would look forward to the opportunity to discuss our proposal in detail.

We standardly use a program-wide method to calculate cost savings - a Health Economic Model (HEM) to estimate savings from the CareEngine (which underlies all of our health management programs), methods to measure or estimate the additional value of disease management, lifestyle coaching and maternity - varying by the size of the population being served. Please refer to the attached savings methodology exhibit for a detailed overview of our ability to estimate savings.

Attachments: [4.2.8.3 Savings Methodology.docx](#)

4.2.8.4 When are performance penalties paid out?

Answer: Please refer to our response to Attachment I3 - Healthcare Management Implementation and Performance Guarantees, showing ActiveHealth's care management performance guarantees and pay out information requested in this question.

Attachments:

4.2.8.5 Can tracking and reporting of the performance standards be based on State-specific data?

Answer: Yes; elements tracked will be based upon State-specific data.

Attachments:

4.2.8.6 Please confirm that you will permit and cooperate with internal audits on any aspect of the administration of the program, as the State determines to be necessary and appropriate. State personnel or outside auditors that the State selects may perform these audits, including audits that may take place after the end of the contract period.

Answer: Confirmed; We will permit and cooperate with internal audits on any aspect of the administration of the program, as the State determines to be necessary and appropriate - as defined within our service agreement with the State.

Attachments:

4.2.8.7 Please confirm that you will provide claims, payment documentation and other necessary information required for the State to complete its annual health funds audits.

Answer: Confirmed; We will provide claims, payment documentation and other necessary information required for the State to complete its annual health funds audits - as defined within our service agreement with the State.

Attachments:

4.2.8.8 Please indicate whether or not you agree with the following statements regarding Audits.

	Agree
You will allow auditing of your operations as they relate to the administration and servicing of this account.	1: Agree
Your organization will not charge for services rendered in conjunction with the audit.	2: Disagree
If problems are discovered, follow-up audits will be paid by your organization.	2: Disagree

Detail: We will likely not charge for audits but as the State can understand we would need to have some parametrs regarding "services rendered in conjunction with the audit."

Attachments:

4.2.8.9 Do you have a dedicated internal audit staff?

Answer: 1: Yes

Detail: We have a quality department that manages our regulatory and client audits along with our operational leadership.

Options:

1. Yes
2. No

Attachments:

4.2.8.10 What percentage of member calls is monitored?

Answer: All calls are recorded. The percentage of audits will vary based on the experience and success of the staff member:

- 100 percent of a new employee's calls are audited until they reach the 90 percent performance threshold.
- The RN call monitoring frequency is a combination of three to five audits per month per employee for all lines of business once an employee has reached a 90 percent acceptable performance score.
- The Customer Service call monitoring frequency is 15 audits per month per employee for all lines of business.

Additionally, our Medical Directors audit 60 randomly selected RN cases per quarter.

Attachments:

4.2.8.11 How long are recorded calls maintained?

Answer: Recorded calls are maintained for as long as clients require, often over six years. ActiveHealth Management has the ability to record and retrieve calls through its Centricity Product, provided by Envision Telephony, Inc. Centricity allows our calls to be recorded and saved 24/7 through a web-based product platform called Envision Centricity. This system also allows recording of the data entry by the staff into our medical management tool and standardized templates used to evaluate the quality of the call. Centricity provides: workforce optimization, including analytics,

performance management, workforce management, quality monitoring and E-learning. Centricity allows supervisors to listen to calls, save calls, and send coaching packages to staff for learning purposes. Supervisors meet with their staff to review opportunities for development. In addition, we have one way silent monitoring for telephone calls, preceptor programs that utilize side by side reviews and management side by side reviews of the staff.

Attachments:

4.2.9 Data Analysis

4.2.9.1 Data Collection

4.2.9.1.1 Provide a brief example of when you shared participation data or referrals to a data aggregator or vendor partner in any care management area (case management, disease management, wellness, etc).

Answer: To facilitate ongoing flow of participation data, we have set up completely integrated workflows, web portal access and data feeds for our clients' third-party vendors, easing the referral and transfer processes thereby creating a seamless, best in class, member experience.

During the implementation process we define the criteria and processes for integration with the plan sponsor's other vendors including the medical carrier, UM/CM, EAP, wellness/disease management, disability, etc. We use warm transfers as well as secure email and fax to support referral processes. We establish a case conference / grand rounds process with other vendors as well as establish ad-hoc processes for connecting with other vendors should issues arise outside of the grand round conference schedule. We also can share a summary level view into our care management workflow platform using our application ActiveAdvice View. This allows external entities who meet the requirements for access to member data to view eligibility for and participation status in various care management programs, as well as utilization and authorization details.

Attachments:

4.2.9.1.2 Provide a brief example of when you accepted participation data or referrals from a data aggregator or vendor partner (case management, disease management, wellness, etc).

Answer: As an example of our ability to seamlessly integrate data, we note that ActiveHealth collects data from twelve health plans and other vendors for one of our clients. The key to the success of the project has been the consistent coordination of data transfer schedules across the various vendors. Ensuring that data are received according to a mutually agreed upon schedule enables us to meet the data update times per our agreements. For many of our clients, we've customized our technology platform and designed workflows to match their specific business models and to tie in directly to their required reporting and confidentiality requirements.

ActiveHealth develops fully integrated, seamless member experience processes with other health plans, PBMs, and lab vendors as well as HRA, wellness/lifestyle, behavioral, and disability programs. This includes shared access to CareEngine data and Care Considerations, cross-referral capabilities, and customized workflows to facilitate shared responsibility.

Attachments:

4.2.9.1.3 Explain whether your organization will release detailed claims data to a central data warehouse for non-AlaskaCare health plan related analysis. Indicate if you are paid to provide this data.

Answer: Yes; We will release detailed claims data to a central data warehouse for non-AlaskaCare health plan related analysis.

Attachments:

4.2.9.1.4 Do you utilize a data warehouse for reporting and claim and trend analysis?

Answer: Yes; We utilize an internal warehouse for reporting and analytics. We can also make this warehouse and extensive reporting capabilities available to our clients. This service is called ActiveAnalytics, powered by the DART data warehouse for reporting and claim and trend analysis. This service is available for an additional fee detailed on our rate sheet.

Attachments:

4.2.9.1.5 If yes, please provide the name of the warehouse and indicate if the State will have access to data and reporting. If there is an additional cost, please indicate the cost on the rate sheet.

Answer: Yes; ActiveHealth provides a service called ActiveAnalytics, powered by the DART data warehouse for reporting and claim and trend analysis. This service is available for an additional fee detailed on our rate sheet with the option for the State access to data and reporting for desktop reporting.

Attachments:

4.2.9.1.6 Describe your organization's data warehousing and population health analytical services, including software used.

Answer: facilitate more informed, strategic decisions. This offering can help you learn from your benefit plan's past, understand where it is presently and manage future change. In addition, our Active Performance MeasuresSM is designed to provide quantitative assessments of quality of care across multiple networks and physicians by comparing this data to evidence-based standards.

By leveraging these tools and ActiveHealth's clinical analytics experience, our customers can rapidly deploy and adjust their population health strategies to promote quality of care and manage health care costs. ActiveHealth Management provides advanced analytics and reporting services to help our customers unlock the power of health care data and transform it into useful insight that is designed to support strategies to identify efficiencies and opportunities for improving care.

ActiveHealth Management's clinical analytics and clinical decision support library includes more than 5,000 clinical analytics rules and 1,453 clinical alerts for over 250 unique conditions. We have also developed more than 190 quality measurements, which include 21 measures endorsed by the National Quality Foundation.

Active Analytics, powered by our wholly owned subsidiary HDMS, through their DART Reporting Tools assimilates ActiveHealth program information, as well as other health and financial data sources into one powerful and central resource to facilitate more informed, strategic decisions.

Reporting can be provided using our standard PDF based reports, analyzed, and summarized by our Outcomes and Account Teams or clients can choose to optimize reporting by adding our data warehouse level reporting tools.

ActiveHealth provides extensive reporting that can be provided in the aggregate as well as by defined population or demographics designations. Our reports are accurate and thorough and are provided by your designated Account Manager in a proactive and consultative review. ActiveHealth has been deeply seeded in data from our inception over 15 years ago and firmly believe that data analytics is the cornerstone of any effective strategy. Our program components include but are not limited to;

- Program Activity - Engagement, web hits, calls, volumes of care considerations, communication detail, etc.
- Clinical & Risk Level Change - Various clinical & risk level metrics are reported depending upon programs selected along with changes to those metrics
- Utilization Changes - ActiveHealth can report on changes in key utilization metrics such as Most

Impactible Hospitalizations and Most Impactible Emergency Room Utilizations

- Financial Results - ActiveHealth reports on financial outcomes using both avoided adverse event financial savings models and claims based financial results (ROI)

Enhanced Data Analytics:

- HDMS DARTSM is our comprehensive, web-based data analysis and reporting tool that provides users access to their data via any Internet connection. The DART database is integrated from a variety of sources based on each client's individual needs, including medical and Rx claims, enrollment, disease management and wellness, dental, vision, behavioral health, health risk assessments, disability, worker's comp, absence and other specialized data sources.
- DART can help you learn from your benefit plan's past, understand where it is presently and manage future change. DART data analysis and reporting tool delivers the powerful reports needed to analyze and detect trends and opportunities, reduce costs and increase efficiencies
- There are currently over 100 standard DART report templates covering the following areas: Executive Summary, Dashboards, Plan Performance, Components of Trend, Inpatient Facility, Outpatient Facility, Professional, Provider Analysis, Episode Analysis, Benchmarks, Prescription Drug, Disability, Vendor Performance, Clinical Profiles, Quality of Care and Enrollment. Report templates are fully customizable on an ad hoc basis and can be saved by the user for future use. Please refer to Attachment A for a listing of and samples of standard DART reports.
- The DART report writing interface is intuitive and easy to use via the report layout screen. It is a point and click interface where the users can quickly create new reports from scratch or modify existing report templates to suit their reporting needs. Dimensions and measures can be moved from columns to rows and vice versa or added and deleted quickly and easily. The report layout screen can be changed from tabular to graphical with a click of a button. Users have complete control over the look and design of graphical reports similar to the tabular reports.

The data in any one person's record can include:

- International Classification of Diseases, Ninth Revision codes (ICD-9)
- Current Procedural Terminology codes (CPT)
- Logical Observation Identifier Names and Codes (LOINC)
- National Drug Code identifiers (NDC)
- Utilization Management data
- Case Management data
- Disease Management data
- Health Coaching Data
- Bio-metric Data
- Self-reported data (DM and Wellness Coaching sessions, PHR, On-Line DM, etc))
- Other (e.g., disability, external health risk assessment data)

HDMS has provided data warehouse and analytic services for over fourteen years to our client base. The HDMS DARTSM solution has been available since 2003 and is currently utilized by over 60 large employers under direct contract with HDMS, and by 19 health plans that in turn provide access to hundreds of their employer accounts.

DART enables employers to quickly respond to the dynamic needs of their respective organizations. Our focus is typically large employers (10,000+ employees) primarily interested in:

- Full integration of benefit sources
- Integration of multiple, diverse data feeds
- Launching complex health advocacy strategies that require strong data underpinning
- Accurate, timely reporting to support internal and external constituents

- Our clients represent a wide variety of industries and enterprises including government, manufacturing, retail, pharmaceutical, hospitality, financial and insurance, and all have utilized our leading edge technologies to reveal unbiased health care information and to develop cost-saving strategies and solutions.

In terms of functionality, ease of use and flexibility are the primary driving forces behind the design of DART. Drill-down capability is available in all reports. DART offers access to both summarized and detail claim and member records, where users can quickly drill down from summary level reporting to the underlying claim detail to gain a better understanding of trend drivers and cost differentials.

Because of the underlying flexibility of the SAS datasets, virtually any dimension can be reported on or “split out” for reporting purposes within DART. These dimensions can be further analyzed and reported on by the use of the powerful filtering component of the software. Filtering allows for several segments of the data to be reported on separately as well as compared to the results for the total database. Combining the flexible report set with the underlying SAS database leads to information that can be segmented at both the aggregate level and the individual patient level on an ad hoc basis.

Attachments: [4.2.9.1.6 Data model and reporting highlights.docx](#)

4.2.9.1.7 What resources do you provide from a health data analyst perspective to support your clients?

Answer: Our account management strategy includes a health data analyst that is dedicated to a new client during implementation and designated thereafter for ad hoc report generation and ongoing data quality analysis. The data analyst plays a much larger role when we provide data warehouse services that assimilate program information, as well as other health and financial data sources into a powerful and central resource to facilitate more informed, strategic decisions.

Attachments:

4.2.9.2 Data Reporting

4.2.9.2.1 Provide a list and detailed description (including frequency) of the reporting package available as part of the standard fees (at no additional cost)

Answer: Please refer to the attached detailed reporting package exhibit, which includes tables highlighting relevant characteristics of our reporting suite.

Attachments: [4.2.9.2.1 Reporting Overview.docx](#)

4.2.9.2.2 Does the client receive aggregated and de-identified reporting on overall medical (biometric) screening results and primary disease burdens regardless of number of participants and number of locations? If there is an additional cost, please indicate the cost on the rate sheet.

Answer: Yes; at no additional cost the State will receive aggregated and de-identified reporting on overall medical (biometric) screening results and primary disease burdens regardless of number of participants and number of locations.

Attachments:

4.2.9.2.3 Are you able to accommodate requests for ad-hoc or customized reporting (including utilization information) at no cost to the State? If there is an additional cost, please indicate the cost on the rate sheet

Answer: Yes; with our standard program ActiveHealth accommodates requests for ad-hoc or customized reports during implementation at no cost for a mutually agreed upon number of initial ad hocs requests. After the implementation is completed we would begin charging for report development; however, once the report is developed it can be repeatedly run against a population for

no additional cost. With a buy up option for our data warehousing services, the State would be able to request unlimited ad hoc reports.

Attachments:

4.2.9.2.4 If you are able to accommodate ad- hoc or customized reporting, what is the normal turnaround time to fulfill such request.

Answer: Turn around time for most requests would be less than a week; however time would vary dramatically based on the type and complexity of the finished report.

Attachments:

4.2.9.2.5 Describe any custom reporting and data dashboards you have created for your clients, be specific and how they integrated into the full suite of services being proposed.

Answer: Our customizable dashboard reporting, delivered via e-mail or via secure FTP, provides comprehensive views of the population, updated daily for internal review and trending of the population and delivered monthly to the customer (the dashboards will be delivered Monthly and Standard report packages will be delivered quarterly).

ActiveHealth's call center nurse workflow software, ActiveAdvice, provides nurses with customizable outcomes dashboards that zero in on each participants status. These workflow dashboards are driven by CareEngine and other program data, to identify the current status of clinical outcomes for each participant based on their conditions, gaps in cares, and risks. For example, diabetic dashboard metrics include the following: a) member has had an annual eye exam, b) member's HbA1C value < 7, c) member has had 2 HbA1c tests in 12 months, etc. The dashboard view is available at a member specific level as well as the nurse can view the metrics across all the members he or she is managing. This is an important outcomes-improvement feature because it guides nurses to prioritize members for engagement as well as the specific metrics to focus on with members that will positively impact the overall health of that member and the population.

There are also a number of customizable reporting capabilities throughout our systems used by operations staff to manage day to day operations and program delivery. Many of the reports access data in ActiveAdvice, the care management workflow platform. These reports highlight the administrative aspects of program delivery, such as number of members identified, number of members in outreach, number of member engaged, nurse workloads, etc. These reports support management in evaluating program delivery to ensure the program is operating as expected, and identify program improvement opportunities.

Additionally, clients have the ability to run queries/reports out of Active Analytics (online analytics tool that is available for additional cost and updated at least monthly).

Attachments:

4.2.9.2.6 Are reports available via the web?

Answer: Although our standard reporting package is not available by website, ActiveHealth's data warehouse analytics reporting suite (available for additional cost) is available through the web.

Attachments:

4.2.9.2.7 If you are able to provide electronic feeds of medical (biometric) screening data is there an extra fee for this? If there is an additional cost, please indicate the cost on the rate sheet.

Answer: Yes; ActiveHealth is able to provide electronic feeds of medical (biometric) screening data for no additional cost.

Attachments:

4.2.9.2.8 Describe the available reporting specifically relating to each program including the types of data and information included.

Answer: ActiveHealth will provide ongoing evaluation (quarterly and annual) of program activity, and of clinical, utilization and financial outcomes to measure program success - with the goal of improving the overall health of the State's population while reducing costs. During and after implementation we can utilize multiple communication paths and reports including:

Communication Activities:

- Status and delegation reporting.
- Bi-weekly conference calls.
- Quarterly, semi-annual and annual reports.
- Face-to-face visits to provide progress-to-date reports.
- Ongoing consultation with the State's designated staff on data findings, provisions of program recommendations and joint efforts to target potential performance improvement.
- Work with the State to refine ROI reports, conduct analyses and program satisfaction surveys, including data collection and coordination of resources and logistics.

Program Activities:

ActiveHealth's quarterly reports will include operational statistics for the CareEngine and disease management, such as;

- Number of Care Considerations (CC) issued to providers and to the State's members, by severity level, type of CC (perform a test, discontinue a drug, etc.) major diagnostic category, and specific clinical subject.
- Number of the State's members participating in disease management at each level of engagement.
- Number of the State's members identified with each clinical condition.
- Volume of outreach letters and telephone calls of each type.
- Types and volumes of clinical issues addressed by disease management nurses.
- Number of medication reviews by type.
- Health education activities by topic.
- Number of other interventions by type of intervention.
- Comparison of the State's statistics to benchmark levels.

Clinical Outcomes:

Clinical outcomes for the disease management program are specific to each clinical condition in disease management.

- Some are based on medical or pharmacy claims evidence, e.g., use of recommended medications for high cholesterol or cardiovascular risk factors, etc.
- Some are based on self-reported information given to our nurses, e.g., achieving blood pressure or cholesterol target levels, stopping smoking, etc.

Clinical outcomes for the CareEngine program are primarily measured in terms of the number of Care Considerations successfully resolved. We only report success when we actually receive claims evidence of compliance, e.g., that a recommended prescription was not only written by the physician, but was filled by the member. The quarterly reports show Care Consideration success rates by;

- Severity level.
- Specific type of Care Consideration.
- Major diagnostic category.

Utilization and Financial Outcomes:

ActiveHealth will deliver quarterly and annual ROI/Savings reporting. We can also report upon a list of hospitalizations that are impacted by our disease management programs.

Attachments:

4.2.9.2.9 How frequently are reports available?

Answer: 5: Other, please specify: [Dashboard reports are delivered monthly. Most other reports are delivered quarterly. Please refer to the attached reporting overview exhibit for timeframes for each type of report.]

Detail:

Options:

1. Monthly
2. Quarterly
3. Semi-annually
4. Annually
5. Other, please specify: [Text]

Attachments: [4.2.9.2.1 Reporting Overview.docx](#)

4.2.9.2.10 Are reports available via the web? If there is an additional cost, please indicate the cost on the rate sheet

Answer: 2: Yes, for an additional fee (indicated on rate sheet)

Detail:

Options:

1. Yes, included in base pricing
2. Yes, for an additional fee (indicated on rate sheet)
3. No

Attachments:

4.2.9.2.11 Is there an additional fee for customization? If there is an additional cost, please indicate the cost on the rate sheet.

Answer: 1: Yes (indicated on rate sheet)

Detail: Limited customization within our reporting suite is free of charge during implementation.

Options:

1. Yes (indicated on rate sheet)
2. No

Attachments:

4.2.9.2.12 How often do you report participation rates to the client?

Answer: Participation rates are included in our monthly dashboard reporting.

Attachments:

4.2.10 Financial

4.2.10.1 Provide a sample of your administrative fee invoice.

Answer: 1: Attached

Detail:

Options:

1. Attached
2. Not Attached

Attachments: [4.2.10.1 Invoice Sample.pdf](#)

4.3 State Objectives

4.3.1 Plan Design

4.3.1.1 Please describe how you can assist the State with identifying possible plan enhancements that would support the states objectives as identified in Section 1.0 of the RFP.

Answer: Our account management strategy includes a health data analyst that is dedicated to a new client during implementation and designated thereafter for ad hoc report generation and ongoing data quality analysis. The data analyst plays a much larger role when we provide data warehouse services that assimilate program information, as well as other health and financial data sources into a powerful and central resource to facilitate more informed, strategic decisions.

The State of Alaska has clearly articulated a vision and objectives that will transform health care delivery in the State. While not necessarily unique, they do require the State to partner with an organization that is innovating and evolving at a rapid rate to fully support the short and long term objectives. Aetna, in partnership with ActiveHealth for an integrated medical and healthcare management proposal, is an organization that can support the objectives and continue to bring forth approaches and solutions critical to the State of Alaska's future success through four key pillars:

INNOVATION, DESIGN AND PERFORMANCE EXCELLENCE- Aetna is the administrator for 643 national account customers, 318 public and labor organizations, 197,467 Medicare customers, 1,257,110 Medicaid members, and 17,818,931 commercial members. This portfolio of customers is the result of continuously innovating and supporting our customers. Our insured book of business is also important as we also require all of the innovation and support, the same as our self-funded customers.

We have a culture of innovation at Aetna and have developed multiple areas of the organization to support organizational improvements from all of our employees. This ranges from innovation at every level of the organization to our Emerging Business Unit focused on developing critical customer solutions. This innovation has resulted in on-going enhancements in how we are improving our operations to both streamline the administrative processes and enable design solutions to support our customers. This begins with the simple measures of having our clinical policies be included in our network contracts and our claim system tied to those same policies. Our network and any custom network solutions are fully integrated into our claim system to streamline the payment process. Our

leadership has empowered all Aetna employees to identify methods to improve our operations to deliver the highest quality program to our plan sponsors and members.

Our innovation, design and performance excellence enables us to support the following State of Alaska objectives:

- Embedding clinical decision support tools into daily practice
- Using information technology to support patient education, patient care planning, coordination of care, and monitoring of compliance
- Comprehensive collection, analysis and utilization of data to inform and guide policy and plan design decisions
- High accuracy in claims processing
- Quality customer service

CONSUMER ENGAGEMENT - The age of the consumer is here and Aetna fully recognizes this as a key area to cost management. We are creating the critical support for the member with the personnel and technology to provide information and advocacy through the method sought by the member. We truly believe that the support the State of Alaska requires to transform health care is through One Member at a Time. Our Health Concierge Service model is the My AlaskaCare Single Point of Contact. The My AlaskaCare SPOCs are specially trained personnel with the tools to be the member advocate and truly the “Concierge” role across the full benefit program continuum. Our technology is the other mechanism that puts the power of transparency, clinical decision support and provider directories (in and out of network) at the member's fingertips via web and mobile phones. For the State of Alaska, the My AlaskaCare SPOC and web and mobile tools are a key cornerstone to supporting your members both in and out of Alaska. It supports the advocacy and member experience across Aetna and all of the State of Alaska benefit programs essential to delivering upon State of Alaska objectives.

Our consumer engagement enables us to support the following State of Alaska objectives:

- Encouraging patients to engage in the management of their own health
- Providing them with resources and skills to obtain appropriate health care services
- Using information technology to support patient education, patient care planning, coordination of care, and monitoring of compliance

EVIDENCE-BASED MEDICINE - Aetna has not wavered from using evidence-based medicine to manage our customers' benefit programs on both a self-funded and fully insured basis. This begins with our disciplined approach to developing clinical policies based on evidence-based medicine. Our Clinical Policies are often used by TPAs and other insurance carriers, because of the disciplined approach and rigor around the on-going review process. Our Care Engine technology is the Clinical Decision Support the State of Alaska is seeking by ensuring evidence-based medicine is applied to all medical and pharmacy claims. The application of evidence-based medicine includes our dental program that leverages our Dental Medical Integration grounded on dental care that drives medical costs.

Our evidence-based medicine enables us to support the following State of Alaska objectives:

- Designing the delivery system to ensure the provision of effective, efficient clinical care
- Embedding clinical decision support tools into daily practice
- Using information technology to support patient education, patient care planning, coordination of care, and monitoring of compliance
- Increasing overall value through cost reduction and improved health outcomes and improved quality of health care
- Comprehensive collection, analysis and utilization of data to inform and guide policy and plan

design decisions

PROVIDER COLLABORATION - Our network management is built on sound principles beginning with evidence-based medicine approach to our clinical policies to our reimbursement approach in Alaska. Our experience in core network management and breadth of our book of business will further support the necessary network development in the State.

More importantly, we are in a material shift in health care delivery through the evolution of Patient Centered Medical Homes and Accountable Care Organizations. Aetna has been a leader in national quality networks through Aexcel and the on-going evolution of high performance networks. This experience and our supporting technology have enabled us to be a market leader in the development of Accountable Care Organizations and the infrastructure to support other Patient Centered Medical Home models. Our collaboration includes the early stage evaluation of an Accountable Care Organization in Alaska, which would benefit the State of Alaska.

Our provider collaboration enables us to support the following State of Alaska objectives:

- Designing the delivery system to ensure the provision of effective, efficient clinical care
- Embedding clinical decision support tools into daily practice
- Using information technology to support patient education, patient care planning, coordination of care, and monitoring of compliance
- Increasing overall value through cost reduction and improved health outcomes and improved quality of health care
- Comprehensive collection, analysis and utilization of data to inform and guide policy and plan design decisions

Our experience across these four cornerstones in Alaska and the lower 48 will allow us to support the State of Alaska's objectives across each of the RFP components. When integrating each of the RFP components, we can deliver a fully integrated comprehensive solution that will support the goals and objectives, which includes delivering the cost controls so critical to the future of the State of Alaska benefit program.

Plan Enhancement Support

The identification of the plan enhancements is a key area that Aetna will support the State of Alaska. There are several elements to identification of plan design enhancements that we bring to the table:

Data Analytics - We have robust reporting tools that will enable us to effectively evaluate the State of Alaska's data. We have the ability to report across all of the critical facets and will structure the State of Alaska account to fully support reporting needs. Our reporting addresses all of the key areas and supports break downs by plan, group, location, etc. to effectively evaluate drivers. We have data analytics resources and subject matter experts to support the full assessment process. We leverage core reporting through our ePSM tool that provides key metrics and our more robust reporting tool AHIA. AHIA is a comprehensive reporting tool built on our data warehouse and enables robust data mining to fully identify cost drivers and issues. For State of Alaska, we will deploy all of our reporting tools to support the identification of cost drivers.

Solution Identification - While data analytics is essential, we feel the more fundamental need for our plan sponsors is the solution identification. We have made material investments in our processes to determine issues and the solutions. This begins with the use of our experts in analytics, clinical, operations, network management, Accountable Care Solutions and wellness to name a few. We also have reports exclusively focused on a detailed program review that identify issues and customer

opportunities that we call Actionable Information Report. The report identifies key solutions and opportunities for the State that align to the State of Alaska's goals for policy and design, consumer engagement and provider delivery. For the State of Alaska, we commit to using our Actionable Information reporting approach as well as the full complement of our experts to develop recommendations for the State of Alaska.

Another fundamental element is the strategy and solution development process. As the State of Alaska is seeking significant change to transform health care in the State, we recommend a multi-faceted strategy and solution development process. We will facilitate the session with the State of Alaska and if appropriate, other State of Alaska vendor partners.

The Phase 1 of the strategy process is an annual review of the objective and short and long term goals. We will support the annual review and development of goals based on the market dynamics and leading edge approaches. We envision the goal development and strategy session will include our Account Team, Clinical Advisory Team and Alaska Advisory and Support Team to map out the strategy, barriers to success and general solutions. Through this framework, solutions begin to be framed addressing each of the areas of consideration in alignment with the State of Alaska's goals. Aetna will support the facilitation of the session and vetting national and Alaska specific solutions to support the goals. These solutions will be grounded in the tools and resources we bring to the table and specifically the level of advocacy Aetna can support through My AlaskaCare Single Point of Contact (Health Concierge) and technology to speed the deployment of solutions.

Upon completion of the session, we will take the goals and objectives along with the potential solutions to evaluate against the State's data. We will mine the State of Alaska's data to determine the impact of solutions and begin to address necessary change management to deploy the solutions. Through this analysis, we will develop a discussion guide along with an outline of multiple paths and expected outcomes and impact to discuss with the State.

The last phase of the strategy process is a comprehensive ideation process with the State of Alaska. The ideation session will be based on sound practices used by our Emerging Business area to align to similar practices used to finalize decisions on proceeding with a business. We will assess solutions and convergence of solutions to use a brainstorming approach to develop the “product” for deployment. The ideation process uses the facets on issues, solution and overall adoption. The goal is to refine or reject solutions to arrive at an overall package for the State. We will leverage experts from our Emerging Business area to help support this process and arrive at solutions that fully understand the behavioral components and member experience so essential for long term sustainability.

Our expectation is to arrive at comprehensive solutions that are specific to the State's issues and extend beyond basic plan design or programmatic changes. We believe the real value we bring is the evaluation of more aggressive changes and the timing for deployment. As the State of Alaska will see, there are many solutions as we define in question 2.3.2.1. As we assess the most pivotal areas of how we can support the State of Alaska it is grounded in several key areas:

- Consumer Engagement - We have conducted significant research in consumer engagement from our Health Fund Study results, Consumer Engagement Metrics to our experiences with product development. Our focused studies in behavioral health and overall brain health are also informing us on the impact and handling of stressors. We have the ability to support solutions through all forms of designs and consumerism inclusive of leveraging our expertise on successful Health Savings Accounts and Health Reimbursement Accounts plans as well as consumer solutions for traditional PPO plans. The transformation will require overall consumer engagement and aligns with our commitment to support this one member at a time.

- **Network Solutions** - A core area of change necessary in the State of Alaska is the overall approach to network. While Aetna brings a highly effective and broad Alaska network that balances cost and quality, there are areas of Alaska that have boycotted networks. To a certain extent, our unwavering requirement for clinical and claim payment provisions has been a deterrent for some providers to contract. As we work with the State, we will focus solutions very specific to each borough in the State including the use of alternative arrangements as appropriate. Our expertise in Accountable Care Solutions, Patient Centered Medical Homes, Institutes of Quality for Bariatric and Cardiology, and High Performance Networks will inform solutions. A critical consumer facing tool for network solutions is our transparency tools.
- **Tele-medicine** - Another area of exploration is alternative providers and the role they can play for the State. Teledoc is an alternative provider option that can be leveraged for care delivery for members in rural locations as well as reduce emergency room utilization. Medical Home Exchange is another solution. These solutions reinforce an overall need to define a full strategy and align to an overall local provider base. Our expertise in these solutions and impact on networks will be evaluated with the overall network solutions for the State.
- **Technology** - The area of technology is rapidly expanding for us and will offer tremendous solutions for the State. iTriage is one of our solutions that is expanding over the next year and is a key tool for every State of Alaska member. Our technology and ability to integrate third party tracking (EOS Health for diabetes) for all areas will support the evolution of the State of Alaska's program.

While the active plan enables immediate solution deployment opportunities, we will also support the State in Pre-Medicare and Medicare design alternatives. We fully recognize the protected nature of the retiree medical program, but also recognize the plan lacks critical features to both manage costs and more importantly support retirees in health maintenance. We have extensive expertise with retiree populations to develop programs that fully balance preventive care, cost sharing and condition management to support retirees and their dependents in achieving their optimal health. We view our role as additional expertise and analytics to support the State in developing an optimal program for retirees that can be offered as a replacement or along-side the current plan.

We will support the State with the necessary solution development and analytics. The approach outlined and our support also materially changes the focus of quarterly meetings from a review of data to change measurement and solution refinement. The power of refinement is supported by the My AlaskaCare Single Point of Contact and ability to change their messaging to your members as they deliver the necessary advocacy to achieve your goals. Each year is a building block on achieving critical changes for your members and the provider network that is fully empowered by our people and solutions.

Once solutions are defined, we will use our implementation processes to deploy these solutions. The process will leverage our tools and capabilities as well as the communication budget for roll out. A critical element of any change will be the My AlaskaCare Single Point of Contact and the support the team will provide with both education and overall advocacy for the members. Leveraging our Alaska knowledge and experience along with Government and National Account experience will deliver effective design solutions to achieve the State's objectives.

Attachments:

4.3.2 Policy Development

4.3.2.1 Please describe how you can support the State in policy development through the use of data driven analysis and best practice recommendations. Please include any additional resources your organization can provide.

Answer: Aetna has both experience as well as the underlying infrastructure to support the State in policy development. Our geographic footprint and the fact that we provide insurance coverage in Alaska and the lower 49 are benefits to the State in policy development. This experience and our disciplined approach with evidence-based medicine provide us with a unique position to support the State in policy development.

A significant element of policy development is the understanding of health care delivery and the variation by geography. The Account Team and advisory teams covering clinical and Alaska care delivery are a critical element to the policy development process. This team will leverage national and regional resources in the areas of clinical policy development, government affairs, Accountable Care Solutions, Primary Care Medical Home Enablement, Medicaid and Medicare program administration, health care reform, transparency and alternative payment approaches (e.g., reference based pricing and case rates) to name a few. Overall, we have the infrastructure and resources to support the State's policy development as well as a determination of pilot opportunities.

Our process will be to work with the State on developing the areas of policy development including the goals in specific areas. The team will leverage our national resources to identify best practices and approaches to impact the State's goals. Our sessions with the State will leverage the clinical and Alaska specific expertise to uncover opportunities. In addition, we will have participation by our subject matter experts to address emerging solutions in the market and address policies to support deployment of those solutions.

Once areas are identified we will work with our internal resources for the analysis of the data available. We will leverage our resources that handle our internal evaluation processes including data analytics, review of evidence, and understanding of provider and member impact. We have supported organizations in the review and development of policies for their own organization as well as State legislation. While we do not provide legal advice, we have resources to support review and make recommendations on the type of changes that can change care delivery. Our role in health care reform emphasizes our desire to impact cost and quality in the health care delivery. The State of Alaska is in a unique position to drive health care delivery through policies that support the change. Our Alaska experience combined with the national resources can support the development of policy for the State of Alaska program only as well as for the State.

We envision a key component of the policies to be a potential demonstration of projects that explore changes to care delivery in the State. Our robust experience with Accountable Care Organizations and Patient Centered Medical Homes will be valuable in not only developing solutions, but guiding set up of changes in the delivery system.

ActiveHealth provides a service called ActiveAnalytics, powered by the DART data warehouse for reporting and claim and trend analysis. This service is available at various levels, for an additional fee detailed on our rate sheet with the option for the State access to data and reporting for desktop reporting.

The ActiveAnalytics program assimilates ActiveHealth program information, as well as other health and financial data sources into a powerful and central resource to facilitate more informed, strategic decisions. This offering can help you learn from your benefit plan's past, understand where it is presently and manage future change. In addition, our Active Performance MeasuresSM is designed to

provide quantitative assessments of quality of care across multiple networks and physicians by comparing this data to evidence-based standards.

By leveraging these tools and ActiveHealth's clinical analytics experience, our customers can rapidly deploy and adjust their population health strategies to promote quality of care and manage health care costs. ActiveHealth Management provides advanced analytics and reporting services to help our customers unlock the power of health care data and transform it into useful insight that is designed to support strategies to identify efficiencies and opportunities for improving care.

Attachments:

4.3.3 Innovation

4.3.3.1 Briefly describe the four most important ways you propose to assist the State in controlling health costs in Alaska now and in the future.

Answer: Whether your organization requires a specific set of population health management services or a fully-integrated suite of population health services, ActiveHealth Management has the ability to develop a customized program that meets your requirements. From wellness initiatives that empower individuals to make behavioral changes to utilization management programs and value-based benefit designs, our programs and services are designed to support your strategies to promote the health of your population while demonstrating measurable return on investment for your business.

Turning data into insight that can help support patient care and reduce costs

At the heart of many of our health management and clinical decision-support programs is our patented and innovative platform that is designed to help integrate data from different sources and make it more accessible and usable. CareEngine was developed to collect and analyze massive volumes of data on a daily basis (including medical claims, pharmacy and lab data) and match it with the latest and most advanced clinical standards. As a result of this process, CareEngine can provide customers with tools to help continually identify gaps in care at an individual level, and once these issues are identified, send clinical alerts to the individual and/or the physician.

CareEngine is a fourth generation, well-established and rigorous analytics platform that reviews and assesses an individual's available health care information across:

- More than 1,500 monitored events
- Based on more than 5,000 clinical rules
- Derived from accepted clinical guidelines
- Continuously managed by a team of over 30 board-certified physicians, pharmacists and registered nurses
- These clinical alerts, called Care ConsiderationsSM, may help inform individuals and providers about opportunities clinical risks and potential gaps in care. All of these Care ConsiderationsSM are based on accepted standards of quality and are developed by our clinical team who are constantly reviewing and testing the CareEngine.

The CareEngine System is designed to empower providers, enhance the provider/patient relationship, and support more educated treatment decisions and quality of care and utilization management. This state-of-the-art system can also reduce medical errors and help to optimize utilization by enabling individuals to avoid unnecessary hospitalization and emergency room visits.

ActiveHealth Management pairs evidence-based clinical standards with advanced technology to help you empower providers, engage individuals and support organizations in promoting their population's health. We have also developed more than 190 quality measurements, which include 21 measures

endorsed by the National Quality Foundation.

INTEGRATED MEDICAL AND HEALTHCARE MANAGEMENT OFFERING

The four most important ways we can support the State in controlling health care costs in Alaska now and in the future, aligns to our four pillars. Overall, we believe the State must align with an organization that materially takes the State beyond a transactional administrator and to an organization supporting its strategic direction. The State of Alaska has clearly outlined a vision and objectives that require an organization that provides the infrastructure, tools and resources to support the development and deployment of its strategy.

Aetna is uniquely situated due to its role in providing insurance coverage in Alaska today and the sophisticated customer base operating in Alaska and the lower 48. Our experience in Alaska and the lower 48 with government and commercial customers supports the State's strategies both now and in the future. The four most important ways we support the State are:

- **CONSUMER ENGAGEMENT** - Consumer engagement is not only one of the State's objectives, but a critical area of Aetna's strategic direction. This is a demand from our customers operating in Alaska and lower 48 as well as an area critical for Aetna under the Accountable Care Act. The ability to control costs is highly dependent on consumer engagement and alignment to supporting members through the optimal method for that member.

Consumer Engagement is one member at a time and a key cornerstone of our solutions for the State and controlling costs. Our proposed solutions and development are focused on both personnel and technology to address the various mediums members want and need to engage. We provide the critical level of advocacy and support that helps the member navigate their State of Alaska benefit program:

- o It begins with the My AlaskaCare Single Point of Contact, which is through our Health Concierge Service model under our medical proposal. This model is our next level of customer service that transforms health care from a transactional service to full advocacy for your members. This team is designed to respond to all member inquiries and personalize each call, but more importantly act as the advocate across the full benefit offerings by the State of Alaska. This team is specially trained and tested to ensure they are fully qualified to support the member through every facet of the health care delivery system and across all of the State of Alaska's benefit program and vendors.

Health Care is very complex and the My AlaskaCare Single Point of Contact will support the member in navigating the delivery system and truly being the health care advocate. This team is trained to listen to verbal queues from each call and take the member call “personally.” A simple way to think about it is a Concierge will communicate the time the parade starts just like any Service Representative, but will then take it to the next level and support the member in determining how they will get there, the time it will take, other logistical challenges and even schedule the transportation if necessary. As we think of the complexities of health care and supporting the State in achieving its objectives, this level of service and advocacy is essential.

We will also work with the State to define the messaging the My AlaskaCare Single Point of Contact will deliver to your members. The systems available to this team enable them to identify members calling the first time in the year to ensure critical messages from the State are delivered. For the State of Alaska, we are even suggesting a Welcome Kit that encourages the members to reach out to the My AlaskaCare Single Point of Contact Team to find out exactly what is available both via this team and other critical tools and resources. The Health Concierge model is in place today for organizations with Alaska membership and will be the ideal model to support care delivery and steerage in Alaska and the lower 48 for the State.

o On-line and Mobile Tools - Another critical facet of consumer engagement is providing members with tools to support health care decisions. We have robust tools with clinical decision support, personal health record and other support for the overall health care management of the population. Our tools are designed to support our customers and members with the information critical to their needs.

o Experts - Between all of the Aetna companies, we have experts covering all facets of the mental, physical and clinical elements of consumer engagement. Our proposed annual strategy and deployment process reflect the complexities associated with member adoption of change and the critical time investment needed to develop the solutions that your State of Alaska members will embrace. We will provide the necessary expertise to develop solutions that both support the State of Alaska's objectives and will be embraced by your members through a consumer-oriented roll out. This support addresses all elements of design and incentives.

The ability to support cost management is dependent on consumer engagement. Members must make the changes necessary to achieve their optimal health. Our investments in the expertise to develop solutions are fully empowered by the personnel, tools and resources we make available to the members. Health care is extremely complex and success in both health improvement and corresponding cost reductions come from fully providing the members with the support they need..

- **EVIDENCE-BASED MEDICINE** - We have placed extensive rigor on integrating evidence-based medicine throughout our operations. A significant area of cost likely impacting the State of Alaska is inappropriate care in the delivery system. The ability of an organization to support the State of Alaska in reducing inappropriate care is to have the approach and tools to support evidence-based medicine delivery.

Our support for the State of Alaska is based on tools and processes as well as our ability to support policy development and ensuring it translates all the way through to claim payment.

- o Our Care Engine technology is a key part of our Health Care Management solution we are proposing to the State of Alaska and is available for the population the program is rolled out to. The Care Engine is a market-leading Clinical Decision Support tool that mines medical, lab, pharmacy and health assessment results to identify care considerations. The technology is constantly mining claim data and identifying care considerations that range in level and approach for outreach to providers. The Care Engine is connecting all claims and health risk assessments to provide information most individual providers do not have for a patient. We have over 1,100 clinical algorithms to analyze member data and identify potential errors, omissions and commissions of care.

Our approach to evidence-based medicine will have a material impact on the State of Alaska's costs. Our investments in evidence-based medicine and our ability to support the State of Alaska in detailed policy development will have a year over year cost savings for the State.

- **PROVIDER SOLUTIONS** - Our network solutions cover the spectrum of simple network solutions to high performance networks to Patient Centered Medical Homes to Accountable Care Organizations. Our solutions through Active Health are the cornerstone of connecting clinical decision support to the delivery system.

- **OPERATIONAL EXCELLENCE** - Operations is often an overlooked facet of the cost management for an organization. As both an administrator and insurance carrier, we fully understand the importance in market leading operations and the impact this has on all facets of cost management and the consumer experience. As stated above, this begins with ensuring clinical policies and integrated systems. We are continuously seeking enhancements to our processes and clinical programs. We learn

and build to align with the needs of our customers who need programs to both manage cost and quality, but enable the critical attraction and retention. Our National Account and Public Sector customers demand the level of service that we deliver.

Operations brings everything together in a fashion that translates to an overall impact. We commit to working with the State to continuously measure and determine opportunities for improvement. Our resources and analytics will provide the State with critical information to make informed decisions and achieve the strategic objectives. We recognize success in achieving those objectives relies on a partner that continuously evolves and brings market leading approaches to the table. We commit to being that partner and bringing forth solutions specific to Alaska.

Attachments:

4.3.3.2 Please provide a white paper with information on innovative steps your organization is prepared to implement in order to assist the State is achieving its vision as stated in Section 1.0 of the RFP. Include any programs or innovations that have proven successful with other similar clients. Focus on cost containment and cutting edge health care support, as well as integration with other key vendor partners.

Answer: 1: Attached

Detail:

Options:

1. Attached
2. Not Attached

Attachments: [4.1.1.4 North Carolina Case Studies.pdf](#)
[4.3.3.2 Published Studies.zip](#)
[4.3.3.4 Aetna Accountable Care Information.zip](#)

4.3.3.3 How is your organization leveraging Patient Centered Medical Homes? What are the outcomes of your programs?

Answer: Leveraging Patient centered medical homes (PCMHs) is a fundamental part of our future. Our client, North Carolina is one of the first states where the state health plan is instituting a broad-based strategy to move members toward a community-based Patient-Centered Medical Home (PCMH) model of care. In January of 2012, ActiveHealth began to identify and transition high-risk members -- those most in need of intensive management -- to participating primary care providers. Our provider based population health management tool, Active CareTeam, provides practitioners access to valuable, integrated and actionable patient data in the form of a condition registry stratified by risk level, dashboard. CMS and other customized quality metrics at the point of care. .

Outcomes to date:

ActiveHealth has already enrolled over 135,000 members in our new provider based ACO solution with NCSHP, and will have PCMH models in 61 out of 100 counties by the end of 2013.

After just one year of providing disease, case management, maternity and lifestyle coaching services for members of the North Carolina State Health Plan for Teachers and State Employees (Plan), ActiveHealth Management (ActiveHealth®) has engaged 81 percent of eligible members in care management programs. Member engagement in these programs can help lead to better health outcomes through enhanced management of existing health conditions as well as members taking steps to address health risks identified through the program. ActiveHealth began providing disease

management, case management and wellness coaching services for the Plan on January 1, 2011. Members are considered "engaged" after they have been contacted by ActiveHealth, and have agreed to participate and scheduled a follow-up appointment for the care management program. Now ActiveHealth is working with Community Care of North Carolina (CCNC) to implement local assistance for the highest-risk members and deploying its Active CareTeamSM technology to support the effort.

Attachments: [4.1.1.4 North Carolina Case Studies.pdf](#)

[4.3.3.2 Published Studies.zip](#)

[4.3.3.4 Aetna Accountable Care Information.zip](#)

4.3.3.4 How is your organization supporting the creation of Accountable Care Organizations?

Answer: Strong partnerships with healthcare providers starts with even stronger ties to healthcare innovators. Each member of the Aetna Accountable Care Solutions network is widely recognized as a market leader in its respective field. Combined, they create the end-to-end intelligent solution set that allows healthcare providers to deliver better care and better value at every touch point in the care delivery journey.

To support ACOs, the CareTeam Suite includes the following capabilities:

Population view and reporting: Being able to quickly identify the population that requires attention, and drill down to the individual needing support or follow up is a key function in the new PCMH (Patient-Centered Medical Home), pay for performance and ACO (Accountable Care Organization) models of healthcare. Without access to physician and population-specific reports and tables, an organization will not be able to ensure systemic improvements and change in their patient population.

Financial analysis: As more practices and organizations are taking on financial risk, the only way to succeed is to have a firm understanding of your patient population from clinical quality, outcomes, and financial perspectives. Using our Data Analytics and Reporting Tool (DART), Active CareTeam can identify and report trends and risk factors to drive financial viability.

Clinician-directed dashboard: Powered by a clinical engine that analyzes all patient data in real time to identify gaps in care and care improvement opportunities. The Dashboard is designed to prioritize the most relevant clinical items with opportunities for intervention, allowing delegation and immediate follow-up actions.

Workflow management functions: Allows timely patient follow up, proactive identification of patient "to dos" prior to visit, and messaging and communication between the entire care team.

Clinically relevant summaries: Current EMRs provide access to data, but not in a format that is actionable and focused. Active CareTeam was designed by physicians for physicians to display relevant data, allowing quick clinical decision making and access to the full data set and history.

Patient education and management tools: The patient is a key player in better managing clinical outcomes. Their education on clinical issues and compliance has a large impact on clinical results. ActiveCare Team has a patient portal and personal health record that provides access to patient education information and tools that drive compliance and facilitate communication between the care team and patient.

Seamless Integration & Scalability: Active CareTeam has cloud-hosted options to decrease maintenance costs, and it is scalable to meet the needs of a growing health system or ACO. The

CareTeam is able to connect via any HIE to a vast majority of EMRs, lab, pharmacy, and payer systems. Active CareTeam also comes with human support to train your staff to get the most out of the product.

Care Management and Coordination: Provides tools that identify both population and patient-specific gaps in care, and facilitate patient follow up and management in a coordinated fashion by the team of caregivers. Disease management services are currently offered through a disease registry platform. The system helps drive patient assessments, care plans and overall care management, allowing the entire care team to focus on the critical elements of patient care and follow up.

Attachments: [4.1.1.4 North Carolina Case Studies.pdf](#)
[4.3.3.4 Aetna Accountable Care Information.zip](#)

4.3.3.5 Is your organization planning to or participating in any private exchanges today? If so, which ones?

Answer: Aetna is always exploring new and innovative ways to improve access to high quality health benefits, and we believe private exchanges are one opportunity. Currently, we are in discussions with several parties who are considering offering a private exchange. While we have not yet made any final decisions, we are discussing how Aetna might be a participating carrier if the parties proceed in establishing an exchange.

In addition, we are also evaluating the possibility of establishing our own private exchange, but we have not announced any plans to do so at this time.

Attachments:

4.3.3.6 Is your organization planning to participate in the public/State exchanges? If so, which states?

Answer: Yes; Aetna is planning to participate in public/State exchanges. As of December 2012, we plan to participate on up to 15 exchanges, but we continue to evaluate and monitor state and federal progress as exchanges develop.

We have dedicated significant resources to ensure we are prepared for health care reform-related changes that will occur by 2014 (i.e., with the implementation of the health insurance exchanges). As the marketplace continues to evolve, our mission continues to be to deliver value for our customers, whom we put at the center of everything we do. As such, we have been, and will continue to be, involved in the discussions around the appropriate design of health insurance exchanges so that they meet the access and affordability needs of individuals and small group employers (2 to 50 employees). We are committed to the individual and small group markets, and believe our strategy will allow us to maintain viable and affordable product offerings for these customers.

In general, we support insurance exchanges that increase competition and help consumers choose the plan that best suits their needs. We believe that exchanges should:

- Provide convenience and transparency so the consumer can choose a plan that addresses specific needs.

- Empower consumers by involving them more directly in health-related economic decision making, and choosing plans and providers.

-Avoid adding cost to consumers and cost of insurance.

-Complement the existing competitive marketplace.

As states move toward implementing exchanges, we will assess their ability to achieve the goals outlined above. Ultimately, we intend to compete on exchanges that are designed effectively, and improve competition, transparency and consumer engagement, while offering a competitive selection of affordable health insurance plans that meet the diverse needs of consumers.

Attachments:

4.3.4 Performance Incentives

4.3.4.1 In accordance with Section 3.2 of the RFP, please describe in detail any proposals you are including with your cost proposal relative to fee increments for accomplishing state objectives as outlined in Section 1.0 of the RFP such as:

- a. Increased Utilization Of Preventive Care Fee Increment. An annual fee increment in an amount to be proposed by the Offeror to be awarded if utilization of preventive care among the Employee population increased by x% over the prior fiscal year.
- b. Increased Participation in Wellness and Disease Management Programs Increment. An annual fee increment in an amount to be proposed by the Offeror to be awarded if participation in the wellness and disease management programs among the Employee population increased by x% over the prior fiscal year.

Note that these are examples and the State is willing to review other proposed performance incentives.

Answer: Please refer to exhibit 4.3.4.1, which is a list of sample performance guarantees available for consideration.

Attachments: [4.3.4.1 Sample Performance Guarantee Template.docx](#)

4.4 Cost

4.4.1 Fees

4.4.1.1 Confirm you have submitted a cost proposal based upon an administrative fee charge on a per Employee and per Retiree per month basis.

Answer: Confirmed; ActiveHealth submitted a cost proposal based upon an administrative fee charge on a per Employee and per Retiree per month basis.

Attachments:

4.4.1.2 Confirm you have completed the rate table, and included any additional costs identified within the questionnaire.

Answer: Confirmed; ActiveHealth completed the rate table, and included any additional costs identified within the questionnaire.

Attachments:

4.4.1.3 Confirm that your rates are guaranteed for at least 3 years.

Answer: Confirmed; ActiveHealth rates are guaranteed for 3 years.

Attachments:

4.4.1.4 You understand that any response except "Yes" within this section may result in an adjustment to the pricing terms and fees you input in other sections within this RFP and/or may disqualify your offer from being considered.

Answer: Confirmed; ActiveHealth understands that any response except "Yes" within this section may result in an adjustment to the pricing terms and fees input in other sections within this RFP and/or may disqualify ActiveHealth's offer from being considered.

Attachments:

4.4.1.5 Healthcare Management Pricing Tables

Please confirm you have completed the Excel worksheets in Attachment F3 and provided the completed worksheets as an attachment in section 4.5 Required Documents. Detailed instructions are provided in the worksheet.

Answer: 1: Confirmed

Detail:

Options:

1. Confirmed
2. Not Confirmed

Attachments:

4.5 Response Documents - Healthcare Management

4.5.1 Please complete an attach the following file labeled "Attachment F3 - Healthcare Management Pricing Tables and Examples.xlsx"

Attachment [Attachment F3 - Healthcare Management Pricing Tables and Examples.xlsx](#)

Answer: 1: Attached

Detail: We have also included a redacted version of each file we consider confidential, with the confidential information removed. Only redacted files, may be released in an open records requested.

Options:

1. Attached
2. Not Attached

Attachments: [State of Alaska EAP Program.pdf](#)
[State of Alaska Attachment F3 - Healthcare Management Pricing Tables and Examples.xls](#)

4.5.2 Please complete an attach the following file labeled "Attachment I3 - Healthcare Management Implementation and Performance Guarantees.xlsx"

Attachment [Attachment I3 - Healthcare Management Implementation and Performance](#)

[Guarantees.xlsx](#)

Answer: 1: Attached

Detail: We have also included a redacted version of each file we consider confidential, with the confidential information removed. Only redacted files, may be released in an open records requested.

Options:

1. Attached
2. Not Attached

Attachments: [CONFIDENTIAL Attachment I3 - Healthcare Management Implementation and Performance Guarantees.xls](#)
[CONFIDENTIAL HCM Performance Incentive Proposal.doc](#)
[EAP Performance Guarantees.pdf](#)
[REDACTED Attachment I3 - Healthcare Management Implementation and Performance Guarantees.xls](#)
[REDACTED HCM Performance Incentive Proposal.doc](#)

4.6 Reference Documents - Healthcare Management

4.6.1 Attachment G3 - Healthcare Management Scoring Methodology.docx

Document: [Attachment G3 - Healthcare Management Scoring Methodology.docx](#)

4.6.2 Attachment H3 - Healthcare Management Scoring Methodology Example.xlsx

Document: [Attachment H3 - Healthcare Management Scoring Methodology Example.xlsx](#)

5 Dental Claims Administration and Managed Network

5.1 Company Profile

5.1.1 General

5.1.1.1 Describe your company's ownership structure. Explain why your organization is best suited to provide Dental Claims Administration and Managed Network services.

Answer: The ultimate parent of our insurance companies is Aetna Inc., a publicly traded Pennsylvania corporation. Aetna Inc. is the publicly traded parent company of the Aetna group of companies. We have offered indemnity dental plans since 1957 and Dental PPO plans since 1997. We acquired our DMO® plans from Prudential HealthCare® in 1999. Prudential HealthCare introduced the DMO plans in 1985. We have over 35,000 employees nationally with 15 of those in Alaska.

Aetna is best suited to provide the services the State of Alaska is seeking in this RFP, due in large part to the overall breadth of the Aetna group of companies. The State of Alaska's objectives to transform healthcare in the State of Alaska require an organization that can support this along with all of the State of Alaska's objectives. Aetna's strategic direction, investments and full breadth of the Aetna portfolio will be leveraged to support the State of Alaska. We believe the transformation will take place one member at a time through our support in engagement through the program or method for which that member can be engaged.

The State of Alaska clearly needs an organization that has the full breadth of resources and capabilities to deliver both in Alaska and the lower 48. We are an organization that is not only known for its claim and network administration for many of the Fortune 100 and Public entities, but we also have active and retiree fully insured book of business. Our role in the State of Alaska covers each of these and provides the State of Alaska with a partner that will bring other plan sponsors to the table to support the health care transformation.

The Aetna portfolio that will benefit the State of Alaska includes:

Aetna - Aetna is a key player in the push for cost and quality in the health care delivery system in Alaska and the lower 48. We have made material investments in all facets of supporting the consumer and focusing on evidence-based medicine. Aetna is building solutions for today and tomorrow through a health concierge model that will provide the State of Alaska with "My AlaskaCare Single Point of Contact", web and mobile technology to engage every member by providing them with both essential information as well as the level of advocacy critical to behavior change and improved health.

Aetna is a key administrator and insurance carrier in the State of Alaska and throughout the lower 48. Our structure is a single organization that owns and operates a National network and most of the solutions critical to meet the State's needs. Our network resources will work with the State of Alaska to define the optimal strategies to achieve your objectives. We will leverage network contracting, plan design and resources to improve overall effectiveness of the delivery system through our Accountable Care Solutions team. We place extensive rigor on evidence-based medicine across medical, pharmacy, leave and disability, voluntary and dental solutions that will support the State of Alaska's goals to fully impact health care delivery.

ActiveHealth Management an Aetna Company - ActiveHealth is the creator of the Care Engine which is the market leading Clinical Decision support tool. The tool is based on evidence-based medicine and fully connects medical, pharmacy and health assessment information to identify Care Considerations as well as gaps in care. ActiveHealth is a critical facet of our Accountable Care

Solutions in delivering the clinical decision support to the Accountable Care Organization through their Care Team platform. Our data warehouse solution is also through Active Health's Health Data & Management Solutions organization.

Medicity an Aetna Company - Medicity is our health information exchange (HIE) and is the leading innovator and largest provider of HIE technology - with more than 750 hospitals, 125,000 physicians and 250,000 end users in its connected ecosystem. Medicity's solutions empower hospitals, physicians and HIEs with secure access to and exchange of health information - improving the quality and efficiency of patient care locally, regionally and nationally. In short, it is the "pipes" that enable an entire delivery system to be connected and operate as an Accountable Care Organization. While critical for an ACO, it can also bring together a delivery system for a plan sponsor such as the State of Alaska to connect the Alaska delivery system.

Aetna's structure fully enables the acquisitions and innovations needed to support the State of Alaska's goals on both a short term and long term basis. It is all based on the Values that guide all of the Aetna companies:

- Integrity - We do the right thing for the right reason
- Excellence - We strive to deliver the highest quality and value possible through simple, easy and relevant solutions
- Inspiration - We inspire each other to explore the ideas that can make the world a better place
- Caring - We listen to and respect our customers and each other so we can act with insight, understanding and compassion

Overall, Aetna is best suited to provide dental claim administration and network services as a direct result of our people. We are an organization built on pushing the next level of solutions and delivering the best service to our members and plan sponsors. In fact, we have developed an entire infrastructure and personnel to support the unique needs of Public and Labor entities. This enables us to deploy the essential resources to focus on your business objectives by bringing all of the Aetna Company resources to the table. We fully understand the needs of large national accounts and Public organizations such as the State of Alaska.

The model we have proposed is focused on supporting health care transformation in Alaska - one member at a time. The My AlaskaCare Single Point of Contact is the member advocate that will support the connection of all the State of Alaska's benefit programs and support navigation through the health care delivery system. This experience is built on the people of Aetna, technology and a comprehensive understanding of the member experience.

Aetna is an organization built to support the development of the State of Alaska's short and long term strategy and more importantly to bring forth and deploy strategies to reduce costs, engage members and improve the overall health of the population. We pride ourselves on developing partnerships to deliver long term success and this will be critical for the State of Alaska's health care transformation.

DENTAL/MEDICAL INTEGRATION

At Aetna, we harness the power of integration because benefits work better when they work together. Successful integration occurs when all components share a common focus. That shared perspective is simple, but clear - keep the member at the center of everything we do.

Dental - Connecting Oral Health to the Body

Through integrated medical and dental data, we are in a unique position to help identify and share disease patterns that may otherwise go unnoticed. We want our members and doctors to know that

regular dental care is a key factor in the management of our members' overall health.

Industry research, as well as our published research with Columbia University College of Dental Medicine, shows the impact gum disease has on overall health. Our belief is that improved oral care will help prevent periodontal disease which research has linked to diabetes, coronary artery disease and premature births.

We add more value

Based on our study with Columbia University College of Dental Medicine, periodontal care appears to have a positive effect on the cost of medical care. Earlier treatment may result in lower medical costs for diabetes, coronary artery disease and cerebrovascular disease (stroke). The goal for our Dental/Medical Integration program (DMI) is to help future potential costs, risks, and adverse outcomes that could challenge a member's well-being and drive up medical costs.

Since the DMI program started, we show the following book of business data:

- Up to 20 percent of employees are likely to be automatically identified by our DMI program as having an 'at-risk' medical condition¹
- Our DMI program proves that over 50 percent of medically at-risk members, who were not getting care, did seek dental care
- At least 35 percent of these at-risk members saw a dentist within 90 days after receiving our DMI outreach mailer

This means that our DMI program is making a positive impact on the lives of those members who may need dental care the most.

When our members receive their enhanced dental benefits available with our DMI program, they're getting care they need. Your employees could too.

The majority of the members using the enhanced benefits visit their dentist for scaling and root planing and periodontal maintenance (the most common treatment to help control gum disease).

Aetna's DMI program automatically identifies members who have an at-risk medical condition. We review these members to see who has not had a recent dental visit. This is our eligible DMI population. We then use private mailers and phone calls to educate and encourage at-risk members to seek care.

When a member has Aetna dental and medical, with the Personal Health Record powered by the Aetna CareEngine®, along with MedQuery®, and they complete the ActiveHealth® HRA and/or SimpleSteps® HRA (for diabetes care considerations), they may receive dental care considerations. The care considerations are member messaged quarterly through the Personal Health Record. Diabetes, cardiac conditions, joint replacement and bisphosphonate use trigger dental preventive care considerations. Here's how:

- The CareEngine analyzes the member's medical claims
- The member is identified as being a high-risk patient because of diabetes and no recent dental claims

- A dental care coordinator contacts the member to discuss dental treatment and help make a dental appointment
- The member sees the dentist and starts any necessary treatment

We are helping to create a future where all benefits seamlessly work together to enhance your bottom line and the well-being of your employees.

1 At-risk is defined as having heart disease, diabetes or pregnancy.

Attachments: [Executive Summary.pptx](#)

5.1.1.2 Describe how your company meets and exceeds the minimum requirements listed in Section 2.7 of the RFP.

Answer: Dental Claims Administration and Managed Network - Offeror must have:

- provided dental claim administration and managed network services for at least one employer of 6,000 or more employees for at least 5 years
- provided dental claim administration and managed network services for at least one group of 20,000 or more retirees for at least 5 years
- at least 5 years of experience in processing over 5,000 dental claims per month for one group
- provided dental claim administration and managed network services for a government employer or public pension plan for at least 3 years

- We meet this requirement with our customer Costco
- We meet this requirement with our customer State of New Jersey
- We meet this requirement with our customer State of New Jersey
- We meet this requirement with our customer Anchorage School District

Please find additional supporting information attached on how Aetna meets all the State of Alaska's minimum requirements.

Attachments: [1.a Signed Attachment B - Offeror Information and Certification.pdf](#)
[1.b Attachment B - Offeror Information and Certification.docx](#)
[2. Subcontractor Commitment Letters.zip](#)
[3. Minimum Qualification Question 2.1.1.2 Response- CONFIDENTIAL.doc](#)
[3. Minimum Qualification Question 2.1.1.2 Response- REDACTED.doc](#)
[4. State of Alaska Business Licence.pdf](#)
[5. State of Alaska Certificate of Authority.pdf](#)
[6. Legal Clarifications \(Deviations\).doc](#)
[7. Plan Clarifications.xlsx](#)
[8. Confidentiality Request.docx](#)

5.1.1.3 Provide client references for whom you provide (or have provided) the same services you are proposing to the State that meet the following qualifications. The same references may be used to meet one or more qualifications but five distinct references must be provided.

- A client with more than 6,000 employee participants for at least 5 years;
- A client with at least 20,000 retiree participants for at least 5 years;
- A client you have processed over 5,000 claims per month for at least 5 years;
- A client you have had for two years or less;

- A client whose contract has ended with you in the last two years; and
- A governmental client for at least 3 years.

Name of client					
Type of business	Retail	State Government	County Courthouse	Public Transit	School District
Beginning year of providing service to client	1994	2005	2011	2005	2005
Number of participants (total Lives)	210,000	290,000	1,300	13,200	5,400
Name, address and telephone number of the designated client representative					
Types of coverage or plans provided; and	Medical, Dental, FSA, AGB: ExPats and World Travelers, Dedicated clinical service and subrogation teams	Medical, Dental, and Behavioral Health	Dental	Self Insured Dental PPO	Medical, Dental, Pharmacy and Cobra
Reason for Termination (if applicable)	Not applicable	Not applicable	Not applicable	Financial	Not applicable

Detail: CONFIDENTIAL - The names, addresses and phone numbers of Aetna active references are confidential.

Attachments:

5.1.1.4 Describe a situation in which you brought a client's dental trend down. This client should be similar to the State of Alaska in size, as well as in industry.

Answer: Our Dental/Medical IntegrationSM (DMI) program focuses on improving member quality of life, and ultimately, reducing costs and increasing productivity. We do this by:

- Targeting those who are at-risk and not receiving dental care
- Increasing member awareness of good dental health
- Motivating members to seek appropriate care through enhanced benefits
- Supporting members' healthy decisions through outreach

A strong scientific foundation

There is a strong connection between oral health and overall well-being. Our research shows that individuals with certain conditions, such as diabetes, coronary artery disease, cerebrovascular disease, and pregnant women, may benefit the most from the earlier dental and periodontal care that is more likely in an integrated program.

Our DMI program was founded on this scientific evidence to provide a coordinated care approach and enhanced benefits for members who need it the most.

Positively impacting costs

Our DMI program aims to avoid future costs, risks and adverse outcomes that can negatively impact a member's well-being. As we target members with certain chronic conditions, we can produce both dental and medical cost savings.

Studies have shown:

- Individuals with diabetes, coronary artery disease, and cerebrovascular disease, who received dental care earlier, lowered the risk or severity of their respective conditions, which reduced their overall medical costs.¹
- Women who received preventive dental care had fewer birth complications than those who did not.²

In addition, you may save administrative costs when you use one carrier for both medical and dental coverage.

Increasing productivity

Employees miss millions of hours of work each year for dental-related illnesses or dental visits, and that number increases for parents who miss time for their children's dental appointments. Our DMI program helps lower absenteeism rates by making it more likely for an employee to receive care earlier.

We also know that better overall health leads to increased productivity. Our proactive approach to care decreases “presenteeism” and helps employees perform to their fullest when on the job.

DMI case study

Client A and DMI

Aetna Informatics recently completed a comparison of Client A's medical and dental claims data for members eligible for DMI versus the claim data of the same population at Client B.

- Both clients are in the same industry and have virtually the same demographics and dental plan designs.
- The comparison included members that had Aetna Medical and Dental coverage for at least two years
- Client B did not have DMI or disease management programs in place during the time period studied.

The comparison showed:

- An increase in utilization of Preventive Dental Services for Client A's Cardio/Diabetes population in both 2010 and 2011. Client B had a negative trend in Preventive utilization in 2011.
- Client A's Diabetics had a negative trend for Inpatient Admissions of -3.5% versus an increased trend of +5.4% for Client B's Diabetic population
- In 2011 Client A's Diabetic/Cardio population had better HbA1C control than Client B's (HbA1C > 8, Client A - 6.3% vs. Client B - 10.3%)
- Client A's population had a higher outpatient visit trend (4.9%) for Diabetes and Cardio/Diabetic populations (8.1%) than the comparator group, (2.2% and 7.4% respectively) but lower for Cardio (Client A - 4.9%, Client B 12.0%)
- 60.3% of Client A's members utilized dental services in the 12 months prior to becoming pregnant, compared with 54.1% of women for Client B. 57.5% of Client A's members had dental services while pregnant versus 50% for Client B.

¹An examination of periodontal treatment and Per Member Per Month medical costs in an insured

population, BMC Health Services Research, August 16, 2006. Continued analysis of retrospective study proves sustained results, Aetna Health Analytics, August 2008.)

2 An Examination of Periodontal Treatment, Dental Care, and Pregnancy Outcomes in an Insured Population in the United States, AM J Public Health. Published online ahead of print November 15, 2010: e1-e6. doi: 10.2105/AJPH.2009.185884).

Attachments:

5.1.2 Account Management Team

5.1.2.1 Please submit a written narrative providing a thorough description of the proposed account management structure. Your narrative must include the following:

- I. An organizational chart depicting the account management structure.
- II. The individuals who will comprise the account management team.
- III. For each individual on the proposed account management team:
 - a. name
 - b. title
 - c. physical work location where normally based
 - d. years of industry experience
 - e. years with organization
 - f. level of educational attainment
 - g. resume
 - h. years in current position
 - i. level and scope of decision making authority.
- IV. How often the account management team will meet with the Project Director and/or his designee(s) and whether the account management team will meet in person with the State on a quarterly basis in Alaska or other locations to be specified by the State.
- V. Maximum number of accounts assigned to each member of the account management team.
- VI. List other projects and or plans anticipated to be implemented by each member of the account management team during 2013/2014 and evaluate their impact on each member's ability to implement the scope of work set forth in the RFP relative to Dental Claims Administration and Managed Network.

Answer: 1: Attached

Detail:

Options:

1. Attached
2. Not Attached

Attachments: [State of AK - Org Chart.ppt](#)

5.1.3 Organizational Capacity

5.1.3.1 Confirm you, as the Offeror, have reviewed and understand the information presented in the Introduction section of the RFP.

Answer: 1: Confirmed

Detail:

Options:

1. Confirmed
2. Not Confirmed

Attachments:

5.1.3.2 Identify and describe how all aspects of the work for each function identified below will be organized and staffed (“the Project Team”).

- A. Company Profile
 - a. HIPAA Compliance
 - b. Communications
 - c. Information Technology
 - d. Integration with Other Vendors
- B. Patient Value Chain
 - a. Network
 - b. Plan Design
 - c. Eligibility & Enrollment
 - d. Customer/Member Services
 - e. Utilization Management
 - i. Approvals/Denials
 - f. Claims Processing
 - i. UCR Management
 - ii. Explanation of Benefits (EOB)
 - iii. Coordination of Benefits (COB)
 - g. Quality Control
 - i. Performance Guarantees
 - h. Appeals
 - i. Data Analysis
 - i. Data Collection
 - ii. Reporting
 - j. Financial
 - i. Subrogation
 - ii. Banking
 - iii. Direct Bill
 - iv. COBRA
- C. State Objectives
 - a. Plan Design
 - b. Policy Development
 - c. Innovation
 - d. Performance Incentives

For each function, please provide the following information:

1. A work flow chart depicting how the work associated with each function will be performed and a narrative describing the processes depicted in each flow chart. In your narrative please specifically address, for each function:
 - i. The role of customer service and communications.
 - ii. Special expertise, if any, that you can provide the State with respect to each function.
 - iii. Your experience and background in performing each specific function.
 - iv. How your system technologies uniquely position you to perform each specific function.

- v. What innovation you can provide to the State with respect to each specific function.
 - vi. How you will coordinate with other Contractors who may be awarded Contracts under this RFP.
 - vii. If applicable, specify how the process will be different for members outside of Alaska.
2. Whether the specific function will be managed and staffed by you, a subcontractor or joint venturer.
 - i. If the function will be managed and/or staffed by a subcontractor or joint venturer, please identify the subcontractor or joint venturer and identify how long the subcontractor or joint venturer has been providing the service to a client of similar size to the State.
 - ii. If the function will be managed and/or staffed by a subcontractor or joint venturer, explain how communication and coordination occurs between your organization and subcontractors or joint venturers who will provide the functional service.
 3. Describe your organization's process for quality oversight of all subcontracted vendors and joint venturers and provide sample corrective actions used if performance needs to be improved.
 4. Please include an organizational chart depicting all personnel or positions that will be assigned to accomplish each function.
 5. Please identify the geographic location where the work associated with each identified function will be performed, including which functions will be performed exclusively in Alaska.
 6. For any function that will not be performed exclusively in Alaska, please identify the total number of positions that will be based in Alaska for each function.
 7. Please identify the proposed point-of-contact for each function.
 8. Please identify customer service hours of operation for each function. Specify hours of operation by Alaska Standard Time and the applicable time zone where the function will be performed if not in Alaska.
 9. Please identify for which functions you will provide onsite support. For example, enrollment meetings and health fairs.

Answer: Please refer to the attached "RESPONSE TO 5.1.3.2" document for a complete description of our capabilities to provide each function requested above.

Attachments: [Appeals Resolution Flow Chart.ppt](#)

[Banking Flow Chart.ppt](#)

[Claim Process Flow Chart.ppt](#)

[EOB Flow Chart.xls.xls](#)

[Enrollment Flow Chart.ppt](#)

[Fresno Service Center Organizational Chart.ppt](#)

[Information Technology Flow Chart.pdf](#)

[Network Diagram.pdf](#)

[PayFlex Organizational Chart.docx](#)

[RESPONSE TO 5.1.3.2.doc](#)

[Western Dental Service Center Org Chart.ppt](#)

[West Region Network Staff.ppt](#)

[COBRA Flow Chart.pdf](#)

[Subrogation Flow Chart.pdf](#)

[State of AK Organizational Chart.ppt](#)

5.1.3.3 Provide a copy of your standard Administrative Services Organization contract.

Answer: 1: Attached

Detail:

Options:

1. Attached
2. Not Attached

Attachments: [Aetna Sample Master Services Agreement.pdf](#)

5.1.4 Implementation Plan

5.1.4.1 Identify and describe, by function, how you will execute a successful implementation for each aspect of the work set forth in Section 1.04 of the RFP instructions relative to the Dental Claims Administration and Managed Network component. For each function, please provide:

- I. A work flow chart depicting how the implementation work associated with each function will be performed and a narrative describing the processes depicted in each flow chart.
- II. Whether the specific function will be managed and staffed by you, a subcontractor or joint venturer.
- III. If the function will be managed and/or staffed by a subcontractor or joint venturer, please identify the subcontractor or joint venturer and identify how long the subcontractor or joint venturer has been providing the service to a client of similar size to the State.
- IV. If the function will be managed and/or staffed by a subcontractor or joint venturer, explain how communication and coordination occurs between your organization and subcontractors or joint venturers who will provide the functional service.
- V. Describe your organization's process for quality oversight of all subcontracted vendors and joint venturers and provide sample corrective actions used if performance needs to be improved.
- VI. An organizational chart depicting the implementation management team structure.
- VII. Whether you will provide an Alaska-based implementation project manager during the term of the implementation.
- VIII. The individuals who will comprise the implementation management team.
- IX. For each individual on the proposed implementation management team:
 1. name
 2. title
 3. physical work location where normally based
 4. years of industry experience
 5. years with organization
 6. level of educational attainment
 7. resume
 8. years in current position
 9. level and scope of decision making authority
 10. whether the individual management team member will be exclusively assigned to the implementation until completion.
 11. For those individuals not assigned exclusively to the implementation, please identify the amount of time they will be devoted to the implementation.
- X. The geographic location where the work associated with each identified implementation function will be performed, including which implementation functions will be performed exclusively in Alaska.
- XI. For any implementation function that will not be performed exclusively in Alaska, please identify the total number of positions that will be based in Alaska for each implementation function.
- XII. The proposed point-of-contact for each implementation function.
- XIII. Timeline for implementation.
- XIV. How often the implementation team will meet with the Project Director and/or his designee(s) and whether the implementation team leader will meet in person with the State on a monthly basis in Alaska or other locations to be specified by the state.

Answer: 1. Please refer to the implementation plan included with this proposal. We have included an implementation plan based upon your timeline of a 7/1/13 effective date and a decision date of 3/29/13. We have the people and processes to continue to support a 7/1 effective date. We would want to work with the State to determine an implementation date for the actives to ensure a smooth transition. We have included an implementation plan for integrated dental services and stand alone.

2. The implementation for State of Alaska will be performed solely by Aetna. No sub-contractors will be involved.

3. Not applicable.

4. Not applicable.

5. Not applicable.

6. Please refer to the implementation organizational chart included with this proposal.

7. The assigned implementation manager, Laura Ocegueda, will serve as the transition project manager. Laura is located in California and will manage the project. The State's account management team will also be an integral part of the implementation process and will be available to meet on-site with Alaska as needed. The primary account management team will be located in Washington and Alaska.

8. Please see below for specific information for each of the implementation team members.

9. Please see below for specific information for each of the implementation team members.

1. Name - Laura Ocegueda

2. Title - Senior Implementation Manager for National Accounts - Public & Labor Plan Sponsor Services

3. Physical work location - Teleworker/California

4. Years of industry experience - 27 years

5. Years with organization - 27 years

6. Level of Educational Attainment - Bachelor's of Science

7. Resume - Please see below

8. Years in current position - 10 years

9. Level and scope of decision making authority - Laura has decision making authority. For anything non -standard she will seek approval either from management or other business partners

10. Whether the individual management team member will be exclusively assigned to the transition until completion. - No. A designated Implementation Manager will be assigned to the transition and will remain engaged for approximately 30-45 days following the effective date. The Account Team and Plan Sponsor Administration team will assume ongoing responsibility for managing your account.

11. For those individuals not assigned exclusively to the implementation, please identify the amount of time they will be devoted to the transition - On average, 35% but may increase based on project scope.

Resume - Laura Ocegueda joined National Accounts Customer Implementation Management Services in July 2002. Her current responsibilities include overall project management for Aetna's new and existing plan sponsors' benefit programs. Her responsibilities include management of all implementation team activities between customers and service personnel relating to the coordination and installation of new and revised services for National Account customers.

Prior to joining CIMS, Laura was an Account Executive in the San Francisco Sales Organization. As

an Account Executive she had overall responsibility for client retention, growth, negotiating renewals, and cross selling of new products for her assigned book of business.

Laura is a graduate of California State University at Hayward where she earned a Bachelor of Science degree in Business Administration

1. Name - Sara Kesler
2. Title/function - Sr. Billing Consultant
3. Physical work location - Teleworker/Walnut Creek, CA office
4. Years of industry experience - Please see the included biography for Sara Kesler
5. Years with organization - Sara has been with Aetna since 2006
6. Level of Educational Attainment - High School Diploma
7. Resume - Please see below
8. Years in current position- 6
9. Level and scope of decision making authority - For anything non -standard she will seek approval either from management or other business partners
10. Whether the individual management team member will be exclusively assigned to the transition until completion. - Yes
11. For those individuals not assigned exclusively to the implementation, please identify the amount of time they will be devoted to the transition - Not applicable

Resume: Sara joined the Aetna team in January of 2006. Sara is a Senior Billing Premium Consultant on the National Accounts Team. Sara handles Traditional Premium Billing and Reconciliation.

Sara came to Aetna with many years of experience having been employed in the banking/accounting/bookkeeping field for over twenty five years. Sara was employed initially in the banking field eventually being promoted to Operations Manager and Assistant Vice President. Sara worked for many years for a Certified Public Accountant and was employed prior to joining Aetna as a billing specialist for a firm of attorneys, billing for three locations that included multiple attorneys and paralegals.

Sara has completed several work related classes to assist her in her working environment which includes Excel, Word, Quicken, QuickBooks Pro, Accounting I, Accounting II, Mastering Payroll and Word Perfect.

1. Name - Christina Bryfogle
2. Title- Claim Data Specialist, Christina will install plan sponsor benefits in the claim adjudication system
3. Work Location - Allentown, Pennsylvania. Christina handled the Automatic Claims Adjudication System (ACAS) installation for this plan sponsor in the past and we would like to be able to capitalize on her experience.
4. Years of industry experience - 13 years
5. Years with organization - 13 years
6. Level of Educational Attainment - 12 years plus
7. Resume - Please see below
8. Years in current position - 6 years
9. Level and scope of decision making authority - No direct reports. Will be able to decide if benefits are supportable or not. For anything non -standard she will seek approval either from management or other business partners.
10. Whether the individual management team member will be exclusively assigned to the transition until completion. - Christina will not be exclusively assigned to State of Alaska
11. For those individuals not assigned exclusively to the implementation, please identify the amount of

time they will be devoted to the transition - The time amount spent will depend upon the needs of State of Alaska

Resume: Christina began her career with Aetna in May of 1999 as a claims processor. Two years later she was selected to become a Quality Analyst, performing internal quality audits for claim processors. In this role Christina developed a passion for Quality which is seen in all tasks that she performs. In 2005, Christina was selected to join the Manual Plan Set-up team (MPSU). Christina has been on the MPSU team for 6 years. Her experience and dedication to quality is evident in each customer build she performs on the ACAS.

1. Name - Deborah Smith
2. Title- Automatic Claims Adjudication System (ACAS)Regional Liaison for Public & Labor. Deborah will attend customer installation meetings, verify system supportability of benefits, and monitor case activity through to claim readiness
3. Work Location - Blue Bell, PA
4. Years of industry experience - 14 years
5. Year with organization - 14 years
6. Level of Educational Attainment - 12 years plus
7. Resume - Please see below
8. Years in current position - 5 years
9. Level and scope of decision making authority - No direct reports. Will be able to decide if benefits are supportable or not. For anything non -standard she will seek approval either from management or other business partners
10. Whether the individual management team member will be exclusively assigned to the transition until completion. - Deborah will not be exclusively assigned to State of Alaska
11. For those individuals not assigned exclusively to the implementation, please identify the amount of time they will be devoted to the transition - The time amount spent will depend upon the needs of State of Alaska

Resume: Deborah began her career with Aetna in March 1998 as a claims processor. She became one of the first in the Blue Bell office to be trained to process on the ACAS platform. In 2001 Deborah became a member of the Manual Plan Set-up team actually building the plans on the ACAS platform. In 2007, Deborah became the Regional Liaison, overseeing the implementation process for plan sponsors handled out of the Mid-Atlantic and Northeast Markets. This involved assisting plan sponsors with system support answers for benefits, providing timelines for claim readiness and following up with each area to make sure deadlines were reached. In 2012, Deborah was selected as the Public & Labor Regional Liaison performing the same tasks.

1. Name - Terisita (Tet) Go
2. Title - Plan Set Up
3. Physical work location North Hollywood, California
4. Years of industry experience: 19.5 years
5. Years with organization: 19.5 years
6. Level of educational attainment: 12 years plus
7. Resume: Please see below
8. Years in current position: 10 years
9. Level and scope of decision making authority: Tet will have decision making authority but for anything non -standard she will seek approval either from management or other business partners
10. Whether the individual management team member will be exclusively assigned to the transition

until completion: Tet will not be exclusively assigned to State of Alaska

11. For those individuals not assigned exclusively to the implementation, please identify the amount of time they will be devoted to the transition: The time amount spent will depend upon the needs of State of Alaska

Resume: Tet is the Plan Coordination Consultant for the Los Angeles national market.

Tet joined Prudential Healthcare in 1993 as a Claims Examiner for the ASO team. In 1996, Tet was certified as a Plan Description Record Specialist. In 1997, Tet was appointed to do the revalidation of quality reviewed plans. Under Aetna, Tet was the Installation Support Consultant for middle market and was trained as a PCC when the LA center became a national site.

Prior to joining Prudential, Tet held various positions for sixteen years with Carnation Company. The last position she held at the Carnation Company was as a Payroll Administrator.

Tet received an Office Automation Specialist Certificate from Glendale Community College.

1. Name - Sandra Lloyd

2. Title - Benefit Consultant

3. Physical work location where normally based - Pittsburgh, California

4. Years of industry experience: 26 years

5. Years with organization: 11 years

6. Level of educational attainment : 12 years plus

7. Resume: Please see below

8. Years in current position: 7 Years

9. Level and scope of decision making authority: Sandra will have decision making authority but for anything non -standard she will need to seek approval either from management or other business partners

10. Whether the individual management team member will be exclusively assigned to the transition until completion: Sandra will not be exclusively assigned to State of Alaska

11. For those individuals not assigned exclusively to the implementation, please identify the amount of time they will be devoted to the transition: The time amount spent will depend upon the needs of State of Alaska

Resume: Sandy began her career with Aetna in June 2001. She is currently a Work-at-Home Benefit Consultant located in Pittsburg, California (40 miles east of San Francisco). In her current position she is responsible for negotiating contracts and benefit language, drafting Administrative/Master Services Agreements, and drafting benefit plans.

Sandy started her career with Aetna as an Administrative Assistant in Law & Regulatory Affairs, where she was promoted to Paralegal after obtaining her Paralegal certification. Prior to coming to Aetna, she was a Legal Secretary with highly rated law firms in Texas and California that specialized in diverse fields such as: Patent, Trademark and Copyright, Oil and Gas, Estates and Trusts, Business and Corporations, Bankruptcy and insurance defense litigation, and personal injury/property damage insurance prosecution.

1. Name - Barri Frank

2. Title - Eligibility Consultant and ID card consultant

3. Physical work location where normally based: Antioch, California

4. Years of industry experience: 12 years

5. Years with organization: 12 years

6. Level of educational attainment: Bachelor Degree

7. Resume: Please see below

8. Years in current position: 12 years

9. Level and scope of decision making authority: Barri will have decision making authority but for anything non -standard she will seek approval either from management or other business partners

10. Whether the individual management team member will be exclusively assigned to the transition until completion: Barri will not be exclusively assigned to State of Alaska

11. For those individuals not assigned exclusively to the implementation, please identify the amount of time they will be devoted to the transition : The time amount spent will depend upon the needs of State of Alaska

Resume: Barri is a Senior Eligibility Consultant in Walnut Creek, CA. She joined Aetna in August of 2000 and is currently responsible for processing electronic eligibility into Aetna systems. Barri is also involved with the coding of product ID cards which are distributed to Aetna members. In addition, she responds to customer, vendor or claims inquiries for information and/or problem resolution.

Prior to joining Aetna, Barri spent three years as a health insurance/benefit analyst for a contract security company in Oakland, CA. In addition to her benefits background, Barri has six years accounting experience.

Barri's professional and consultative customer focus has been recognized numerous times over the years by internal partners, Account Management Teams and Plan Sponsors. She has been formally recognized with two Aetna Ways Excellence Award nominations for her "best in class" service.

Barri graduated from the University of Iowa with a Bachelor of Arts degree in English. She also has an associate's degree in accounting.

10. Please see above for specific information for each of the implementation team members.

11. The majority of the implementation functions will be done outside of Alaska, but staff can visit Alaska for any essential activities, if on-site is needed. The State's account team will be an integral part of the implementation and will be available to meet with the State as needed. The account team will be comprised of local resources as well as 4 Alaska-based sales support consultants and an Alaska Advisory Team.

12. A contact list is included in the Implementation Schedule identifying each functional contact involved in the implementation.

13. Please refer to the Implementation Schedule included with this proposal. We have included an implementation plan based upon your timeline of a 7/1/13 effective date and a decision date of 3/29/13. We have the people and processes to continue to support a 7/1 effective date. As the retirees are a 1/1 plan year, we would work with the State and the current administrator for the processes and data feeds needed for a smooth mid-year transition.

14. Our project plan assumes a weekly implementation project call, leveraging all of our project management tools. At a minimum we have assumed the account team will meet in person with the State on a monthly basis. We will work with the State on defining all of the face to face meeting dates based on final notification and implementation date.

Attachments: [Implementation Org Chart.ppt](#)
[State of Alaska Implementation.doc](#)
[State of Alaska Implementation Dental Only.doc](#)

5.1.4.2 Will you provide welcome kits as part of the implementation? If so, please identify and describe all information that will be contained in the welcome kits. If there is an additional cost, please indicate the cost on the rate sheet.

Answer: 1: Yes: [Our fees/rates include the cost of standard enrollment and new member materials.

We supply the following enrollment and new member materials to the State through bulk shipment for distribution to employees:

- **Benefit summaries**
- **Enrollment forms**
- **Product brochures**
- **Booklet-certificates**
- **Summary of coverage documents**

Our fees/rates do not include the cost of printing or mailing provider directories to members' homes. If requested, we can mail a limited quantity of directories to the State through bulk shipment. There is an additional cost to provide a directory for each employee.

Members have immediate online access to our provider directories through DocFind® at www.aetna.com. DocFind allows members to search for local participating general and specialty dentists. Members can also request driving directions. We update DocFind six times per week.

]

Detail:

Options:

1. Yes: [Text]
2. No

Attachments:

5.1.4.3 Please confirm that you will be able to provide ID cards without Social Security Numbers to all members prior to the effective date of the Contract. If there is an additional cost, please indicate the cost on the rate sheet.

Answer: 1: Confirmed

Detail: We do not use the subscriber's Social Security number as identified on the ID card. We assign a 12 character identifier to each subscriber and dependent. ID cards will be mailed directly to all members prior to the plan effective date. There is no additional cost.

Options:

1. Confirmed
2. Not Confirmed

Attachments:

5.1.4.4 Offeror must perform comprehensive systems testing and quality assurance audits, with results reported to the State, prior to the contract effective date as part of the base administrative fees with no additional charge to the State. If there are any costs, please detail.

Answer: 1: Yes

Detail: We test all new plans as part of the implementation process. A key tool in this process is the Single Source Document (SSD). We use the document as the basis to build and test the benefit plan. SSD captures major plan changes and serves as a confirmation of the benefits plan.

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

5.1.4.5 At the State's option, the Offeror must have its website available prior to the State's open enrollment to assist those members implementing from the current vendor as well as for potential new members to view formulary information, pricing tools and other plan information.

Answer: 1: Yes

Detail: We offer a pre-enrollment opportunity for the State to experience Aetna Navigator®, our secure member website. The State may use a guest user name and password, and provide it to your employees, to allow potential enrollees access to a live-site environment.

The Aetna Navigator guest ID experience is illustrative only, and may differ from the actual information a registered member may see on their site, once they are enrolled in an Aetna plan and depending on their benefit elections. It provides access to tools such as the Estimate the Cost of Care tool and Healthwise® Knowledgebase.

We provide a variety of guest IDs so that potential enrollees may fully explore the many features of this online tool. A guest ID can be used by multiple users at the same time.

Access to the guest ID site is at www.aetna.com.

User name and passwords for PPO Dental:

- User name: ppodental1
- Password: ppodental1

The Aetna Navigator guest experience is for illustrative purposes only. Please note:

- Plan-related information, such as products included on the site, benefits levels, and copay information, may not mirror those offered by each customer.
- Member cost information, such as shared member costs or coverages in the Price-A-Drug tool, may vary by plan and the member's deductible and coinsurance activity; however, the total cost of a drug displayed would be accurate.
- Transactional activities, such as EOBs, completing a health risk assessment, viewing disability claims, requesting an ID card, changing a PCP/PCD, are not activated for guests.

ADDITIONAL INFORMATION AETNA'S CONSUMER TOOLS

Members can visit www.aetna.com and select Member Tools under TOOLS. This information is available to anyone, even people without Aetna coverage.

Options:

1. Yes
2. No. Explanation: [Text]

Attachments:

5.1.4.6 Please confirm that your cost proposal includes the cost of all implementation expenses. If not, please identify all additional costs on the rate sheet.

Answer: 1: Confirmed

Detail:

Options:

1. Confirmed
2. Not Confirmed

Attachments:

5.1.4.7 Please confirm that you will provide run-out administration, including communications and data support for transition to a new Contractor, for a period of 12 months following contract termination. If there is an additional cost, please indicate the cost on the rate sheet.

Answer: 1: Confirmed

Detail:

Options:

1. Confirmed
2. Not Confirmed

Attachments:

5.1.4.8 Within your implementation team, is employee compensation tied directly to performance?

Answer: 1: Yes

Detail: Employee compensation includes a base salary and bonus program. We base annual salary increases and quarterly bonuses on the following:

- Manager assessment
- Individual overall performance

Options:

1. Yes
2. No
3. Partially

Attachments:

5.1.4.9 Please outline your procedures for loading patient payment histories from the prior carrier. If there is an additional cost, please indicate the cost on the rate sheet.

Answer: The implementation manager and account executive will meet with you to discuss the transfer of financial information as soon as we are selected as a benefits partner. In order to correctly process claims, we request a list of financial accumulators for each employee and dependent. The list may vary based on your needs and can include:

- Coinsurance amounts
- Deductibles
- Lifetime maximums

In order to load this data into our claims system, we ask for the following information:

- Employee's Social Security number
- Claimant's last name
- Claimant's first name
- Claimant's relationship to employee
- Claimant's date of birth (YYYY-MM-DD)

When only one employee/retiree is transferring mid-year, the service center would manually update the accumulators.

FORMAT AND TIMING

We accept the information in both Microsoft Excel® (preferred method) and text delimited formats. We accept these formats through password-protected e-mail or via the Internet through secure file transfer protocol.

Because the former carrier continues to process claims during the run-out period, this data can quickly become outdated. To keep data current, we will work with the State on frequency and handling process as a retiree member claims submission impacts accumulators. We will work with the State on the process, communications and call handling by our Fresno Service Center.

Attachments:

5.1.5 HIPAA Compliance

5.1.5.1 Confirm your organization is in compliance with and will administer the proposed benefit plan (s) in accordance with all applicable legal requirements, including HIPAA, COBRA, DOL, ERISA, and state and local mandates.

Answer: 1: Confirmed

Detail: We are fully compliant with all HIPAA requirements that have been issued to date. We use all HIPAA EDI mandated code sets.

Options:

1. Confirmed
2. Not Confirmed

Attachments:

5.1.5.2 Describe how you maintain confidentiality of patient and plan data.

Answer: We have policies, procedures and technologies in place to protect sensitive information against inappropriate and unauthorized use and disclosure. These include written privacy and security

policies, privacy and security awareness training for employees, integrity and access controls, message authentication and/or encryption, firewall and proxy server technologies, etc. We restrict access to protected health information (PHI) to those employees who need it to provide products or services to our members through “role-based access control” (RBAC). We maintain physical, electronic and procedural safeguards to protect PHI against unauthorized access and use. Access to our facilities is limited to authorized personnel, and we protect information we maintain electronically through use of a variety of technical tools.

In addition, as part of our HIPAA Privacy and Security compliance programs, we have identified specific individuals to serve as business area privacy and security managers. These individuals are responsible for day-to-day enforcement of Aetna's privacy and security policies and the procedures that support them. Each privacy and security manager is the “go to” person for business area questions about our privacy and security policies and procedures - in the event these individuals encounter questions/issues they cannot resolve, they confer with the company's Privacy Office.

Finally, adherence to privacy and security policies and procedures is subject to ongoing monitoring. For example:

- Our Internal Audit Department periodically performs assessments on the company's Privacy policies and procedures. As needed, corrective action plans are developed to address the findings of the Internal Audit reviews;
- Key business areas (e.g., member services) have incorporated review of employee adherence to privacy policies in ongoing quality management efforts; and
- For years, our IT security program has received extremely favorable evaluations from external consultants, including the performance of safeguards to counter efforts to penetrate our IT resources. We will continue relying on reviews by external consultants as part of the ongoing security assessment required by the HIPAA Security Rule.

We do not disclose member health information, except as permitted by law or with the member's consent.

When necessary for a member's care or treatment, the operation of our health plans, or other related activities, we use member health information internally, share it with our affiliates and disclose it to health care providers (physicians, dentists, pharmacies, hospitals and other caregivers). We may also provide the information to other insurers, third party administrators, payors (employers who sponsor self-funded health plans, health care provider organizations and others who may be financially responsible for payment for the services or benefits the member receives under our plan), vendors, consultants, government authorities and their respective agents. These parties are required to keep member health information confidential as provided by applicable law. We train employees who handle member health information regarding our confidentiality privacy policies and procedures.

Aetna and participating providers need access to member health information to fulfill a number of important and appropriate functions, including, claims payment, misuse prevention, coordination of care, data collection, performance measurement, compliance with state and federal requirements, quality management, utilization review, research and accreditation activities, preventive health, early detection and disease management programs.

Our Notice of Privacy Practices, which provides detailed information about our policies concerning disclosure of member information, is available on our website at

www.aetna.com/about/information_practices.html.

AETNA.COM WEBSITE

Aetna has adopted and adheres to stringent security standards designed to protect non-public personal information at aetna.com against accidental or unauthorized access or disclosure. Among the safeguards that Aetna has developed for this site are administrative, physical and technical barriers that together form a protective firewall around the information stored at this site. We periodically subject our site to simulated intrusion tests and have developed comprehensive disaster recovery plans.

AETNA NAVIGATOR WEBSITE

Aetna Navigator is a secure site employing secure socket layer (128-bit encryption) which is the industry standard for Internet security.

AETNA MOBILE APPLICATIONS

Authentication methods for Mobile application are consistent with the same as Web application.

AETNA SECURE E-MAIL ENCRYPTION

Attached is our secure E-mail Privacy Practice document.

Attachments: [Aetna Secure Email.pdf](#)

5.1.5.3 Confirm you are currently receiving eligibility files in the HIPAA 834 format.

Answer: 1: Confirmed

Detail: We are fully compliant with all HIPAA requirements and regulations.

Options:

1. Confirmed
2. Not Confirmed

Attachments:

5.1.5.4 Are your eligibility and claim systems compliant with recently updated HIPAA regulations?

Answer: 1: Yes

Detail: We are fully compliant with all HIPAA requirements and regulations.

Options:

1. Yes
2. No

Attachments:

5.1.5.5 Please list the dates in which your eligibility and claims systems were reviewed or validated against the updated HIPAA regulations.

Answer: We are in full compliance with the requirements that have been issued to date. This includes review and validation of our eligibility and claim systems. Following is a brief summary:

PRIVACY

As of the April 14, 2003 Privacy Rule compliance deadline, we had taken all steps necessary to

comply with the Privacy Rule requirements, including:

- Naming a chief privacy officer and establishing a Privacy Office.
- Implementing new and/or revised company-wide privacy policies and procedures.
- Training impacted personnel.
- Implementing system changes and workflows to provide members with (i) access to their health information, (ii) an accounting of many types of disclosures, (iii) a process for requesting amendments to their health information, and (iv) the ability to request restrictions or have confidential information mailed to an alternative address.
- Delivering a Privacy Notice to full risk subscribers.
- Adopting specific disciplinary procedures and sanctions for employees who violate our Privacy Policies.

TRANSACTIONS AND CODE SETS

As of October 16, 2003, we were positioned to support HIPAA compliant electronic transactions and code sets. We have the flexibility to accept both compliant and non-compliant electronic claims, consistent with guidance provided by the Centers for Medicare and Medicaid Services (CMS).

SECURITY

To prepare for the HIPAA Security Rule, we performed a thorough risk assessment of our systems (including our eligibility and claim systems) and operations and developed and executed a remediation plan. We were compliant with the HIPAA Security Rule as of the April 20, 2005 compliance date.

UNIQUE IDENTIFIERS

Aetna has been compliant with the unique Employer Identifier Number (EIN) requirement since July 30, 2004.

As of May 23, 2007, we were ready to accept and process HIPAA standard electronic transactions that comply with the National Provider Identifier (NPI) regulations. Effective March 16, 2009, to comply with HIPAA regulations, we began rejecting electronic claims and encounters submitted without a billing provider NPI. If a "pay to" provider is identified on a claim, the NPI for that provider must also be included. We continue to work diligently with providers to educate them and bring them into compliance according to the HIPAA regulation.

The Payer regulation is not final. Once finalized, we will have two years to comply. Our approach will ensure compliance within the 2-year requirement.

Attachments:

5.1.5.6 Was an outside auditor/reviewer employed for HIPAA review/validations of these two systems?

Answer: No. We do not employ an outside auditor for HIPAA validation. HIPAA compliance is managed internally and Aetna is in compliance with all required regulations.

Attachments:

5.1.5.7 How soon after the contract award will you provide the HIPAA companion guide for creating eligibility files that load to your system?

Answer: The State of Alaska's assigned eligibility consultant can forward the EDI record layout upon award of contract or during the implementation period.

Attachments:

5.1.5.8 Confirm your ability to administer HIPAA creditable coverage notices.

Answer: HIPAA certificates are only produced for medical products.

We do not produce HIPAA certificates for limited scope products (i.e., dental, vision or pharmacy plans not bundled with medical coverage). The law does not apply to limited scope plans and thus we do not include these plans as being in the scope of the production of HIPAA certificates of creditable coverage.

Attachments:

5.1.6 Communications

5.1.6.1 Confirm that you are able to customize all communication/educational materials to include the AlaskaCare logo as the prominent feature.

Answer: 1: Confirmed

Detail:

Options:

1. Confirmed
2. Not Confirmed

Attachments:

5.1.6.2 Can you provide communication materials in an electronic and editable format for use by the State in their communications? If there is an additional cost, please indicate the cost in the rate sheet.

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

5.1.6.3 Please confirm all communications/educational materials will be submitted to the Project Director, or his designee, for review and approval before dissemination to members. If you cannot confirm, please explain.

Answer: 1: Confirmed

Detail: The State is welcome to review our member communication materials and we will work with you to ensure your satisfaction with all communications.

Member communications are provided in simple, easy-to-understand language. The material is produced in compliance with all applicable regulatory requirements and adheres to recommended reading levels. We submit our material to the National Committee for Quality Assurance (NCQA) and adhere to their strict guidelines for writing understandable plan information. We also conduct consumer research to test members' understanding of our material.

Options:

1. Confirmed

2. Not confirmed, please explain: [Text]

Attachments:

5.1.6.4 When are new ID cards generated?

Answer: 4: Other. Please explain: [Our standard is to generate ID cards at initial election. However, a new card will be generated when information changes during the year. We will send a new ID card when data on the card changes. Below is a list of the data changes that trigger a new card:

- Claim office change
- Unique customer number change, except when we suppress this code on the ID card
- ID number change (employee only)
- Name change (employee and/or dependent)
- New member enrollment (dependent)
- PCP/PCD changes
- Plan changes

After we receive the request, members typically receive replacement cards in approximately 7-10 days. There is no cost for replacement ID cards or revised cards (e.g. change name).

Members can view and print their ID card-level information through the temporary ID feature on Aetna Navigator®, our secure member website at www.aetna.com.

Members can view their ID card directly from their mobile phone.]

Detail:

Options:

1. At Initial Election
2. Annually
3. At Life Event Change
4. Other. Please explain: [Text]

Attachments:

5.1.6.5 Describe your process for generating and mailing ID cards within 3 business days on an ongoing basis as new enrollees are reported eligible.

Answer: Our standard delivery for members to receive their new card is about 7 to 10 business days. In the 2nd quarter of 2012, 93.6 percent ID cards were printed and mailed within 3 calendar days.

When the State sends us updated eligibility information, the eligibility analyst process the changes into the system. Each night, we process all ID card event triggers and create an output file. The file goes to a secure FTP site. From there, the ID card vendor, Source One Direct, picks up the file and begins production.

Attachments:

5.1.6.6 Are extra ID cards available for a dependent child living away from home? If there is an additional cost, please indicate the cost on the rate sheet.

Answer: 1: Yes

Detail: There is no additional cost.

Options:

1. Yes
2. No

Attachments:

5.1.6.7 Please describe the process that will be implemented to ensure that internal reference source(s) provided to your personnel are consistent with the State's documentation such as employee communication materials, open enrollment information, plan documents.

Answer: We ensure that all of our service center staff are specifically trained on the State's benefit program, special administrative issues and other unique requirements.

During this training, we use copies of the State's employee benefit booklets, announcements, other communications and any materials that the State recommends. We review your communication documents to our staff which provides our staff with a clear understanding of your program. This provides continued support in responding to employee inquiries, as well as claim settlement. We welcome the State's participation in this process.

We test all plans as part of the implementation process. A key tool in this process is the Single Source Document (SSD). We use the document as the basis to build and test the benefit plan. SSD captures major plan changes and serves as a confirmation to the State of the benefits plan.

ONLINE TRACKING SYSTEM

We use an online tracking and documentation system called Aetna Strategic Desktop (ASD) for member and provider contracts including telephone calls, written correspondence, Internet e-mail and walk-in visitors.

When a member opts out of Aetna Voice Advantage for additional service, the customer service representative (CSR) will receive a screen pop up that provides important information about the member and what they are calling about. The system provides a 360 degree view of the member's information on file. They have access to eligibility data, benefit descriptions, provider files, detailed claim history and other online resources that allow them to resolve many inquiries during the initial contact with the member.

Attachments:

5.1.6.8 Is the creation, customization, production, and distribution of the materials itemized below included in your cost proposal?

- I. If there is an additional cost for any of the items listed below, please indicate each additional cost on the rate sheet.
- II. Will each of the items listed below be made available online?
- III. Please identify any additional communication and/or educational materials not listed below that are included in your cost proposal, and provide an example of each where possible.
- IV. Please identify any additional communication and/or education materials not listed below that you can provide for an additional fee. Please indicate each additional cost on the rate sheet.

	Can Provide?	Included in Fees? If no, include fee on rate sheet.	Can Customize?
Employee ID Cards	1: Yes	1: Yes	1: Yes
Replacement ID Cards	1: Yes	1: Yes	1: Yes
Claim Forms	1: Yes	1: Yes	1: Yes
Provider Directories	1: Yes	1: Yes	1: Yes
Summary Plan Descriptions	1: Yes	2: No	1: Yes
Summary Annual Reports	1: Yes	2: No	1: Yes
Summary of Material Modifications	1: Yes	2: No	1: Yes
Annual Benefit Statements	1: Yes	2: No	1: Yes
General Letters and Correspondence Sent to Employees	1: Yes	1: Yes	1: Yes

Detail: 1. Please refer to rate sheet for cost of Summary Plan Description, Summary of Material Modification and Annual Benefit Summaries.

2. The above is available online.

3. We offer user-friendly online tools to help members more effectively use their dental plan and make more informed care decisions. Resources include:

- DocFind® - Our online directory of participating providers is accessible from our public website and is available in English and Spanish. We update DocFind six times per week.
- Simple Steps to Better Dental Health® - Our educational website at www.simplestepsdental.com provides members with comprehensive dental health information.
- Aetna SmartSourceSM - Our intelligent online search tool is available through Aetna Navigator, Simple Steps To Better Dental Health and our Personal Health Record (PHR).
- Ask Ann - Our virtual assistant, “Ann”, provides members with personalized guidance to find health and dental benefits information on our Aetna Navigator website. In her role as a subject matter expert, members can ask her questions in their own words.
- Aetna IntelliHealth - Our health information subsidiary at www.intelihealth.com is a leading source of online health information.
- Access Healthwise® Knowledgebase - Our user-friendly decision-support tool helps members make more informed health decisions, such as when to treat a health problem at home, when to call a doctor or dentist and what treatment options may be available.
- Estimate the Cost of Care (ECC) - This interactive tool provides members with cost information to help them plan for and better manage their dental care expenses.
- Dental Plan Selection & Cost Estimator Tool - Available upon request, we offer this decision support tool during open enrollment to help the State's employees select the dental plan that is right for them. We customize the tool to reflect the State's Aetna benefit offerings.

4. Claim Forms: We are able to customize claim forms with the State's name (plan name), logo and control number, for an additional charge. We can also provide a PDF-formatted version of the claim

form that can be stored on your intranet.

Summary Booklet: We provide the State with booklet materials in PDF format that describe the benefit plan. We include the cost of printing these materials in our rates. We will print these materials for an additional cost. Our Customized Communications GroupSM (CCG) can also develop and deliver customized SPDs for the State. Pricing for customized materials is provided based on the scope of each specific request.

Attachments: [Aetna Dental Plan Selection and Cost Estimator.pdf](#)
[Aetna Smartsource Brochure.pdf](#)
[Simple Steps to Better Health Website.mht](#)
[Aetna DocFind Brochure.pdf](#)

5.1.6.9 What is the average number of work days from placing an order to time of delivery for the following communication materials?

	Average Days to delivery
Employee ID cards	7
Enrollment forms	5
Claims forms	5
Provider Directories	0
Program Descriptions	5

Detail: Printed member communications are available throughout the year, within 5-10 business days from the time of request from our fulfillment center. The timeframes listed above are for hard copy communications. Enrollment forms, claim forms, provider directories and program descriptions are all available for members in real-time through our member website.

Attachments:

5.1.6.10 Please attach sample member communication materials, including a sample ID card and sample member welcome letter.

Answer: 1: Attached

Detail: Our fees include the cost of standard enrollment and new member materials.

We supply the following enrollment and new member materials to the State through bulk shipment for distribution to employees:

- Benefit summaries
- Enrollment forms
- Product brochures
- Booklet-certificates
- Summary of coverage documents

Our fees do not include the cost of printing or mailing provider directories to members' homes. If requested, we can mail a limited quantity of directories to the State through bulk shipment. There is an additional cost to provide a directory for each employee.

Members have immediate online access to our provider directories through DocFind® at www.aetna.com. DocFind allows members to search for local participating general and specialty dentists. Members can also request driving directions. We update DocFind six times per week.

Options:

1. Attached
2. Not Attached

Attachments: [Aetna Dental Enrollment Form.pdf](#)
[Aetna Navigator Brochure.pdf](#)
[Aetna Dental PPO Family ID Card.jpg](#)
[Aetna Dental PPO Individual ID Card.jpg](#)
[Aetna Dental PPO Plan Booklet.doc](#)
[Aetna Dental PPO Product Brochure.pdf](#)

5.1.7 Information Technology

5.1.7.1 Describe how your company will use its systems technologies to perform each aspect of the work set forth in Section 1.04 of the RFP instructions relative to the Dental Claims Administration and Managed Network.

Answer: Industry leading technology is at the heart of our programs. We will use our advanced technologies and systems to help ensure that the State's plan runs at the optimal level of efficiency. We will use the following systems, software, and applications in connection with the State's plan:

CLAIMS PROCESSING

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

UNBUNDLING SOFTWARE

We use dental logic software to detect the unbundling of charges. As the software is built into our claim system, it is an automated process. We also refer claims to dental consultants in our utilization review units to identify services that are unbundled.

NETWORK INFORMATION

Provider information is loaded into our Enterprise Provider Database (EPDB), a relational database, which is the single source of provider network information. The EPDB also holds provider credentialing data; however, extensive credentialing and recredentialing data is held in our Enterprise Provider Credentialing (EPC) database. Provider contracts are stored in our Strategic Contract Manager system (SCM), another relational database. Fee schedules and hospital and ancillary rate information are loaded into our Service Code Service Rate system (SCSR), a repository of service codes, rating systems and provider reimbursement rates.

Our claim system reads the EPDB directly for provider matching, and then accesses the SCM or SCSR for provider rate information. Inquiry screens provide information on individual, facility and ancillary providers. Our claims staff can retrieve specific provider information when searching by name, provider identification number or tax identification number.

CUSTOMER SERVICE

We use an online tracking and documentation system called Aetna Strategic Desktop (ASD) for member and provider contacts including telephone calls, written correspondence, Internet e-mail and walk-in visitors. This system allows us to monitor and follow those inquiries until they are resolved. We document all calls with the exception of transfers or general information questions.

ELIGIBILITY AND BILLING

Member Enrollment Application (MEA) is our billing and enrollment system. We originally developed the system in-house in 1988. We redeveloped the system in 2004 leveraging data and structure in place since 1988. The billing features of MEA interface with the appropriate financial system.

AETNA HEALTH INFORMATION ADVANTAGE

Aetna Health Information Advantage™, our new information application software tool created by Aetna Informatics®, makes performance experience data available in real time through the Internet.

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

We have made significant investments into our technology offering. The following describes our recent history regarding technology expenditures.

For 2011, total Information Technology spend was \$1.1 billion, with \$477 million or 43 percent earmarked for “Projects” (new application development and significant enhancements), with Pharmacy/Fulfillment (including mail order integration with CVS-Caremark), Strategic System & Processes Program (multi-year program that migrates applications to a single platform), and regulatory requirements for ICD-10 revisions and Health Care Reform (processing mandated changes and tracking) making up a significant portion of that investment (52 percent, altogether).

2012 Plan currently calls for Total Information Technology spend of \$1.07 billion, with \$403 million or 38 percent earmarked for “Projects”, with about 25 percent being invested in Regulatory activities (Health Care Reform and ICD-10), 17 percent in Integrated Front-End and application simplification, 18 percent to drive medical cost management, and the remaining 40 percent going towards various investments in several areas, including development of mobile applications, improvements in member transaction services, large customer commitments, and Medicare.

Our technology identifies opportunities for improved care by applying clinical rules to the medical information derived from members' medical and pharmacy claims, lab data and health risk assessments. While separate units handle care management, eligibility, member services and claims functions, the data associated with each of these is integrated online. This allows each function to review the others when needed. Through our electronic utilization management system, claims processors, member services and eligibility consultants can view all medical utilization decisions and documentations. These are immediately available in real time after entered by our nurse reviewers. We also continuously integrate information from our pharmacy claims system with other medical claims and eligibility information.

We are delivering on our promise to provide our constituents with the most comprehensive suite of tools and services that today's technology can deliver. Whether it is reducing the time for claim payments to physicians, providing members with 24-hour access to personalized benefits information or offering the State the ease of online benefits administration, we are taking advantage of technology to enhance the services we provide.

Attachments:

5.1.7.2 Does your automated data processing capability include the ability to interface with the State's health reporting eligibility system when fully operational?

Answer: We work with many customers who use third party enrollment vendors; however, we do not directly interface with their systems. The State can extract data and send our proprietary 2000-byte file layout, our new Consolidated Eligibility Format file or an ANSI standard layout for electronic processing. Because electronic submission tends to be more efficient and accurate, we encourage the State to implement an electronic submission method, regardless of the human resources information system you use. This process is available for initial and subsequent enrollments.

Additionally, our Account Team can establish processes to access the State's systems and we will work with the State to create the optimal process for the member's experience. In addition, we can use your system to check eligibility when it has not yet been loaded into our system.

Attachments:

5.1.7.3 Describe the proprietary software that will be used in administration of this Contract, as well as any services or software purchased or licensed from outside vendors to update your system.

Answer: We will use the following systems, software, and applications in connection with the State's plan:

CLAIMS PROCESSING

We process claims on Automatic Claim Adjudication System (ACAS). We customized ACAS, based on the Dun and Bradstreet system ClaimFacts®, to support our book of business. The system hardware is IBM.

NETWORK INFORMATION

Provider information is loaded into our Enterprise Provider Database (EPDB), a relational database, which is the single source of provider network information. The EPDB also holds provider credentialing data; however, extensive credentialing and recredentialing data is held in our Enterprise Provider Credentialing (EPC) database. Provider contracts are stored in our Strategic Contract Manager system (SCM), another relational database. Fee schedules and hospital and ancillary rate information are loaded into our Service Code Service Rate system (SCSR), a repository of service codes, rating systems and provider reimbursement rates.

Our claim system reads the EPDB directly for provider matching, and then accesses the SCM or SCSR for provider rate information. Inquiry screens provide information on individual, facility and ancillary providers. Our claims staff can retrieve specific provider information when searching by name, provider identification number or tax identification number.

CUSTOMER SERVICE

We use an online tracking and documentation system called Aetna Strategic Desktop (ASD) for member and provider contacts including telephone calls, written correspondence, Internet e-mail and walk-in visitors. This system allows us to monitor and follow those inquiries until they are resolved. We document all calls with the exception of transfers or general information questions.

ELIGIBILITY AND BILLING

Member Enrollment Application (MEA) is our billing and enrollment system. We originally developed the system in-house in 1988. We redeveloped the system in 2004 leveraging data and structure in place since 1988. The billing features of MEA interface with the appropriate financial system.

AETNA HEALTH INFORMATION ADVANTAGE

Aetna Health Information Advantage™, our new information application software tool created by Aetna Informatics®, makes performance experience data available in real time through the Internet.

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

OWNERSHIP

We own or lease the hardware and software. Where third party software programs exist and are used, appropriate service agreements are in place and, if necessary, vendor personnel are located on-site for maintenance support. The Applications Development Services group provides application programming support for Aetna's primary software applications.

Attachments:

5.1.7.4 Are all data feeds for set-up and on-going maintenance included in your pricing? If not, please include the fees on the rate sheet.

Answer: Confirmed. Please refer to our rate sheets.

Attachments:

5.1.7.5 Please indicate any additional charges for any required manual interventions (workarounds) due to system interface incompatibility, file format issues, plan compliance, etc. on the rate sheet.

Answer: Our pricing assumes no manual workarounds.

Attachments:

5.1.7.6 Describe your system access security process with members, providers and the State.

Answer: MEMBERS

Aetna Navigator®, our secure member website, has complies with all HIPAA privacy rules. Navigator is a secure site employing secure socket layer (128-bit encryption) which is the industry standard for Internet security. If a family member requests that access to his/her information be restricted, or the family member is an adult dependent, that member's information will be filtered out of Aetna Navigator, and will not be visible on the site.

PROVIDERS

Through Aetna's secure provider website, providers have access to a multitude of transactions and a variety of features. Providers must register through the site where they will receive a secure login ID and password.

Aetna EDI ConnectSM allows providers to submit electronic transactions to Aetna free of charge, without using a third-party vendor. Providers must register through Aetna EDI Connect where they will receive a secure login ID and password. The website is available to all providers whose practice management system can submit files conforming to the American National Standards Institute (ANSI) ASC X12 standards.

STATE OF ALASKA

Aetna Health Information Advantage

The account manager facilitates the registration process with the State's representatives who require access to their plan data through Aetna Health Information Advantage. We will issue a User ID and password and provide registration instructions.

ASD and Employer Secure Website

Access to ASD External View and our Employer Secure Website is granted after all proper individuals have been identified.

Attachments:

5.1.7.7 Describe the advantages of your Internet home page, including access and capability to communicate with the State and members on information regarding:

- a. Claims status
- b. Eligibility (name, address, covered dependents, etc.)
- c. Providers (including name, location, education background and credentials, gender, specialty, languages spoken, standard rates for selected procedures, patient satisfaction levels, etc.); and
- d. Health improvement and education information

Answer: As one of the nation's leading providers of dental benefits, we are pleased that national organizations and publications recognize us for our innovations in technology. The following list represents some of the achievements of which we are most proud.

- In 2012, Aetna and Silverlink Communications received a top award in Consumer Innovation at the 2012 TripleTree iAwards for Wireless Health for their text messaging program for members diagnosed with diabetes.

- In 2011, the International Data Group (IDG) recognized us for removing paper from the contracting process. Each year, IDG's InfoWorld Green 15 Awards honor the 15 most innovative IT initiatives that embrace sustainability. We are the first health insurer to offer electronic contract processing to doctors, hospitals and other health care facilities. Using an e-signature solution, we:

- Complete contracts faster and more reliably
- Reduce fax and mail expenses
- Reduce our carbon footprint

- In 2010, Aetna's wholly-owned subsidiary, ActiveHealth Management®, was honored as the 2010 Gold Web Health Award winner in the category of Web Portal/Gateway Site for its personal health portal, MyActive HealthSM. The portal offers personalized resources to help members take action to improve their health.

- In 2010, InformationWeek ranked Aetna number 50 in its annual InformationWeek 500, a list of the top technology innovators in the country. The list identifies companies that harness the power of innovation in information technology, including tools and technology that are redefining the health care delivery system.

MEMBERS

Members are looking for convenient, round-the-clock online tools and information to help them make educated health care decisions and manage their benefits online. Aetna Navigator®, our secure member website at www.aetna.com, offers several online resources which include benefits information, health education, health assessment tools, cost and quality tools and health care decision

support.

- Aetna Navigator offers secure functionality allowing members to:
- View eligibility and GPD selections for themselves or covered dependents.
- Inquire or view details about the status of a medical, dental and pharmacy claim for themselves or a covered dependent.
- View benefit balances such as deductible and coinsurance maximums.
- View EOB statements.
- Contact Member Services through secure email messaging.

Aetna Navigator member ID information, registration, claim search and Contact Us features are available on a mobile version of the website, allowing for the functionalities to be available in a more user-friendly format, specific to the mobile device being used.

We offer user-friendly online tools to help members more effectively use their dental plan and make more informed care decisions. Resources include:

- DocFind® - Our online directory of participating providers is accessible from our public website and is available in English and Spanish. We update DocFind six times per week. DocFind includes details about participating dentists, such as location, dental school attended and year of graduation. Public DocFind is also available on mobile devices.
- Simple Steps to Better Dental Health® - Our educational website at www.simplestepsdental.com provides members with comprehensive dental health information in collaboration with The Columbia University College of Dental Medicine. The site includes 17 major topic areas, interactive tools, an “Ask the Dentist” feature, detailed information on over 50 conditions and procedures, and information on the effects that medical conditions such as diabetes and heart disease can have on oral health. The site also features resources for children to learn about dental terms and the importance of taking care of their teeth at an early age. For example, children can watch a video that shows the typical experiences of a young girl when she visits her dentist for a check up. Children can also play interactive games such as “Connect the Dots” and explore the “What's In Your Mouth” tool. The site also provides important information to parents about children's dental health, from a baby's first dental visit to the teen years.
- Aetna SmartSourceSM - Our intelligent online search tool is available through Aetna Navigator, Simple Steps To Better Dental Health and our Personal Health Record (PHR). Users simply enter a dental term to find easy-to-understand information and articles about the search topic, estimated costs for dental care, dental discount program information, and dental clinical policy bulletins. Aetna SmartSource integrates information about the importance of good oral health into search results for related health conditions, such as diabetes or pregnancy. It also features this information for users who have identified relevant health conditions in their PHR. For example, users who list diabetes as a condition on their PHR will see featured articles about gum disease.
- Ask Ann - Our virtual assistant, “Ann”, provides members with personalized guidance to find health and dental benefits information on our Aetna Navigator website. In her role as a subject matter expert, members can ask her questions in their own words. Ann translates a member's natural language and

returns the appropriate responses and additional web links. Ann knows specific information about each member, so she can offer personalized support. Ann knows which page the member is on and supplies relevant page information specific to the member. With an average of over 20,000 chats per day, her fast and relevant responses range from simple transactional information to expansive knowledge that targets the two most important member topics - claims and benefits.

- Aetna IntelliHealth - Our health information subsidiary at www.intelihealth.com is a leading source of online health information. We partner with Columbia University College of Dental Medicine to provide credible dental content to educate members and engage them in their dental health.
- Access Healthwise Knowledgebase - Our user-friendly decision-support tool helps members make more informed health decisions, such as when to treat a health problem at home, when to call a doctor or dentist and what treatment options may be available. Available in both English and Spanish, we designed Healthwise Knowledgebase to encourage informed health decision-making, allowing users to better understand their treatment options.
- Estimate the Cost of Care (ECC) - This interactive tool provides members with cost information to help them plan for and better manage their dental care expenses. Members can compare the estimated average in-network and out-of-network costs in their area for selected dental services and see the potential cost savings by choosing a participating dentist. ECC also links to Aetna IntelliHealth and Healthwise Knowledgebase.
- Dental Plan Selection & Cost Estimator Tool - Available upon request, we offer this decision support tool during open enrollment to help the State's employees select the dental plan that is right for them. We customize the tool to reflect the State's Aetna benefit offerings. The tool educates employees about their dental benefits and encourages them to select the most cost effective dental plan to meet their needs. It includes high-level in-network plan details, such as copay, coinsurance and deductible amounts, so employees can compare costs of dental plan options. We have found that this approach not only encourages employees to become better dental care consumers but also builds employee satisfaction with their dental benefits.
- CarePass and iTriage - We recently launched an open digital platform, CarePass® that will enable consumers to securely share information across mobile applications, sharing information as they specifically permit. As part of the March launch, we also introduced the updated iTriage® application, the first application connected to the CarePass platform. Through iTriage, members can locate all dentists in an area, those participating in our Aetna networks, and those who do not.

STATE OF ALASKA

While Aetna Navigator is geared toward our members, we offer the State other tools that you can access to view important plan information.

EMPLOYER SECURE WEBSITE

Our Employer Secure Website makes it easy for you to get the information you need, whenever you need it. The site features one-stop benefits administration functions available through single sign on and an easy to navigate home page with links to commonly used resources.

The Employer Secure Website allows you to quickly perform common administrative functions. The State can:

- Check eligibility status.

- Request an ID card.
- Review plan information and link to plan documents.

The home page of the Employer Secure Website provides quick links to the most commonly used customer resources, including:

- Access to reports - You can view our full suite of reports with a single sign on. From utilization reports to claim, banking, medical management and wellness reports, the site provides a convenient way to access data in one place. You can also view ad hoc reports from the site.
- Contact with the account team - The site provides direct e-mail access to the State's account team. This includes the account manager, account executive, eligibility consultant and claim contact.
- The latest news and announcements - From the Employer Secure Website home page, you can catch up on the latest developments at Aetna and in the health care industry as a whole.
- Access to other resources - You can link directly to Aetna Navigator®, DocFind® and our aetna.com home page.
- Requests for site customization - We can provide customer logos, customized DocFind, contact information for the account team, and customized links.

ACCESS TO CLAIMS AND BENEFITS INFORMATION

We have the capability to provide the State with access to member eligibility, benefit information and claim information using external access to Aetna Strategic Desktop (ASD). Customers approved for external access to Aetna Strategic Desktop will have the ability to view:

- Detailed member/subscriber information, including eligibility
- Detailed plan information
- COB information on file
- Detailed benefit information, including general policy provision, special programs available, and benefit changes that may have occurred
- Both allowed and remaining accumulator amounts, including deductible, coinsurance amount, office visits (i.e., eye exams)
- Detailed claim history and payment inquiry, including provider name, procedures codes, diagnosis codes, type of service codes and place of service codes. Customers will have read only access to this information and will not have the ability to reprocess claims.

The State will have the ability to create their own notes in ASD, as well as access to view notes that they previously created. Due to privacy issues, you will not have access to call tracking/resolution notes created by our customer service representatives. Our customer service representatives will have the ability to view customer input notes and can use them to assist callers with calls they may have relating to the same issue.

Attachments:

5.1.7.8 Explain your process of providing a secure electronic portal for members and providers to contact you via e-mail for customer service inquiries.

Answer: MEMBERS

Member can use Aetna Navigator to send a written inquiry to member services. Every page on the Aetna Navigator site has a "Contact Us" link, making it simple to send a secure message to member services whenever they have a question or concern. If the State also selects Aetna for medical, the member will also have the ability to have live chat with the My AlaskaCare Single Point of Contact (health concierge).

PROVIDERS

Our secure provider website offers many features to providers, including the ability to submit inquiries to customer service via e-mail.

Attachments:

5.1.7.9 Describe your company's use of current system technologies to notify customers of issues that relate to them.

Answer: Your account team will be well informed internally about any issues, changes, or items that the State should be aware of and personally notify the you to ensure that any appropriate actions will be taken.

Lynda Gable, your account executive, and Katie Lynch, your account manager, will be the liaisons between the State and Aetna. They are responsible for the plan's day-to-day and strategic activities and are readily available to work with you to ensure all of your needs are met on a daily basis. They can advise and assist you on all facets of your plan including member issues, network information, outages, response to weather events, etc.

Additionally we will provide a single point of contact for assisting you with any service center-related issues. We will also assign an eligibility consultant to work with you regarding eligibility file submissions and any eligibility issues that may arise.

The State can also use our Employer Secure Website to contact our account team. The site provides direct e-mail access to the State's account team. This includes the account manager, account executive, eligibility consultant and claim contact. The State can also get the latest news and announcements from the site's home page to catch up on the latest developments at Aetna and in the health care industry as a whole.

Attachments:

5.1.7.10 Describe any on-line comparative reporting tools you make available to assist members in choosing elective care providers and facilities.

Answer: We offer user-friendly online tools to help members more effectively use their dental plan and make more informed care decisions. Resources include:

- Aetna SmartSourceSM - Our intelligent online search tool is available through Aetna Navigator, Simple Steps To Better Dental Health and our Personal Health Record (PHR). Users simply enter a dental term to find easy-to-understand information and articles about the search topic, estimated costs for dental care, dental discount program information, and dental clinical policy bulletins. Aetna SmartSource integrates information about the importance of good oral health into search results for related health conditions, such as diabetes or pregnancy. It also features this information for users who have identified relevant health conditions in their PHR. For example, users who list diabetes as a

condition on their PHR will see featured articles about gum disease.

- Estimate the Cost of Care (ECC) -This interactive tool provides members with cost information to help them plan for and better manage their dental care expenses. Members can compare the estimated average in-network and out-of-network costs in their area for selected dental services and see the potential cost savings by choosing a participating dentist.
- Dental Plan Selection & Cost Estimator Tool - Available upon request, we offer this decision support tool during open enrollment to help the State's employees select the dental plan that is right for them. We customize the tool to reflect your Aetna benefit offerings. The tool educates employees about their dental benefits and encourages them to select the most cost effective dental plan to meet their needs. It includes high-level in-network plan details, such as copay, coinsurance and deductible amounts, so employees can compare costs of dental plan options. We have found that this approach not only encourages employees to become better dental care consumers but also builds employee satisfaction with their dental benefits.
- DocFind® - Our online directory of participating providers is accessible from our public website and is available in English and Spanish. We update DocFind six times per week. DocFind includes details about participating dentists, such as location, dental school attended and year of graduation. Public DocFind is also available on mobile devices. Members can also get a complete listing of dentists (not just those participating in our networks) through the iTriage application.

Attachments:

5.1.7.11 Indicate services you offer to members and providers via e-mail and electronically.

Answer: MEMBERS

Members are looking for convenient, round-the-clock online tools and information to help them make educated dental care decisions and manage their benefits online. Our Aetna Navigator® secure member website offers many member self-service functions and robust dental health information, tools and resources.

Aetna Navigator features secure functionality allowing members to:

- Check claim status and view claim details such as the amount paid by the plan and the member's responsibility
- View eligibility information for themselves or a covered dependent
- Request a replacement ID card, view ID card information and print a scaled-down wallet sized image, if needed
- View explanation of benefits statements
- Contact member services through secure email messaging, and if the State selects the Aetna medical plan as well, members can live chat with our My AlaskaCare Single Point of Contact (health concierge)
- Download personal claims safely and securely to a computer or disk for use in planning for dental care expenses, tax reporting and record keeping

We offer user-friendly online tools to help members more effectively use their dental plan and make

more informed care decisions. Resources include:

- **Simple Steps to Better Dental Health®** - Our educational website at www.simplestepsdental.com provides members with comprehensive dental health information in collaboration with The Columbia University College of Dental Medicine. The site includes 17 major topic areas, interactive tools, an “Ask the Dentist” feature, detailed information on over 50 conditions and procedures, and information on the effects that medical conditions such as diabetes and heart disease can have on oral health. The site also features resources for children to learn about dental terms and the importance of taking care of their teeth at an early age. For example, children can watch a video that shows the typical experiences of a young girl when she visits her dentist for a check up. Children can also play interactive games such as “Connect the Dots” and explore the “What's In Your Mouth” tool. The site also provides important information to parents about children's dental health, from a baby's first dental visit to the teen years.
- **Ask Ann** - Our virtual assistant, “Ann”, provides members with personalized guidance to find health and dental benefits information on our Aetna Navigator website. In her role as a subject matter expert, members can ask her questions in their own words. Ann translates a member's natural language and returns the appropriate responses and additional web links. Ann knows specific information about each member, so she can offer personalized support. Ann knows which page the member is on and supplies relevant page information specific to the member. With an average of over 20,000 chats per day, her fast and relevant responses range from simple transactional information to expansive knowledge that targets the two most important member topics - claims and benefits.
- **Aetna IntelliHealth** - Our health information subsidiary at www.intelihealth.com is a leading source of online health information. We partner with Columbia University College of Dental Medicine to provide credible dental content to educate members and engage them in their dental health.
- **Access Healthwise Knowledgebase** - Our user-friendly decision-support tool helps members make more informed health decisions, such as when to treat a health problem at home, when to call a doctor or dentist and what treatment options may be available. Available in both English and Spanish, we designed Healthwise Knowledgebase to encourage informed health decision-making, allowing users to better understand their treatment options.
- **DocFind®** - Our online directory of participating providers is accessible from our public website and is available in English and Spanish. We update DocFind six times per week. DocFind includes details about participating dentists, such as location, dental school attended and year of graduation. Public DocFind is also available on mobile devices.
- **Aetna SmartSourceSM** - Our intelligent online search tool is available through Aetna Navigator, Simple Steps To Better Dental Health and our Personal Health Record (PHR). Users simply enter a dental term to find easy-to-understand information and articles about the search topic, estimated costs for dental care, dental discount program information, and dental clinical policy bulletins. Aetna SmartSource integrates information about the importance of good oral health into search results for related health conditions, such as diabetes or pregnancy. It also features this information for users who have identified relevant health conditions in their PHR. For example, users who list diabetes as a condition on their PHR will see featured articles about gum disease.

PROVIDERS

We offer our providers innovative technologies that streamline communications, simplify administration, and let them focus their time on caring for their patients. Examples include:

- **Provider website** - We offer both participating and non-participating dentists our dental website, available at www.aetnadental.com. The site provides dentists with a range of information and transactions related to our dental products and services. The secure section of the website for non-participating dentists includes information about our dental networks, policies and procedures, patient education information and access to electronic services. The secure section of the website for participating dentists includes all of these features and adds resources such as continuing education courses and dental office guides.
- **Online provider directory** - Participating dentists and their office staff can use our DocFind® directory, available at www.aetnadental.com, to locate participating specialists.
- **Electronic connectivity** - We work with EDI Health Group Inc. (EHG) to offer their ClaimConnect™ tool and partner with Emdeon to offer their electronic services. Through both EHG and Emdeon, dentists can submit claims, check claim status, and verify member eligibility and benefit information in real time.

Attachments:

5.1.7.12 Describe electronic service methods you use to educate members in accounts you currently manage of similar size to the State of Alaska about health care issues that impact plan costs.

Answer: Electronic member communications that we provide to our dental members include our Member Essentials newsletter, which members sign up for on Aetna Navigator. The newsletter includes topics on overall wellness including dental wellness. We also offer Simple Steps to Better Dental Health, which members can sign up for to get weekly emails about dental health topics and tips.

We can also provide member-facing videos which the State can share with their employees. We also offer written dental communication materials available for distribution during open enrollment. If the State also selects us as their medical vendor, we could send post-enrollment mailers about our Dental/Medical Integration program which can benefit members with certain health conditions.

In addition, we provide other communication materials such as dental flyers and brochures as well as html e-mails promoting our online tools and resources.

We provide these services to dental customers of all sizes including large public sector clients.

Attachments:

5.1.7.13 Provide an overview of your documentation, storage, retrieval and recovery of electronic files.

Answer: CLAIMS

Our claims system maintains claims history online indefinitely. This includes detailed claim history for each family member on submitted expenses and processed claims (paid, pending and denied).

We move claims greater than five years old that meet specific criteria into an archive database. These claims are available for recall (in most cases, immediately) and will display all claim details.

We also keep three years of financial data on the claims system that are used during adjudication. Financial data beyond the three years are available for historical view only. This includes the family/member's accumulator information such as plan limits, deductibles and amounts accumulated towards those limits.

ELIGIBILITY

The eligibility system maintains current plus at least two years of historic eligibility data online. We have found two years to be the optimal period of online retention for our customer and business needs. The claims systems interface with the eligibility systems and edit claims against the data. There is currently no time limit on how long we maintain offline eligibility.

DATA WAREHOUSE

Our vast data warehouse consists of 18 terabytes of integrated claim, membership, product, and provider information. The data warehouse stores all available months from the current year plus 3 previous years. Therefore, 37 months to 48 months of data are available at any given time.

Attachments:

5.1.7.14 Explain your Computer Disaster Recovery plan. Provide the most recent outside assessment of its readiness.

Answer: Aetna's disaster backup and recovery (DBAR) strategy is to provide and maintain an internal disaster recovery capability. The strategy leverages Aetna's internal computer processing capacity of its two large state of the art and hardened computer data centers, located in both Middletown and Windsor, Connecticut. Both facilities have extensive fire suppression systems, dual incoming power feeds, UPS and backup diesel generators which provide 24x7x365 operations. Physical access is strictly controlled and monitored and access to vital areas is segregated by floor and business function where appropriate. The two data centers house Aetna's computer processing capabilities on 3 major platforms, mainframe (Z/OS), mid-range (Various UNIX versions), and LAN (Windows on X86 processors). The data centers are load-balanced and supplemented by quick ship and capacity on demand contracts so each location can back the other up in the event of a disaster. Contracts with national vendors are maintained to obtain replacement equipment and supplemental capacity as needed to ensure recovery time objectives (RTO) can be met.

Please see attachment "DBAR at Aetna" for a complete summary of Aetna's disaster recovery program.

Regarding outside assessments, Gartner, Inc. performed a Benchmark Assessment of our Disaster Recovery program in 2010. An update will be conducted in 2013.

Attachments: [DBAR at Aetna.pdf](#)

5.1.7.15 Does the online system allow the State to assign different levels of access internally?

Answer: AHIA

Confirmed. There are different levels of access that may be assigned within the Aetna Health Information Advantage System. The State can identify staff members to receive higher and lower access levels as you deem appropriate.

ASD AND EMPLOYER SECURE WEBSITE

The State can identify staff members to receive access to ASD External View and our Employer Secure Website as you deem appropriate. There is only one level of access for these systems.

Attachments:

5.1.7.16 Indicate whether the following web tools are available for the State's use and the members:

Tools Available	Check All that Apply	Comments
Check claim status	1: Available	
Check status of Health FSA and claims	1: Available	
Print a temporary ID card	1: Available	
Request a new ID card	1: Available	
Claims Forms (Electronic)	1: Available	
Find a network dentist	1: Available	
Find an orthodontist or other dental provider in my area	1: Available	
Get plan design information	1: Available	
Get estimated cost for a procedure/service	1: Available	
Review financial information - deductible	1: Available	
Review financial information – out of pocket maximum	1: Available	
Get information about provider quality and/or outcomes	2: Not Available	
Read provider reviews from other members	2: Not Available	
Contact customer service	1: Available	
View and print my EOB	1: Available	
Summary Plan Description	1: Available	
Summary of Material Modifications	2: Not Available	We will provide the employer with revised booklet materials and/or amendments to the booklet materials for distribution to the employees. We do not produce Summary of Material Modifications (SMMs).
Annual Benefit Summaries	1: Available	

Detail:

Attachments:

5.1.8 Integration with Other Vendors

5.1.8.1 Are you willing to provide monthly interface with the data integration vendor or other vendors for claims and utilization data? If there is an additional cost, please indicate the cost on the rate sheet.

Answer: 2: Yes, additional cost (indicated on the rate sheet)

Detail:

Options:

1. Yes, no additional cost
2. Yes, additional cost (indicated on the rate sheet)

3. No

Attachments:

5.1.8.2 Please describe how you will coordinate with other Contractors, if any, to manage functions such as data sharing, eligibility, coordination of benefits and payment of medical, pharmacy and healthcare claims.

Answer: Aetna is proposing to be your sole carrier handling all functions for the State. No coordination with other contractors is required for dental. If the State awards other lines of coverage to other carriers, the following applies:

CLAIMS DATA SHARING

We can transfer data to any vendor that the State designates, with the appropriate confidentiality agreements in place. Recipients of our information use it for analytical reporting, auditing, flexible spending account administration and a host of other health plan functions and services. We typically disclose processed claim transaction data in our standard Universal File format.

We can also import external pharmacy, medical and behavioral health claims data from third-party vendors into selected clinical and reporting applications.

ELIGIBILITY

We work with many customers who use third party enrollment vendors. These vendors can extract data and send our proprietary 2000-byte file layout, our new Consolidated Eligibility Format (CEF) file or an ANSI standard layout for electronic processing.

COORDINATION OF BENEFITS (COB)

We provide COB services as part of our standard offering. We will coordinate benefits using data from our integrated system platforms.

CLAIM PAYMENT

We are offering the State our full administrative services package which includes comprehensive and integrated medical, dental, pharmacy, and health care claims processing services. We do not pay claims for other vendors.

Attachments:

5.1.8.3 Does your program/system have the capability to share data with the following vendors or programs?

- Answer: 1: Biometrics,**
2: Case Management,
3: Demand Management/Nurse Line,
4: Disease Management,
5: EAP/Behavioral health,
6: Health Advocacy/Health Coach,
7: Health Plans/TPA,
8: Health Risk Appraisal,
9: Healthcare savings/FSA,
10: Labs,
11: Maternity Management,
12: Mental Health / Substance Abuse,
13: Nurse and/or doctor line,

14: On site clinics,
15: PBM,
16: Providers,
17: Utilization Management,
18: Wellness/Lifestyle management,
19: Other, please specify: [We can transfer data to any vendor that the State designates, with the appropriate confidentiality agreements in place. Additional charges may apply depending on the number of vendors and the frequency of the transfers.
]

Detail: We have more than 30 years of experience in vendor interface. Recipients of our information use it for analytical reporting, auditing, disease management, flexible spending account administration and a host of other health plan functions and services.

Options:

1. Biometrics
2. Case Management
3. Demand Management/Nurse Line
4. Disease Management
5. EAP/Behavioral health
6. Health Advocacy/Health Coach
7. Health Plans/TPA
8. Health Risk Appraisal
9. Healthcare savings/FSA
10. Labs
11. Maternity Management
12. Mental Health / Substance Abuse
13. Nurse and/or doctor line
14. On site clinics
15. PBM
16. Providers
17. Utilization Management
18. Wellness/Lifestyle management
19. Other, please specify: [Text]

Attachments:

5.1.8.4 Are you capable of designing exports to the FSA vendor to process FSA claims based off dental claim data that is stored within your system?

Answer: 1: Yes

Detail: We provide claims data to your FSA administrators or vendors. A signed confidentiality agreement is required prior to the release of this information. Additional fees could apply depending on the frequency of the feeds and customization requirements.

We can also offer the State our own internal FSA program which would eliminate the need to transfer data to any external vendors.

Options:

1. Yes
2. No

Attachments:

5.1.8.5 Please provide examples of FSA data coordination that you have done with other customers.

Answer: We have worked with approximately 25 different vendors providing claim files for FSA. The vendors that we have sent files to most often are: Wageworks, Hewitt, Aon Hewitt, SHPS, and Ceridian.

Attachments:

5.1.8.6 Are you able to accept electronic feeds of data or referrals from other vendor partners? If there is an additional cost, please indicate the cost on the rate sheet.

Answer: 2: Yes, for an additional fee (indicated on rate sheet)

Detail: We can accept external data for DMI Medical Data Intake. The set up charge is \$12,000 and \$500 per file per vendor for Medical Data Intake Refresh files.

Options:

1. Yes, included in base pricing
2. Yes, for an additional fee (indicated on rate sheet)
3. Yes, for an additional fee IF the number of contracted data feeds are exceeded (indicated on rate sheet)
4. No

Attachments:

5.2 Patient Value Chain

5.2.1 Network

5.2.1.1 Is your network NCQA accredited?

Answer: 2: No

Detail: NCQA is a medical-driven accreditation and generally not applicable to the dental network. We do follow NCQA standards if oral surgery overlaps a medical procedure.

We use Dental Plan Accreditation Standards to credential/recredential our dental networks. The National Association of Dental Plans, a non-profit trade association representing the entire dental benefits industry, created DPAS.

Options:

1. Yes
2. No

Attachments:

5.2.1.2 If your network is NCQA accredited, what was the accreditation date?

Answer: Not applicable.

Attachments:

5.2.1.3 If your network is NCQA accredited, what is the next reevaluation date?

Answer: Not applicable.

Attachments:

5.2.1.4 Please provide your in-network provider list for Alaska, including the numeric breakdown by specialty, name and geographic location of provider.

Answer: 1: Attached

Detail: Please also note that DocFind®, our online provider directory at www.aetna.com, provides information on all our participating providers including physicians, dentists, vision providers, hospitals, and pharmacies.

Options:

1. Attached
2. Not Attached

Attachments: [DPPO- AK.zip](#)

5.2.1.5 Please provide your in-network provider list for the other 49 states, including the numeric breakdown by type, name and geographic location of provider.

Answer: 1: Attached

Detail: Please also note that DocFind®, our online provider directory at www.aetna.com, provides information on all our participating providers including physicians, dentists, vision providers, hospitals, and pharmacies.

Options:

1. Attached
2. Not Attached

Attachments: [DPPO- 49 State.zip](#)

5.2.1.6 Please provide your network provider turnover rate for Alaska.

Answer: As of 9/30/2012, the turnover rate in our Alaska DPPO network was 2.5 percent.

Attachments:

5.2.1.7 Please provide your network provider turnover rate for the remaining 49 states.

Answer: As of 9/30/2012, the turnover rate in our national DPPO network was 4.1 percent.

Attachments:

5.2.1.8 Describe how your in-network provider list for Alaska has changed in the past five years.

Answer: Our in-network provider list in Alaska has increased over three times its size in the last five years.

Attachments:

5.2.1.9 Describe any anticipated changes to your current in-network provider list for Alaska in the next five years.

Answer: We will continue to expand our in-network Alaska provider list based on current client needs and for prospective opportunities.

Attachments:

5.2.1.10 Explain the efforts you are taking to expand your current list of network providers in Alaska.

Answer: We will be happy to work with the State to increase the size of our dental network and incorporate the most highly utilized providers to meet the State's needs.

Aetna Dental agrees to develop a recruitment file identifying the most highly utilized non-network dentists currently utilized by the State of Alaska employees and their dependents. This provider recruitment file will be developed by Aetna based on recent PPO provider claims utilization data, provided by the State of Alaska.

Aetna Dental agrees to specifically target these dentists for participation in our DPPO network. Recruitment activities will include:

Mailing of a letter by Aetna to the 5000 most highly utilized non-network dentists identifying these dentists as a provider of importance to the State of Alaska employees. This letter announces the change in benefit carriers invites dentists to join Aetna's DPPO network and provides instructions for doing so.

A follow-up phone call placed by Aetna to the 500 most highly utilized dentists that belong to another DPPO network. These conversations will facilitate discussion of Aetna's contractual terms and answer any questions that the dentist's office may have regarding our contract.

Aetna will provide a quarterly summary of activity to the State of Alaska outlining the success of this targeted recruitment effort.

Attachments:

5.2.1.11 Explain the efforts you are taking to expand your current list of network providers in the remaining 49 states.

Answer: We continuously monitor our national DPPO network and respond appropriately by addressing local membership needs. When deciding to further develop a local network, we consider:

- Geographic location
- Membership size
- provider availability

The main objectives of network development are quality of service and appropriate provider access. Our network management staff has been successful in meeting the needs of membership growth by actively seeking out quality physicians to provide services. The popularity of our plans reflects our success in developing and maintaining our broad and robust network.

Attachments:

5.2.1.12 Do you wholly own, partially own or lease your network in the state of Alaska?

Answer: We partially own our network in the State of Alaska and nationally.

Attachments:

5.2.1.13 If not wholly owned, please provide details of ownership or leased network arrangement(s).

Answer: We have leased arrangements with two vendors for 30 percent of our network in Alaska

Nationally, we directly contract with approximately 85 percent of our participating providers. The remaining 15 percent come to us through network access arrangements with other network vendors.

Attachments:

5.2.1.14 How quickly will the State be informed when there are changes to the network (additions and deletions)?

Answer: Our standard policy is to notify customers at least 30 days prior to any significant network changes, including hospital or large physician group terminations and additions.

We will have a separate process in Alaska as we work with the state to meet its objectives. Regular network meetings addressing network strategy and expansion will be in place to align to cost and quality goals.

Attachments:

5.2.1.15 How quickly will the provider database be updated (additions and deletions) for member reference?

Answer: We update DocFind, our online provider directory, six times per week.

iTriage will also have our dental network providers. iTriage provides members with information on both network and non-network providers to ensure providers have a full reference in the event they are traveling and need care. It is updated in real time.

Attachments:

5.2.1.16 Are in-network services always provided at the reduced fee for covered services (i.e., charge is less than the provider's normal charge)?

Answer: Confirmed.

Attachments:

5.2.1.17 Please describe your contracted network providers' practices with respect to requesting payment from members at time of service.

Answer: Members may be required to pay copayments, coinsurance and/or deductibles for certain covered services, in accordance with their plan design. While copayments represent a fixed amount, the exact amount of a member's coinsurance or deductible cannot be determined until we process the claim.

Providers learn the member's exact amount owed when they submit the claim to us and wait for the explanation of benefits (EOB), which indicates a description of the services provided, the negotiated amount we reimbursed the provider and the amount the member owes, if applicable. Providers benefit from following this process because it eliminates member overpayment and underpayment, which are time-consuming and costly for the provider to resolve.

We do recognize, however, that some providers are concerned that it may be difficult to collect payment from the member after the date of service and thus seek to fulfill the financial agreement between themselves and the member at the time services are rendered. We believe that these arrangements should be solely between the provider and the patient. Consequently, we will not prohibit providers from requesting a credit card or debit card number at the time of service to facilitate payment as long as the provider informs the member why the information is being requested, the provider agrees to protect the member's card number through encryption or secured access, and the member authorizes the provider to hold the card number. The provider may process the charge of the

member's coinsurance or deductible in the event that the member does not pay the amount indicated as the member's responsibility on the EOB.

Network providers are never permitted to bill the member for any amounts deemed above the allowable limit.

Attachments:

5.2.1.18 Describe how you calculate network savings, including discounts and your financial arrangements. Describe all variables included in the calculation.

Answer: Target savings are calculated on an aggregate basis taking the weighted average of the projected network discounts and employee enrollments by network. Aetna will calculate the client's actual In-network discount savings within the PPO networks by way of the following equation:

Actual Discount Savings Percentage

=

{In-Network Provider Savings (in dollars)*} /
{Trended allowed In-Network FAIR Health Average Charges (in dollars)}

* For the eligible services provided, the difference between the average charges for the area as determined under the trended FAIR Health Benchmark Database Profile and the allowed negotiated fees.

This measurement will be reported using data from Aetna's Informatics data warehouse. Specifically, the Provider Network Experience report within the standard Dental Utilization Report package will be utilized. This report will be generated on a policy year basis.

Attachments:

5.2.1.19 What percentage of your dentists are board certified?

Answer: We do not require board certification to participate in our networks. 100 percent of our general dentists must have graduated from an accredited dental school and be licensed in the state in which they practice.

Attachments:

5.2.1.20 What percentage of your specialist dentists (orthodontists, endodontists, periodontists) are board certified?

Answer: We do not require board certification to participate in our networks. 100 percent of our specialists are required to have completed residency training in an American Dental Association accredited program for the specialty they represent.

Attachments:

5.2.1.21 How often are your dentists and specialists re-credentialed?

Answer: We recredential existing dentists every three years.

Attachments:

5.2.1.22 Please check off those elements that are included in the provider selection process and provide the estimated percentage of network providers that satisfy the following selection criteria elements:

	In Selection Process - Alaska	% of Providers	In Selection Process – other 49 states	% of Providers
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	In Selection Process - Alaska	% of Providers	In Selection Process – other 49 states	% of Providers
Require unrestricted state licensure	1: Yes	100%	1: Yes	100%
Review malpractice coverage and history	1: Yes	100%	1: Yes	100%
Require full disclosure of current litigation	1: Yes	100%	1: Yes	100%
Require signed application and agreement	1: Yes	100%	1: Yes	100%
Require current DEA registration	1: Yes	100%	1: Yes	100%
Review adherence to state and community practice standards	2: No	N/A	2: No	N/A
Onsite review of office location	2: No	N/A	2: No	N/A
Review hours of operation and capacity	2: No	N/A	2: No	N/A
Board eligibility	1: Yes	100%	1: Yes	100%
Review practice patterns and utilization results	2: No	N/A	2: No	N/A

Detail: While we do not review adherence to state and community practice standards in connection with our credentialing process, we do require providers to meet education/training requirements to be admitted.

Similarly, while we do not review hours of operation and capacity during credentialing, our providers must follow our office hour standards once joining our network. If we were to discover a provider was not adhering to office hours standards we would ask the provider to remedy the situation or terminate the dentist from the network.

Attachments:

5.2.1.23 What is the average number of weeks from the date of nomination to the date the provider becomes a part of the network?

Answer: Our standard is to add providers to our network within 4-5 weeks of nomination. Nominees must meet all of credentialing requirements prior to being admitted. We will work with the State on a communication approach to members to nominate dentists during the implementation phase.

Attachments:

5.2.1.24 Please identify and explain your quality and outcome criteria for network providers.

Answer: We utilize our credentialing and quality management programs to ensure a high a level of quality and outcomes from our dental providers.

CREDENTIALING

Prior to acceptance in our network, prospective providers must meet the following criteria:

- Completion of an application with a statement by the applicant, including, but not limited to, the following information:
 - History of malpractice claims
 - History of loss of license
 - Felony convictions

- History of loss or limitation of privileges or disciplinary activity
- Attestation that there is no present illegal drug use
- Attestation to the accuracy of the application
- Current and valid license to practice in the state in which the network is located
- Verification from the state licensing agency of valid license
- Acceptable disciplinary history from the state
- Graduation from an accredited dental college, checked through the state licensing agency
- Successful completion of a regional or state board of dentistry examination, checked through the state licensing agency
- Current unrestricted Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certificate; no negative history of denial, suspension, revocation, and voluntary surrender
- Current and valid state certification permit to render general anesthesia and/or intravenous sedation services as applicable per state law
- \$1 million/\$3 million professional liability insurance for oral surgeons and dentists who render general anesthesia services; \$200,000/\$600,000 for other providers unless state law permits a lower liability limit; coverage may be checked through either the carrier by obtaining a copy of the current malpractice face sheet with starting dates and amount of coverage, or state licensing agency if it performs primary source verification
- Acceptable professional liability claims history, requested on application and checked through the malpractice carrier and National Practitioner Data Bank

RECREREDENTIALING

We recredential existing dentists every three years unless required more frequently by state law. We use the following criteria:

- Current, valid license to practice in the state in which the network is located
- Verification from the state licensing agency of valid license
- Acceptable disciplinary history from the state
- Current unrestricted DEA or CDS certificate; no negative history of denial, suspension, revocation and voluntary surrender
- Current and valid state certification permit to render general anesthesia and/or intravenous sedation services
- \$1 million/\$3 million professional liability insurance for oral surgeons and dentists who render general anesthesia services or \$200,000/\$600,000 for other providers unless state law permits a lower liability limit; coverage may be checked through the carrier either by obtaining a copy of the current malpractice face sheets with starting dates and amount of coverage, or state licensing agency if it performs primary verification

- Acceptable professional liability claims history, checked through the malpractice carrier and the National Practitioner Data Bank for all states

In addition, we request a current statement regarding physical and mental health status and lack of impairment due to chemical dependency/substance abuse.

We recredential approximately 33 percent of participating providers each year.

QUALITY MANAGEMENT

Quality management is provided through our Dental Quality Management (QM) program, which focuses on the ongoing assessment and promotion of appropriate dental care and support services for dental members.

The goals of the QM program are:

- To implement a comprehensive, multidisciplinary program that addresses and responds to the dental needs of the member population
- To measure, monitor and help improve performance in key aspects of dental service quality for members, providers and customers
- To promote the provision of affordable and timely dental services to members
- To facilitate communication among key functional areas
- To promote compliance with applicable law

The National Dental Quality Oversight Committee (QOC) has accountability for and oversees our QM program, including:

- Establishing priorities for the QM program
- Evaluating clinical and operational quality
- Integrating quality management activities among departments
- Reviewing and evaluating services rendered by participating dental providers
- Identifying and evaluating systemic issues and corrective action steps

As appropriate, quality management information gathered and evaluated by the QOC is forwarded to and referenced by the National Dental Credentialing and Provider Performance committee (CPPC) in the credentialing/recredentialing and evaluation of participating providers. The QOC meets at least quarterly.

The National Dental Quality Advisory Committee (QAC) is responsible for reviewing clinical issues and assisting in the establishment of national clinical policies, subject to the oversight and authority of the QOC. The QAC meets and reports on its activities to the QOC, and discusses and makes recommendations to the QOC on clinical issues, quality programs, work plans, policies and procedures. The QAC also reports to the QOC on any delegated activities.

We monitor and evaluate important aspects of care and service delivered to members in various ways, including but not limited to:

- Credentialing/recredentialing of dental providers as described above

- Review and evaluation of:
 - Utilization
 - Quality-related member complaints and appeals
 - Peer review of applicable professional competence and conduct issues
 - Any activities delegated to an outside entity
- Development, implementation and monitoring of clinical practice guidelines

We also evaluate individual instances of alleged or apparent poor quality. Local plan staff is responsible for the investigation and evaluation of the facts surrounding the applicable event, and the facilitation of review and follow-up action by the appropriate committee(s) or individual(s). Examples of situations that may be considered for review include, but are not limited to:

- Member-expressed concerns regarding administrative and/or quality of care issues
- Practitioner-expressed concerns regarding previous dental management
- Evidence of inappropriate dental management identified during routine review of claims or other clinical assessments
- Inappropriate conduct on the part of a dentist

Additional mechanisms used to monitor and evaluate significant aspects of dental care and the delivery of dental services include:

- Member services data
- Member disenrollment
- Fraud detection

Attachments:

5.2.1.25 Do you provide your network providers with incentives or penalties for patient satisfaction results?

Answer: 1: Incentives please describe: [Not applicable]

Detail: There are no network provider financial incentives tied to patient satisfaction results or other performance results.

Options:

1. Incentives please describe: [Text]
2. Penalties please describe: [Text]

Attachments:

5.2.1.26 Please describe and identify any providers identified as centers of excellence or centers of value within your network.

Answer: We offer medical centers of excellence through our robust Aetna Institutes program. However, this program does not address dental care.

We have strong, well developed DPPO dental networks that feature consistent fee schedules from area

to area. Our networks typically include all dental specialties. Members can check the availability of a specialist in their area by accessing our internet provider site, DocFind, at www.aetna.com or by calling the toll-free member services number located on their ID card. Members may also seek out-of-network specialty care.

Attachments:

5.2.1.27 Are in-network providers allowed to balance bill? If so, explain.

Answer: No. We have a hold harmless agreement in our participating provider contracts that prohibits network providers from billing or collecting from members more than the coinsurance or copayment in the members' plan.

Attachments:

5.2.1.28 What performance standards must your providers adhere to for urgent appointments (timeframes)?

Answer: 3: 12 to 24 Hours

Detail: For appointment wait periods, our standard is for participating providers to offer appointments to members as promptly as needed to treat and maintain their dental and/or medical health. We require our access to emergency care within 24 hours.

Options:

1. 0 to 8 Hours
2. 8 to 12 Hours
3. 12 to 24 Hours
4. 24 to 48 Hours
5. Greater than 48 Hours

Attachments:

5.2.1.29 What performance standards must your providers adhere to for routine appointments (timeframes)?

Answer: 4: 4 to 6 weeks

Detail: For appointment wait periods, our standard is for participating providers to offer appointments to members as promptly as needed to treat and maintain their dental and/or medical health. Under usual circumstances, a maximum of three to five week appointment wait period is appropriate for routine (initial, recall or follow-up) dental care.

Options:

1. 1 to 2 weeks
2. 2 to 3 weeks
3. 3 to 4 weeks
4. 4 to 6 weeks
5. 6 to 8 weeks
6. Greater than 8 weeks

Attachments:

5.2.1.30 Describe your method that providers use to check patient eligibility.

Answer: We work with EDI Health Group Inc. (EHG) to offer their ClaimConnect™ tool and partner with Emdeon to offer their electronic services. Through both EHG and Emdeon, dentists can verify member eligibility and benefit information in real time. Providers can also call our provider services to verify member eligibility.

Attachments:

5.2.1.31 How are network claim payments disbursed?

Answer: We bulk print and mail provider checks with delivery within 24 days of the date we receive the claim. We mail the majority on a weekly or biweekly schedule, and on a consistent day of the week, depending on the provider's state of residence. A provider EOB accompanies each provider draft. The EOB breaks down the payment by patient and gives pertinent information about the payment and non-covered expenses.

Attachments:

5.2.1.32 Confirm you have completed and uploaded the requested GeoAccess reports based on the criteria listed below for urban/suburban:

- General and Family Dentist 2 in 10 miles
- Pediatric Dentist 2 in 10 miles
- Orthodontist 1 in 10 miles
- Periodontist/Endodontist 2 in 15 miles

Answer: 1: Confirmed

Detail: Please refer to the dental GeoAccess reports included with this proposal.

Options:

1. Confirmed
2. Not Confirmed

Attachments: [GeoAccess Report Retirees DPO II.pdf](#)
[GeoAccess Report Actives DPO II.pdf](#)
[GeoAccess Report Actives DPO II Top 5.pdf](#)
[GeoAccess Report Retirees DPO II Top 5.pdf](#)

5.2.1.33 Confirm you have completed and uploaded the requested GeoAccess reports based on the criteria listed below for rural:

- General and Family Dentist 2 in 20 miles
- Pediatric Dentist 2 in 20 miles
- Orthodontist 1 in 20 miles
- Periodontist/Endodontist 2 in 30 miles

Answer: 1: Confirmed

Detail: Please refer to the dental GeoAccess reports included with this proposal.

Options:

1. Confirmed
2. Not Confirmed

Attachments: [GeoAccess Report Retirees DPO II.pdf](#)
[GeoAccess Report Actives DPO II.pdf](#)
[GeoAccess Report Actives DPO II Top 5.pdf](#)
[GeoAccess Report Retirees DPO II Top 5.pdf](#)

5.2.1.34 Confirm you have completed and uploaded the requested GeoAccess reports based on the criteria listed below for the top 5 State of Alaska locations, which includes Juneau, Anchorage, Fairbanks, Kenai/Soldotna and Wasilla / Palmer (details provided on census):

- General and Family Dentist 2 in 10 miles
- Pediatric Dentist 2 in 10 miles
- Orthodontist 1 in 10 miles
- Periodontist/Endodontist 2 in 15 miles

Answer: 1: Confirmed

Detail: Please refer to the dental GeoAccess reports included with this proposal.

Options:

1. Confirmed
2. Not Confirmed

Attachments: [GeoAccess Report Retirees DPO II.pdf](#)
[GeoAccess Report Actives DPO II.pdf](#)
[GeoAccess Report Actives DPO II Top 5.pdf](#)
[GeoAccess Report Retirees DPO II Top 5.pdf](#)

5.2.1.35 Confirm you have completed and uploaded the requested GeoAccess reports based on the criteria listed below for the top 5 State of Alaska locations, which includes Juneau, Anchorage, Fairbanks, Kenai/Soldotna and Wasilla / Palmer (details provided on census):

- General and Family Dentist 2 in 20 miles
- Pediatric Dentist 2 in 20 miles
- Orthodontist 1 in 20 miles
- Periodontist/Endodontist 2 in 30 miles

Answer: 1: Confirmed

Detail: Please refer to the dental GeoAccess reports included with this proposal.

Options:

1. Confirmed
2. Not Confirmed

Attachments: [GeoAccess Report Retirees DPO II.pdf](#)
[GeoAccess Report Actives DPO II.pdf](#)
[GeoAccess Report Actives DPO II Top 5.pdf](#)
[GeoAccess Report Retirees DPO II Top 5.pdf](#)

5.2.1.36 Which type of liability insurance do you require of your providers?

Answer: 2: Per occurrence

Detail: We require our participating dentists to carry the following insurance coverage levels:

- \$1 million/\$3 million professional liability insurance for oral surgeons and dentists who render general anesthesia services;
- \$200,000/\$600,000 for other providers

Options:

1. Per professional
2. Per occurrence
3. Other: [Text]

Attachments:

5.2.1.37 How much notice is a provider contractually required to give if they elect to terminate a contract with your network(s)?

Answer: 3: 90 days

Detail: The required notification period for provider termination is 90 days. Participating providers are contractually required to complete work in progress in the event of termination. This includes, but is not limited to:

- Crowns and fixed bridgework when the teeth were prepared prior to the effective date of the termination
- Appliances when the impression was taken prior to the effective date of the provider termination
- Root canal therapy when the pulp chamber was opened prior to the effective date of the provider termination

When the reason for termination prevents completion of the work, the provider must cooperate with the transition of the member's care to another provider.

Options:

1. 30 days
2. 60 days
3. 90 days
4. 120 days
5. Other [Text]

Attachments:

5.2.1.38 Indicate your procedures for removing a provider from your network involuntarily.

Answer: 1: Specific outcome of any malpractice claims,

2: Specific number of malpractice claims,

3: Based on review of irregular claims,

4: Based on review possible claims "abuse",

5: Based on medical/dental outcomes,

6: Based on licensing issues,

7: Failure to meeting contracting requirements

Detail: Other common reasons for involuntary termination include:

- Failure to comply with utilization management programs
- Documented patterns of practice that are inconsistent with community standards of care
- Non-compliance with administrative terms of the provider contract, such as inappropriate balance billing
- Suspension, withdrawal, expiration, non-renewal or revocation of state or local license

Options:

1. Specific outcome of any malpractice claims
2. Specific number of malpractice claims
3. Based on review of irregular claims
4. Based on review possible claims "abuse"
5. Based on medical/dental outcomes
6. Based on licensing issues
7. Failure to meeting contracting requirements
8. Other: [Text]

Attachments:

5.2.1.39 What has been your rate of removal of providers involuntarily from your network?

Answer: 1: Under 5% in prior calendar year

Detail: Our 2011 DPPO turnover rates were as follows:

- National DPPO: 4.9 percent
- Alaska DPPO: 0.0 percent

Options:

1. Under 5% in prior calendar year
2. 5% -- 10% in prior calendar year
3. Over 10% in prior calendar year

Attachments:

5.2.1.40 If a member needs care while in an area where you have a network (but the network is not part of the employer's plan), can the plan benefit from the discounts?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

5.2.1.41 If there are services or specialists that are not available in your dental networks in the service areas where there are plan participants, please explain what provisions are made for plan participants requiring these services.

Answer: Our national network includes all dental specialties; however, there is no guarantee that a member has access to every type of specialist in every area, such as Alaska. Members can check the availability of a specialist in their area by accessing our internet provider site, DocFind, at www.aetna.com or by calling the toll-free member services number located on their ID card.

If we do not have a specialist type in a certain area, members may seek out-of-network specialty care at the non-preferred level of benefits. The State and its members are also welcome to nominate a provider for participation in our network.

Attachments:

5.2.1.42 Describe how your in-network and out-of-network allowances vary nationally along with the structure and number of rating areas.

Answer: IN-NETWORK

Aetna has 45 General practice and 45 specialty practice standard schedules mapped by 3 digit zip code.

Aetna's expected national average discount is approximately 35 percent. Expected discounts are calculated by comparing the average charges as determined under the FAIR Health Benchmark and the allowed negotiated fees. Charges by procedure are weighted to reflect average utilization. Aetna estimates that most of the dental PPO fee schedules fall between the 25th and 50th percentile range.

Expected discounts will vary by zip code area and procedure, and other factors that may influence this are:

- Number of potential providers in a geographic area
- Receptiveness of the provider community to discounted fee schedule arrangements
- Local practice patterns
- Plan design

OUT OF NETWORK ALLOWANCES

Aetna consults with an external database for R&C benefit determinations. In 2011, mid-March, Aetna transitioned from the INGENIX Prevailing Health Charges System (PHCS) to the FAIR Health Benchmark database produced by the not-for-profit entity FAIR Health.

Currently, the FAIR Health Benchmark has 491 geographic regions and is updated semi-annually.

Attachments:

5.2.2 Plan Design

5.2.2.1 Are you flexible with what services you consider preventive, basic, and major?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

5.2.2.2 Please list any procedures and their respective codes that are not covered for each product that you are quoting on.

Answer: Excluded Services generally include the following:

1. Services or supplies that are covered in whole or in part:
 - (a) under any other part of this Dental Care Plan; or
 - (b) under any other plan of group benefits provided by or through your employer.
2. Services and supplies to diagnose or treat a disease or injury that is not:
 - (a) a non-occupational disease; or
 - (b) a non-occupational injury.
3. Services not listed in the Dental Care Schedule that applies, unless otherwise specified in the Booklet-Certificate.
4. Those for replacement of a lost, missing or stolen appliance, and those for replacement of appliances that have been damaged due to abuse, misuse or neglect.
5. Those for plastic, reconstructive or cosmetic surgery, or other dental services or supplies, that are primarily intended to improve, alter or enhance appearance. This applies whether or not the services and supplies are for psychological or emotional reasons. Facings on molar crowns and pontics will always be considered cosmetic.
6. Those for or in connection with services, procedures, drugs or other supplies that are determined by Aetna to be experimental or still under clinical investigation by health professionals.
7. Those for dentures, crowns, inlays, onlays, bridgework, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or to correct attrition, abrasion or erosion.
8. Those for any of the following services (Does not apply to the DMO plan in TX):
 - (a) an appliance or modification of one if an impression for it was made before the person became a covered person;
 - (b) a crown, bridge, or cast or processed restoration if a tooth was prepared for it before the person became a covered person; or
 - (c) root canal therapy if the pulp chamber for it was opened before the person became a covered person.
9. Services that Aetna defines as not necessary for the diagnosis, care or treatment of the condition involved. This applies even if they are prescribed, recommended or approved by the attending physician or dentist.
10. Those for services intended for treatment of any jaw joint disorder, unless otherwise specified in the Booklet-Certificate.
11. Those for space maintainers, except when needed to preserve space resulting from the premature loss of deciduous teeth.
12. Those for orthodontic treatment, unless otherwise specified in the Booklet-Certificate.
13. Those for general anesthesia and intravenous sedation, unless specifically covered. For plans that cover these services, they will not be eligible for benefits unless done in conjunction with another necessary covered service.
14. Those for treatment by other than a dentist, except that scaling or cleaning of teeth and topical application of fluoride may be done by a licensed dental hygienist. In this case, the treatment must be given under the supervision and guidance of a dentist.
15. Those in connection with a service given to a person age 5 or older if that person becomes a covered person other than:
 - (a) during the first 31 days the person is eligible for this coverage, or
 - (b) as prescribed for any period of open enrollment agreed to by the employer and Aetna. This does not apply to charges incurred:
 - (i) after the end of the 12-month period starting on the date the person became a covered person; or

(ii) as a result of accidental injuries sustained while the person was a covered person; or
(iii) for a primary care service in the Dental Care Schedule that applies as shown under the headings Visits and Exams, and X-rays and Pathology.

16. Services given by a nonparticipating dental provider to the extent that the charges exceed the amount payable for the services shown in the Dental Care Schedule that applies.

17. Those for a crown, cast or processed restoration unless:

(a) it is treatment for decay or traumatic injury, and teeth cannot be restored with a filling material; or
(b) the tooth is an abutment to a covered partial denture or fixed bridge.

18. Those for pontics, crowns, cast or processed restorations made with high-noble metals, unless otherwise specified in the Booklet-Certificate.

19. Those for surgical removal of impacted wisdom teeth only for orthodontic reasons, unless otherwise specified in the Booklet-Certificate.

20. Services needed solely in connection with non-covered services.

21. Services done where there is no evidence of pathology, dysfunction or disease other than covered preventive services.

Attachments:

5.2.2.3 Please describe your naturally functioning and asymptomatic tooth provisions, if any.

Answer: The treatment of non-pathologic, asymptomatic teeth are generally excluded from the policy. There are no exclusions or limitations for naturally functioning teeth.

Attachments:

5.2.2.4 What teeth do you consider anterior vs. posterior?

Answer: The clinical definition is slightly different than benefit definition. Clinical: anterior teeth are the central and lateral incisors and cuspids (teeth 6 to 11 and 22 to 27). All the rest (bicuspid and molars) are posterior teeth. Benefit wise, some surfaces of a bicuspid would qualify for restoration with tooth colored material, similar to the anterior rules.

Attachments:

5.2.2.5 What type of service do you consider root canal therapy?

Answer: 4: Other: [Our plans typically consider the anterior (3310) and bicuspid (3320) as basic, and the molar (3330) as major.]

Detail:

Options:

1. Preventive
2. Basic
3. Major
4. Other: [Text]

Attachments:

5.2.2.6 What is the allowable charge for crowns made of semiprecious metal?

Answer: 3: Other: [Aetna considers the semiprecious metal to be a covered benefit. The allowable charge is the fee listed on the fee schedule. If high noble metal is used, the provider may seek the difference in fees from the patient.]

Detail:

Options:

1. Not covered
2. Limited to non-precious metal charge
3. Other: [Text]

Attachments:

5.2.3 Eligibility & Enrollment

5.2.3.1 Can you accommodate an account code structure in the eligibility file that will allow the State to identify trends in claim activity information broken down by different organizational units?

Answer: Yes. We will work with the State to set up an account code structure that will allow the State to identify trends for each organizational unit. We will work with the State to establish the structure that optimizes reporting for all of the Aetna administered programs.

Attachments:

5.2.3.2 Explain whether or not your proposal includes on-line access by the State to view eligibility files. If yes, describe this arrangement, and whether or not this access includes the ability for the State to update member data on an ad hoc basis.

Answer: Yes. We have systems in place to allow the State to view on-line eligibility and make updates as appropriate. We will also provide the State with Aetna resources in Alaska and on the Account Team who can make eligibility updates on an ad hoc basis or review the State's eligibility system.

Attachments:

5.2.3.3 How will eligibility data be transferred from the State to the Contractor?

Answer: We can accept eligibility data in all of the following formats:

- Internet-based Eligibility Transfer Solutions - The State can use a UNIX server or web-based transfer solutions to transmit eligibility files to us during open enrollment and as updates are needed. SecureTransport, which uses customer software, is our preferred method of receiving eligibility through the internet.

- Electronic Transport Method - The State can submit enrollment through any number of electronic transport methods including secure Internet FTP, VAN or mainframe-to-mainframe connections, using ConnectDirect and EDI ANSI X12 formats. If the EDI ANSI format is used, the only connectivity options available are SecureTransport or VAN.

- e.Listing - An e.Listing is an Excel spreadsheet populated with eligibility data. The spreadsheet is scanned into our systems and mirrors an electronic file, eliminating manual intervention. The e.Listing functionality increases the timeliness of eligibility updates so that members can access care quickly.

- Enrollment Forms - The State can submit paper enrollment forms that will be input manually.

Attachments:

5.2.3.4 Please confirm your ability to accommodate the electronic transfer of eligibility from the State's system.

Answer: Confirmed. We can accept the State's 834 eligibility layout.

Attachments:

5.2.3.5 Can you accept eligibility via paper, as well as by electronic feed?

Answer: Yes.

Attachments:

5.2.3.6 How often is eligibility electronically updated? Confirm that you will accept a daily eligibility file.

Answer: We can accept a daily file, but we recommend transaction only or full-inforce files twice per week. This would ensure that we have the most accurate and up-to-date file submissions possible. We find this process beneficial in minimizing disruption in eligibility files for customers. Once we upload the eligibility file to our mainframe system, the State's eligibility consultant reviews an edit of the file online. If there are no other data quality concerns, we update the system. If there are any errors or issues, the eligibility consultant will work with the State to resolve these prior to updating the system.

While we recommend twice weekly files to allow this eligibility verification process to take place, we can accept daily files for an additional charge.

Updated information appears in our eligibility system immediately and in the claim system within approximately 24 hours. If the State grants access, our Health Concierges and Alaska Team can review any questions on eligibility in the State's eligibility system. We can have standard processes to address any emergency eligibility issues in that manner to ensure no issues with coverage.

Attachments:

5.2.3.7 How often is eligibility electronically updated by any subcontractors or joint venturers?

Answer: There are no subcontractors or joint ventures for our dental services. If Aetna is to submit eligibility to any vendors, we are able to support the extract on a once per week basis. We can also discuss any subcontractors that the State may require Aetna to interface with for eligibility.

Attachments:

5.2.3.8 Please confirm you can receive and send FTP files or have other secure methods of transmission.

Answer: Confirmed. We offer the following secure methods of transmission:

- Internet-based Eligibility Transfer Solutions - The State can submit eligibility using our web-based transfer solution called SecureTransport.
- Electronic Transport Method - The State can submit enrollment through SecureTransport using an electronic transport method. We support transfers in:
 - Explicit SSL (FTPs)
 - SSH (sFTP)
 - AS2 protocols
 - EDI ANSI X12 formats
 - Connect Direct with secure+ encryption.

Attachments:

5.2.3.9 Do you allow online access to the client's staff for real-time eligibility updates?

Answer: Yes. We have systems in place to allow the State to view on-line eligibility and make updates as appropriate. We will also provide the State with Aetna resources in Alaska and on the Account Team who can make eligibility updates on an ad hoc basis or review the State's eligibility system.

Attachments:

5.2.3.10 Indicate how dependent eligibility information is stored. Is it part of the member record, or a separate record?

Answer: We store dependent eligibility information as a separate record but attached to the employee ID.

Attachments:

5.2.3.11 What is the standard turnaround time for an eligibility file upload?

Answer: 1: Within 24 hours

Detail:

Options:

1. Within 24 hours
2. By Next Business Day
3. Within 5 Business Days
4. Other: [Text]

Attachments:

5.2.3.12 Are you able to administer 90 day retroactive enrollment adjustments?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No
3. Other: [Text]

Attachments:

5.2.3.13 Are you able to make exceptions to the 90 day retroactive enrollment to allow for longer periods than 90 days?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No
3. Other: [Text]

Attachments:

5.2.3.14 Clearly state your company's timelines and deadlines for Open Enrollment (system updates due to plan changes or file formats, new divisions, manual work-arounds, dates for the last pre-OE updates, OE file updates, etc.).

Answer: We will work closely with you to develop an Open Enrollment schedule based on the State's enrolled employees, chosen products, programs and services. Our Account Team will assist in identifying tasks, needed resources and schedule key milestone dates that work best for the State and their members.

Key milestones dates include:

- Kick-off Strategy Call - 4/1/13
- Begin Implementation - 4/8/13
- Implementation meeting - 4/8/13
- Confirm eligibility 6/14/13
- Confirm ID cards mailed - 6/21/13
- Effective date - 7/1/13

Please refer to the attached Implementation Schedule for all of our implementation dates.

Attachments: [State of Alaska Implementation.doc](#)

5.2.4 Customer/Member Services

5.2.4.1 Will you provide the State with unit(s) dedicated to customer service? Please describe each function supported by these customer service unit(s).

Answer: We recommend the designated staff model because it provides flexibility in meeting staffing needs, resulting in better service.

Designated means there is a defined number of staff members whose primary responsibility is to support a particular account. This team would, as needed, have secondary and tertiary responsibility for other accounts within the group. Should call or claim activity for a given account exceed forecast, we will reposition staff to support teams needing coverage. We continually monitor volume and staffing.

The roles and responsibilities of our service center personnel include:

SITE LEAD

- Develop annual objectives for expense control, productivity, quality, service and cost management
- Implement and modify programs to meet those objectives
- Establish and maintain effective relations with customers
- Manage staffing requirements

DIVISION MANAGERS OR SENIOR TEAM LEADERS

- Responsible for 3 to 5 units of 20-25 staff members
- Responsible for day-to-day office operations
- Assist the site lead in establishing objectives and programs for expense management, productivity, quality, service and cost management
- Monitor the effectiveness of those programs
- Maintain working relationships with assigned customers

SUPERVISORS AND TEAM LEADERS

- Responsible for a unit generally comprised of 20-25 employees
- Manage assigned accounts within their unit

- Maintain working relationships with assigned customers
- Develop and monitor performance
- Explain and promote our cost management programs to providers and employees
- Maintain effective relations with the provider community and customers
- Deliver a disciplined approach to addressing challenges in their day-to-day activities
- Continuous review and analyzing of policies and procedures to gauge effectiveness

CUSTOMER SERVICE REPRESENTATIVES (CSRs)

- Respond to telephone calls, internet inquiries and walk-ins
- Respond to member, provider and customer inquiries using computer terminal, microfilmed or imaged source documents
- Explain and promote our cost management programs to providers and members
- Maintain effective relations with customers
- Anticipate the member's needs at the initial contact

CLAIM BENEFIT SPECIALISTS

- Approve or deny benefits
- Apply our cost containment programs
- Send questionable claims to the subject matter experts for review
- Conduct outreach calls to providers for missing claim information

COST CONTAINMENT ANALYSTS

- Answer fee and questionable treatment referrals for service center personnel
- Initiate referrals to our other offices for investigation
- Coordinate investigation of fraud cases
- Implement and monitor our cost management programs

TRAINERS

- Provide classroom and on-the-job training for new and experienced benefit specialists
- Develop and deliver other training programs as needed

PERSONNEL COORDINATOR

- Help administer company personnel policies and procedures within the office

Attachments:

5.2.4.2 Where will the dedicated offices(s) be located and will those offices be dedicated to customer service, claims processing or both?

Answer: Our Western Dental Service Center located at 6303 Owensmouth Avenue, Suite 900, Woodland Hills, CA 91367 will provide claims processing and member services.

If Aetna is selected as the medical administrator, the Health Concierge will handle initial calls and will leverage dental resources when calls warrant the expertise of the dental team.

Attachments:

5.2.4.3 List how many customer service representatives will be dedicated to the State's plans.

Answer: There will be 20 claim processors assigned to the State. All processors will be trained as experts on your benefits; 10 as primary processors and 10 as back-up processing resources. These 20 processors will be responsible for the processing of the State member and provider claim submissions.

Attachments:

5.2.4.4 Describe your training program for customer service employees.

Answer: Our customer service representatives (CSRs) receive an initial classroom-based training program. This training includes instruction in:

- Dental terminology
- Managed dental concepts
- System navigation
- Dental claim processing
- Customer service techniques

To support first call resolution, we teach CSRs how to identify key opportunities to provide coaching and education to our members as well as issue resolution methods.

Initially, CSRs handle mock telephone calls and later during “learning lab” take live calls in the classroom setting where there is onsite support during their six weeks of lab. They receive training on the Aetna Strategic Desktop system and attend a customer-focused training class specifically for telephone representatives. New CSRs are not released to their teams until they have met quality standards.

If Aetna is selected as the medical administrator, the Health Concierge will handle initial calls and will leverage dental resources when calls warrant the expertise of the dental team.

Attachments:

5.2.4.5 Explain any incentive programs you employ to retain competent customer service employees.

Answer: Creating a positive work environment and focusing on employee engagement are integral components of our operating model. Our commitment to this is evident in many areas including:

- Rewards and recognition programs which encourage the behaviors we value for delivering excellent service to our customers
- Competitive compensation program which includes incentive-based bonus for front line employees.

Attachments:

5.2.4.6 What is the average years of experience for your customer service staff?

Answer: The average years of experience for our customer service staff includes the following:

Management: 17.5 years

Supervisor: 22.5

Customer Service Representative/Customer Service Representative Resources: 8.8 years

Technical/Admin: 18.8 years

Attachments:

5.2.4.7 What is the average length of employment for your customer service staff?

Answer: The average length of service of our customer service staff is 11 years.

Attachments:

5.2.4.8 How many dedicated toll-free phone lines will be made available to answer member and provider inquiries?

Answer: We provide specific, designated toll-free telephone numbers for both members and providers. While the nature of member and provider calls is often different, we train our customer service representatives to handle both types of calls, regardless of what toll-free number is used. This is part of our effort to promote resolution of inquiries at the first point of contact.

If awarded multiple coverage with Aetna, we will optimize a single line.

Attachments:

5.2.4.9 How many dedicated toll-free phone lines for the hearing impaired will be made available to answer member and provider inquiries?

Answer: Members who are hearing impaired can call Aetna's TDD line for specialized communication services over the phone lines.

Attachments:

5.2.4.10 During what hours/days of week will toll free phone lines be staffed?

Answer: The State's members will have customer service support Monday through Friday, 8 a.m. to 6 p.m. local time.

For members located in a different time zone, they will have access to our standard 10 hours of phone coverage through call routing to another office. Standard customer service hours consist of 8 a.m. to 6 p.m. local time to the member.

Attachments:

5.2.4.11 Provide an explanation of how you define "after-hours." How are calls "after-hours" of operation handled?

Answer: We define "after hours" as outside of our normal business hours, which are Monday through Friday, 8 a.m. to 6 p.m. Pacific Time. For inquiries outside of normal business hours, members have the option of using Aetna Voice Advantage, our self-service telephone system or Aetna Navigator, our secure member website.

INTERACTIVE VOICE

The Aetna Voice Advantage® interactive telephone system is available 24 hours a day. Members speak as they normally do and the system helps guide them to the information they are seeking in a clear, conversational way.

Using the self-service features, members can request an ID card, get claim payment information or obtain fund balances, when applicable.

AETNA NAVIGATOR

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

Members can send a written inquiry to member services. Every page on the Aetna Navigator site has a "Contact Us" link, making it simple to send a secure message to member services whenever they have a question or concern.

Attachments:

5.2.4.12 Is there a voice mail system or capability for callers to leave messages after normal business hours? During after-hours?

Answer: The Aetna Voice Advantage® interactive telephone system is available 24 hours a day, 7 days a week to provide information for members when they need it. The easy-to-use tool determines the reason for the call as members talk and finds the information they need. This makes it easy to make better health care decisions.

Callers who exit/opt out of Aetna Voice Advantage after the service center has closed will hear the following message:

“If your call is regarding an emergency, please contact your primary care physician or seek care immediately. Our business hours are Monday to Friday, 8 a.m. to 6 p.m., PT.”

Attachments:

5.2.4.13 Do members reach a live representative or an interactive voice response unit (IVR) when calling customer service during business hours? During after-hours?

Answer: Members are able to request to speak to a live customer service representative (CSR) at any time during the call and can be shifted over to a representative simply saying so or pressing “0.” This transfers the call and all information already gathered to someone who is trained to help.

The CSR option is also available by an explicit menu item on the first feature menu. Callers will have the option to have their call forwarded to a CSR during normal business hours only.

When a member requests to speak to a CSR, their member information already validated will be available to the CSR receiving the call.

Attachments:

5.2.4.14 What percentage of calls are logged into your tracking system?

Answer: All calls are recorded. We use an online tracking and documentation system called Aetna Strategic Desktop (ASD) for member and provider telephone, written correspondence, Internet e-mail and walk-in visitors. We track events in the system from the moment a member contacts us. The system tracks any tasks or activities performed to resolve the service request from beginning to end.

Attachments:

5.2.4.15 Please check all items below which pertain to calls handled by the customer service representatives:

Answer: 1: All calls are recorded,
2: Customer service representatives document all calls on-line and in real-time,
5: Calls are documented in summarization

Detail: Customer service representatives make simple, noncomplex claim adjustments to promote “one and done” resolution of issues. They have the ability to view all adjustments in the system.

Claim benefit specialists make all necessary adjustments to complex claims in real-time.

Options:

1. All calls are recorded
2. Customer service representatives document all calls on-line and in real-time
3. Customer service representatives can make adjustments to claims during a call

4. Calls are documented verbatim
5. Calls are documented in summarization

Attachments:

5.2.4.16 If your customer service unit uses a dedicated on-line call tracking and documentation system, identify whether the following characteristics are tracked:

Answer: 3: Representative who handled the call

Detail: 1. Date of initial call

2. Date of inquiry closed
3. Representative who handled the call
4. Call Status
5. If and where the issued was referred for handling
6. Reasons for call
7. What was communicated to member

We track all of the above.

Options:

1. Date of initial call
2. Date inquiry closed
3. Representative who handled the call
4. Call status
5. If and where issue was referred for handling
6. Reason for call
7. What was communicated to member
8. N/A

Attachments:

5.2.4.17 What other methods of contacting customer service representatives, besides telephone, are available for members to use?

Answer: Members may also use Aetna Navigator, our secure member website, to obtain round-the-clock member service. Enrolled member can register for a secured, personalized view of their benefits. Member can use www.aetn navigator.com to:

Send a written inquiry to member services. Every page on the Aetna Navigator site has a "Contact Us" link making it simple to send a secure message to members whenever they have a question or concern. Our goal is to respond to e-mail inquiries within one business day.

Attachments:

5.2.4.18 Do customer service representatives handle both member calls and provider calls?

Answer: We provide specific, designated toll-free telephone numbers for both members and providers. While the nature of member and provider calls is often different, we train our customer service representatives to handle both types of calls, regardless of what toll-free number is used. This is part of our effort to promote resolution of inquiries at the first point of contact.

If Aetna is the medical administrator, our Health Concierge will handle many of the member calls.

Attachments:

5.2.4.19 Can customer service representatives access claims status and make adjustments on-line in real-time?

Answer: Yes. Our CSRs have online access to claims information. Should a claim payment adjustment be needed, our CSRs will forward to our claim department for further handling. All departments can access the system and the member is not required to reach out directly for claim assistance.

Attachments:

5.2.4.20 Identify the typical work and training experience required of your customer service and claims processing supervisors and/or managers.

Answer: SUPERVISORS

General requirements for the team lead (supervisor) position include proven ability to lead a team, a broad knowledge of dental products and demonstrated technical proficiency. We train team leads in assessing trends in customer issues and identifying solutions that enhance future customer interactions.

We recognize the critical need to provide the newest training additions to the management team and offer a number of management courses:

- Basic principles of a collaborative workplace
- Project management
- Developing high performance feedback
- Delegating effectively
- Solving problems and making decisions in teams

Attachments:

5.2.4.21 What is the current ratio of customer service representatives to supervisors and managers?

Answer: Typically, a supervisor may have approximately 18-20 CSRs in their team. A manager may have approximately 6-7 supervisors reporting to them.

Attachments:

5.2.4.22 What is the ratio of customer service representatives to covered lives in your organization's programs?

Answer: As of 9/30/2012, the Western Dental Service Center customer service representatives ratio to covered lives ratio is 1:18,000.

Attachments:

5.2.4.23 Describe when and how a caller's recurring or unresolved issue is elevated to a supervisor/manager for resolution. Explain how you measure the success of this process over time.

Answer: Our goal is to provide our customer service representatives (CSRs) with the optimum level of training, system access and online information to promptly and accurately respond to virtually any type of inquiry.

CSRs have immediate online access to detailed benefit descriptions, claim history, eligibility data, member contact history, the patient management system and provider files.

We recognize that there will be situations, due to the nature of the inquiry, when it will be appropriate for another department to resolve a member's concern.

In instances where an inquiry requires additional research or the assistance of another department, the CSR will document the information concerning the outstanding inquiry. Our systems will then electronically direct the request to the appropriate department for review and resolution. Once resolved, we will reach out to the member to advise them of the resolution.

If a caller would like to speak to a member of management, the CSR will gather all relevant information and transfer the caller to a team leader. When the team leader is not available, the CSR will try to locate another member of management. If the caller is unable to hold, the CSR offers to take the pertinent information and have a member of management return the call. Management's goal is to return the call within one business day.

Attachments:

5.2.4.24 Provide the turnover rate of your call center representatives for the past three calendar years.

Answer: The turnover rate for the Western Dental Service Center for the past three calendar years is:

2011: 5.4%

2012: 3.8%

Turnover rate is tracked on the overall staff.

Attachments:

5.2.4.25 Using current calendar year data, please provide the following information for each customer service office that will have responsibility for this account:

- Answer Speed
- Wait Time
- Abandonment Rate
- ID Card Issuance (timeliness)

Answer: As of 9/30/2012, our Western Service Center achieved the following results:

Average Speed of Answer - 9.2 seconds

Wait Time: 91.6 of answered calls in 30 seconds

Abandonment Rate: Less 0.5%

ID Card Issuance (book of business): 7-10 business days

Attachments:

5.2.4.26 Please describe your standard procedures for handling transition of care issues for members in dental (including orthodontia) treatment with a provider who is not in your network.

Answer: As part of the transition, we waive the work in progress exclusion (if applicable). We cover the following :

- Inlays
- Onlays
- Removable partial dentures
- Cast or processed restorations
- Dentures
- Fixed bridgework
- Root canals

“Ordered” means that prior to the date coverage ends:

- Denture: impressions have been taken from which the denture will be prepared
- Root canal: the pulp chamber was opened
- Other items listed above: the teeth that will serve as retainers or support, or that are being restored, have been fully prepared to receive the item and impressions have been taken from which the item will be prepared

This does not apply to a member whose coverage terminates while they are "totally disabled" as described under the terms of the plan

Orthodontic Care

For the transition of orthodontic care, the dentist submits an itemized bill that includes the:

- Date the appliance was placed,
- Total charge for the entire treatment plan,
- Expected length of treatment, and
- Amount paid by the prior plan.

We will pay up to the new plan maximum for the entire treatment, including the prior carrier's payments. Once the prior carrier's payments are determined, we calculate the remaining quarterly installments and release any unpaid benefits up to the new plan maximum.

Orthodontic benefits are usually subject to a lifetime maximum. We expect the initial payment to represent approximately 25 percent of the total case fee.

When we receive an initial orthodontia claim, we process the charges and produce an EOB. We release subsequent installments automatically at the plan's payment intervals (e.g., monthly or quarterly).

Attachments:

5.2.4.27 Describe other dedicated or customized customer services you are prepared to offer the State.

Answer: We have implemented a Single Point of Contact (SPOC) program to better meet the needs of plan administrators. Individuals identified by the State have direct access to one of our SPOC relationship managers. They can contact the SPOC for clarification of questions related to the benefit plan administration, or the resolution of any claim or customer service issue brought to their attention.

The SPOC:

- Takes accountability for identified issues
- Acts as the State's advocate
- Interfaces with other areas of Aetna as needed for prompt and accurate resolution

In addition, they look for opportunities to enhance service delivery based on issues submitted to them through trend and analysis.

Attachments:

5.2.5 Utilization Management

5.2.5.1 Approvals/Denials

5.2.5.1.1 During the most recent calendar year, what percentage of all pre-authorized dental procedures were denied due to lack of dental necessity?

Answer: In 2011, six percent of submissions were denied for dental necessity for pre-determinations or date-of-service.

Attachments:

5.2.5.1.2 During the most recent calendar year, what percentages of your procedures are typically subject to denial?

Answer: In 2011, 19.6 percent of submissions were subject to denial.

Attachments:

5.2.5.1.3 Provide details regarding reasons for denial based on dental necessity.

Answer: Clinical policies, supported by documented technology assessments, guide utilization management decisions. Our goals are to help make significant new advances available to members as soon as appropriate and prevent unproven, ineffective and potentially harmful technologies from receiving coverage. Our Chief Dental Officer is responsible for overseeing the update of our dental clinical policies through the dental clinical policy review committee:

- With input from outside experts, the academic community and network providers, we review dental scientific literature. We also rely on our formal research arrangement with the Columbia University College of Dental Medicine.
- Policies are re-evaluated at least annually; however, advancements in treatment disciplines or within the dental community may call for more frequent review.
- We distribute policy bulletins to appropriate internal staff through electronic manuals and shared public folders. The guidelines may also be communicated to participating providers through newsletters, updates to provider manuals, direct mailings, personal communications or online.

Our clinical policy bulletins (CPBs) define the dental necessity, cosmetic, as well as experimental and investigational status of health technologies. We update and revise these annually based on feedback from our constituents and emerging scientific research. We use CPBs along with the terms of the member's benefit plan and other Aetna-recognized criteria to determine health care coverage for our members. We make clinical determinations in connection with coverage decisions on a case-by-case basis.

Our CPBs are available on-line for providers, members, and the State.

Attachments:

5.2.5.1.4 Of the denials, what percentage was overturned on appeal?

Answer: In 2011, we overturned approximately 32 percent of denials as a result of an appeal.

Attachments:

5.2.5.1.5 Is a formal appeal process in place that complies with all Utilization Review Accreditation Commission and Department of Labor requirements?

Answer: Confirmed.

Attachments:

5.2.5.1.6 For denials, does your organization inform both members and providers of appeal rights and the appeal process?

Answer: Confirmed.

Attachments:

5.2.5.1.7 Does your organization offer peer-to-peer discussion prior to an initial denial of services?

Answer: For clinical appeals, a practitioner who typically treats the condition, performs the procedure, or provides the treatment under review and was neither involved in the original denial of coverage determination or Level I appeal, performs the second level review. We do not offer peer to peer review prior to the denial.

Attachments:

5.2.5.1.8 Confirm there is an expedited appeal process of 72 hours or less for situations where the normal appeal timeline could jeopardize a patient's health.

Answer: Confirmed. Expedited first level appeals will be resolved within 36 hours as will any subsequent second level appeals.

Attachments:

5.2.5.1.9 Are appeals specialty matched to a member's condition and/or prescribing physician?

Answer: Confirmed. For clinical appeals, a practitioner who typically treats the condition, performs the procedure, or provides the treatment under review and was neither involved in the original denial of coverage determination or Level I appeal, performs the second level review.

Attachments:

5.2.5.1.10 What guidelines, processes or procedures do you use in determining whether services are "necessary" or "appropriate" and when services are deemed "experimental" or "investigational" in nature?

Answer: 1: Internal,

6: Other: [Please see the description below for more details about guidelines we use to determine whether services are necessary or appropriate.]

Detail: Clinical policies, supported by documented technology assessments, guide utilization management decisions. Our goals are to help make significant new advances available to members as soon as appropriate and prevent unproven, ineffective and potentially harmful technologies from receiving coverage. Our Chief Dental Officer is responsible for overseeing the update of our dental clinical policies through the dental clinical policy review committee:

- With input from outside experts, the academic community and network providers, we review dental scientific literature. We also rely on our formal research arrangement with the Columbia University College of Dental Medicine.
- Policies are re-evaluated at least annually; however, advancements in treatment disciplines or within the dental community may call for more frequent review.
- We distribute policy bulletins to appropriate internal staff through electronic manuals and shared public folders. The guidelines may also be communicated to participating providers through newsletters, updates to provider manuals, direct mailings, personal communications or online.

Our clinical policy bulletins (CPBs) define the dental necessity, cosmetic, as well as experimental and investigational status of health technologies. We update and revise these annually based on feedback from our constituents and emerging scientific research. We use CPBs along with the terms of the member's benefit plan and other Aetna-recognized criteria to determine health care coverage for our members. We make clinical determinations in connection with coverage decisions on a case-by-case basis.

Options:

1. Internal
2. ADA
3. Attending Dentist
4. Medicare or HHS
5. State Dental Assoc. or Org.
6. Other: [Text]

Attachments:

5.2.6 Claims Processing

5.2.6.1 Claims Processing - General

5.2.6.1.1 Will you prepare, print and furnish to the State, at no cost, a Dental Expense Administration Manual, or something similar, containing information of a substantive nature relative to how you will administer the State's plans, including UCR determination, sampling techniques and procedures? Will you provide to the State timely updates of any change in practice or procedure affecting plan administration?

Answer: We can provide booklet materials describing the benefit plan. In addition, we can provide the State with a standard template on which they can provide us with additional ERISA information that, when included with the booklet materials, results in a document that satisfies the Department of Labor's Summary Plan Description (SPD) requirements. Documents are standardly sent electronically to you once benefits have been finalized. If requested and for an additional cost, documents can be printed by Aetna and bulk shipped to you for distribution to employees.

Attachments:

5.2.6.1.2 Describe how you will provide a dedicated system of claims administration.

Answer: The Western Dental Service Center is organized into teams that specialize in either claim processing or customer service. Claim processors and customer service representatives are trained to handle claims and calls for all of the customers in the office. We continually monitor volume and staffing.

Attachments:

5.2.6.1.3 Does your claim system have a common database for edits, pricing, production of EOBs and reporting?

Answer: Yes, our claim system has a common database for edits, pricing, production of EOBs and reporting.

Attachments:

5.2.6.1.4 Explain your capability to accept electronic claims directly from providers and claim clearinghouses on behalf of members.

Answer: We accept claims electronically from dentists. Participating dentists are required to submit claim forms for members in our dental PPO plan, creating a paperless process from the member's point of view.

If a dentist is unable to submit claims electronically, we scan and then convert their paper claim submissions to electronic form for processing.

Providers can submit all claims, including Coordination of Benefits claims and corrected claims electronically. The following providers may use electronic submission:

- Hospitals
- Pharmacies
- Laboratories
- Other institutional providers
- Physicians
- Dentists

They can transmit claims directly to us through:

- An Aetna-approved vendor
- Our secure provider website
- Our direct-connect website, www.aetnaedi.com
- Any number of clearinghouses

Through our electronic data interchange (EDI) vendors, providers can send:

- Referrals
- Precertifications
- Payment estimates
- Claims

We expect that our imaging technology will continue to increase electronic claim processing, which maximizes efficiency, accuracy and productivity.

Attachments:

5.2.6.1.5 Do you review claims for billing irregularities by a provider (such as regular overcharging, unbundling of procedures, up-coding or billing for inappropriate care for stated diagnosis, etc.)? If so, please describe your review process and what action you take in the event you find billing irregularities?

Answer: We use dental logic software to detect the unbundling of charges. As the software is built into our claim system, it is an automated process. We also refer claims to dental consultants in our utilization review units to identify services that are unbundled.

The referral criteria, including any customer-specific variation and workflow, are automatic and promote prompt and accurate claim resolution.

Our dental consultants use standard criteria containing comprehensive information about all procedures including:

- Implants
- Ridge augmentation

- Retreatment of root canals
- Periodontal maintenance procedures
- Consultations
- Occlusal guards
- Fixed bridgework
- Overdentures
- Guided tissue regeneration

Referrals are system generated for claims requiring professional review. A utilization management table identifies the claims. Based on the referral criteria and edits received, the claim system may auto-route certain claims directly to the clinical review unit. If a claim benefit specialist receives the claim, they can intervene during processing to route the claim to the clinical review unit using an online system called Electronic Workflow Management.

Once the clinical review unit receives the claim, consultant assistants will prescreen them for questionable or complicated treatment plans, or incomplete/improper referrals. They forward questionable or complicated treatment plans to the dental consultants for review. Incomplete or improper referrals go back to the referring claim benefit specialist for correction or proper handling.

Once the review is complete, the dental consultant indicates the determination results on the electronic referral coversheet. Based on the utilization management response, the claim may auto-adjudicate or be routed to the claim benefit specialist for final adjudication.

The claim benefit specialist reviews the dental consultant's comments and applies appropriate plan provisions during processing.

We update claim review guidelines on an ongoing basis. The guidelines address clinical issues including:

- Alternate benefits
- Clinical documentation requirements
- General dental coding and procedure descriptions
- Inclusive procedures
- Various periodontal and major restorative services

We review major procedures to confirm the proposed treatment is necessary to the needs of the patient. If not submitted on a pretreatment basis, the consultant reviews the claim when received.

Additionally, our consultants review claims flagged by the claim system as potentially fraudulent or otherwise inappropriate; e.g., a filling in a previously extracted tooth, root canal therapy in a crowned tooth, a second root canal therapy in the same tooth, etc.

Attachments:

5.2.6.1.6 Where will claims processing dedicated offices be located?

Answer: Claims handling for the State will be provided from our Western Dental Service Center, located at 6303 Owensmouth Avenue, Woodland Hills, CA 91367.

Attachments:

5.2.6.1.7 What are the hours/days of operation for the claims processing unit?

Answer: The standard hours of operation for the Western Dental Service Center are Monday through Friday, 8 a.m. to 6 p.m. Pacific Time.

Attachments:

5.2.6.1.8 How many claims processors will be dedicated to the State's plans?

Answer: We recommend the designated staff model because it provides flexibility in meeting staffing needs, resulting in better service.

Designated means there is a defined number of staff members whose primary responsibility is to support a particular account. This team would, as needed, have secondary and tertiary responsibility for other accounts within the group. Should call or claim activity for a given account exceed forecast, we will reposition staff to support teams needing coverage.

Attachments:

5.2.6.1.9 What are the average years of experience for your claim processing staff?

Answer: The average years of experience of our claim processing staff is 11 years.

Attachments:

5.2.6.1.10 What is the average length of employment for claim processing staff?

Answer: The average length of employment of our claim processing staff is 20.5 years.

Attachments:

5.2.6.1.11 Describe your training program for claims processing staff.

Answer: Outlined below is a description of our claim supervisors and examiner training.

SUPERVISOR

General requirements for the team lead (supervisor) position include proven ability to lead a team, a broad knowledge of dental products and demonstrated technical proficiency. Team leads are trained to deliver a disciplined approach to assessing trends in customer issues, and identifying solutions that enhance future customer interactions. We offer management course to enhance their leadership skills.

We recognize the critical need to provide the newest training additions to the management team and offer a number of management courses:

- Basic Principles of a Collaborative Workplace
- Project Management
- Developing High Performance Feedback
- Delegating Effectively
- Solving Problems and Making Decisions in Teams

CLAIM EXAMINER - INITIAL TRAINING

The claim processing training for experienced CSRs is a two week in-house training program delivered through mixed media such as classroom lectures and computer-assisted instruction. We evaluate participants' skills and productivity with written tests and oral quizzes.

As the trainees successfully pass the tests and quizzes, they gradually move into actual claim processing. We teach trainees to make outreach calls to the provider for any missing information necessary to process the claim. Initially, we audit 100 percent of live claims handled by trainees. As the results reach acceptable levels in given categories, we release the trainee from audit for those

categories.

Upon successfully completing this training program, our CSRs are cross-trained as claim benefit specialists with demonstrated skills and accuracy.

ONGOING TRAINING

Training extends beyond our initial programs because on-going training is essential for effectiveness on the job. We hold refresher sessions on trends noted through our various audit programs. We may also conduct special sessions on system enhancements or revised administrative procedures and techniques. We offer other educational programs (e.g., time management) to help our staff become fully functional.

Our training program develops our staff to maintain our position as an industry leader in providing prompt, efficient and accurate service.

Attachments:

5.2.6.1.12 Explain any incentive programs you employ to retain competent claim processing staff.

Answer: Creating a positive work environment and focusing on employee engagement are integral components of our operating model. Our commitment to this is evident in many areas including:

- Robust hiring program
- Rewards and recognition programs which encourage the behaviors we value for delivering excellent service to our customers
- Competitive compensation program which includes incentive-based bonus for front line employees
- Award winning training program - In February 2010, we were ranked 10th in Training magazine's annual Top 125 companies with the best training and work development for their employees. This is the sixth consecutive year we have placed in the top 125. We moved up 16 positions into the top 10. The recognition and best practice award demonstrates our dedication to excellence and the high level of training we provide our employees.

Our dental customer operations maintain turnover rates that are consistently below industry standard.

Attachments:

5.2.6.1.13 What is the average productivity of the claims approvers on a per approver per day basis?

Answer: The claim processors in the Western Dental Service Center office handle approximately 80-100 claims per day. Claim processors are subject to varying production standards based on their responsibilities, experience and complexity of the plans for which they are responsible.

Attachments:

5.2.6.1.14 How does the claim office handle periods of significantly increased workload?

Answer: Our dental service centers (DSCs) use call center management for forecasting, scheduling and monitoring call volumes whenever necessary. The DSCs also use a staggered staffing approach, so that the optimum level of coverage is provided during peak periods of the day.

Weekly meetings of the three DSCs monitor call volume and initiate load balancing of calls, if

necessary. We can then reroute calls to another DSC to promote consistent quality service. This is transparent to the caller.

Attachments:

5.2.6.1.15 How does the claim office's performance for the past two years compare with the claim turnaround time goal?

Answer: 7: Other. Indicate: [Our claim turnaround time goal is to process 93 percent of all claims within 14 calendar days of receipt. In 2011, the Western Dental Service Center processed 98.6% in 14 days and 2012 YTD 99.2% in 14 days. As electronic connectivity and automatic adjudication continue to increase, we may pay many claims in 5 to 10 calendar days.]

Detail:

Options:

1. Up by 5--10%
2. Up by 11--15%
3. Up by 16--20%
4. Down by 5--10%
5. Down by 11--15%
6. Down by 16--20%
7. Other. Indicate: [Text]

Attachments:

5.2.6.1.16 What percentage of claims are processed in 5, 10, 20 and 20+ days?

	Indicate % of claims paid in # of days
% paid in under 5 days	94.9%
% paid in 5--10 days	98.5%
% paid in 10 -- 20 days	99.4%
% paid in over 20 days	99.8%

Detail: 94.9% in 5 days
 98.5% in fewer than 10 days
 99.4% in fewer than 15 days
 99.8% in fewer than 28 days

We track the number of calendar days it takes to process 90% and 95% of claims.

Attachments:

5.2.6.1.17 In the claim processing office that will have payment responsibility for this account, what are your standard targets and average statistics for the following?

	Standard Target	Average Statistics
Claims processing turnaround time	93% of claims paid in 14 calendar days	99.2% of claims paid in 14 calendar days
Answer speed	Less than 25 seconds	8.0 seconds
Wait time	We do not place callers on hold prior to a customer service representative responding to their inquiry.	We do not place callers on hold prior to a customer service representative responding to their inquiry.
	We currently answer 85-90 percent of	We currently answer 85-90 percent of

	Standard Target	Average Statistics
	calls within 30 seconds, with an average speed of answer of less than 10 seconds.	calls within 30 seconds, with an average speed of answer of less than 10 seconds.
Abandonment rate	Less than 2% abandonment rate	0.4% abandonment rate
Payment accuracy	96%	99.01%
Financial accuracy	99%`	99.67%
Member Satisfaction	80%	94%
First Call Resolution	95%	96.7%

Detail: Western Dental Service Center standard targets and average statistics as of October 2012.

Attachments:

5.2.6.1.18 Did you develop the claims system internally? If you did not develop your system internally, which firm developed it and when?

Answer: We began processing claims on Automatic Claim Adjudication System (ACAS) in 1997. We customized ACAS, based on the Dun and Bradstreet system ClaimFacts®, to support our book of business.

Attachments:

5.2.6.1.19 Are all claims processed on a single claims system?

Answer: Yes. ACAS supports the full range of dental products through a single platform, with increased flexibility to support customer plan design variations. System enhancements have significantly increased the percentage of our claims that are handled electronically and resolved automatically.

Attachments:

5.2.6.1.20 How are changes to the claims system implemented?

Answer: We make major enhancements to our system on a quarterly basis via our enterprise release calendar (February, May, August and November). We schedule system releases over the weekends to avoid meaningful downtime for our processing centers, members and providers.

Attachments:

5.2.6.1.21 When was the last update to your claim processing system, and what changes were implemented?

Answer: The last major ACAS release was on November 9, 2012. In 2011, we continued with enhancements for new product offerings, new ADA table's facilities, pricing for non covered services, additional dental rules and policies for claim reviewing with added support for facility claims, and automatic adjudication. In addition, there was system changes needed to comply with legislative requirements including those under Health Care Reform.

Attachments:

5.2.6.1.22 Are system changes planned in the next two years? If there are system changes planned, please indicate the nature of the changes.

Answer: Over the next three years, we will continue with enhancements as described for 2011.

Leveraging technology is a key element of our focus on operational excellence. We continually upgrade our technology to support new products and services. Further initiatives are being defined as we continue to define our multi-year strategies to support the business.

Attachments:

5.2.6.1.23 Please provide a claims workflow diagram from date of receipt of a claim through release of payment and reporting to plan sponsor.

Answer: We have attached a claims workflow diagram.

Attachments: [Aetna Claim Workflow Diagram.ppt](#)

5.2.6.1.24 Does your claims system have the capability to process network and non-network claims on the same system?

Answer: Yes. Our claims system automatically links the member, the plan, the provider, the network, any applicable referral and the fee arrangements.

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

CLINICAL POLICY INTEGRATION

Clinical policies, supported by documented technology assessments, guide utilization management decisions. Our goals are to help make significant new advances available to members as soon as appropriate and prevent unproven, ineffective and potentially harmful technologies from receiving coverage. Our Chief Dental Officer is responsible for overseeing the update of our dental clinical policies through the dental clinical policy review committee:

- With input from outside experts, the academic community and network providers, we review dental scientific literature. We also rely on our formal research arrangement with the Columbia University College of Dental Medicine.
- Policies are re-evaluated at least annually; however, advancements in treatment disciplines or within the dental community may call for more frequent review.
- We distribute policy bulletins to appropriate internal staff through electronic manuals and shared public folders. The guidelines may also be communicated to participating providers through newsletters, updates to provider manuals, direct mailings, personal communications or online.

Our clinical policy bulletins (CPBs) define the dental necessity, cosmetic, as well as experimental and investigational status of health technologies. We update and revise these annually based on feedback from our constituents and emerging scientific research. We use CPBs along with the terms of the member's benefit plan and other Aetna-recognized criteria to determine health care coverage for our members. We make clinical determinations in connection with coverage decisions on a case-by-case basis.

Attachments:

5.2.6.1.25 Does your claims system automatically match claims with predetermination information, both for in- and out-of-network?

Answer: Yes. Our utilization management system uses current technology to identify procedures for prospective or retrospective utilization review. The system reviews each dental claim or predetermination request against a series of electronic tables that detail:

- Clinical and claim policies
- Member and provider characteristics
- Pertinent claim history
- Other customer-specific rules and limitations

Editing capabilities programmed into our system include:

- Covered and non-covered benefits
- Frequency limitations
- Alternate benefit provisions
- Missing tooth clauses

Programming coverage logic has greatly reduced the need for manual handling and increased the rate of auto-adjudication. The system edits are set up for each plan and the system has the flexibility to modify the edit criteria for each plan. We update ADA tables for new CDT coding.

Access to electronic imaging systems allows for online review of diagnostics and creates increased efficiencies in the review process. We store images in the system where we can access them for future claims on the same members, reducing the number of requests for additional information. Dental consultants in different sites can also review the electronic images.

We refer cases that need further review to our in-house dental consultants. Non-selected cases flow directly through auto-adjudication or routine processing.

Attachments:

5.2.6.1.26 Confirm that you are able to pay claims in accordance with provider contracts held by the State and not your network.

Answer: Confirmed. We can pay claims in accordance with custom contracts including those held by the State of Alaska.

Attachments:

5.2.6.1.27 For what period of time are claims records maintained after records are purged from the system?

Answer: We move claims greater than five years old that meet specific criteria into an archive database. These claims are available for recall (in most cases, immediately) and will display all claim details.

We also keep three years of financial data on the claims system that are used during adjudication. Financial data beyond the three years are available for historical view only. This includes the family/member's accumulator information such as plan limits, deductibles and amounts accumulated towards those limits.

ONLINE HISTORY

Our claims system maintains claims history online indefinitely, this includes detailed claim history for each family member on submitted expenses and processed claims (paid, pending and denied). Aetna

Navigator, our secure member website, only displays claim history information online for two years (current and previous year).

We maintain financial data for three years.

Attachments:

5.2.6.1.28 What percentage of claims are auto-adjudicated for contracted Alaska providers? For non-contracted?

Answer: Western Dental Service Center office auto-adjudication rate is 83.6%. We only track the overall auto-adjudicated rate for the service centers. We do not track by providers in a specific area.

Attachments:

5.2.6.1.29 Describe your organization's success in increasing auto adjudication rates for Alaska providers.

Answer: We define automatic claim adjudication as benefit determination through the claims system without processor intervention.

We continue to focus on increasing our automatic adjudication rates. To accomplish this, we continually review the types of claims and benefit designs that could increase our automatic adjudication rates. We also work with the State on your plan designs and identify benefits that would impede automatic adjudication. In general, auto-adjudication rates at or above 85 percent are considered very efficient, taking into account the value of cost containment programs and the impact of customer benefit choices including the extent of customization of the plan design.

Our dental cost containment programs and certain customer benefit design decisions result in the manual review of claims to ensure claim accuracy. We feel that setting a single target is arbitrary and instead seek to meet the State's requirements as efficiently as possible.

We will work with the State on plan design changes that would increase auto adjudication. We anticipate the changes can occur in concert with expansion of the network and potential plan design steerage.

Attachments:

5.2.6.1.30 Is customer/member services housed with the claims paying unit?

Answer: 1: Yes

Detail: Most claim processing and member service teams are co-located where we have office-based staff.

Options:

1. Yes
2. No

Attachments:

5.2.6.1.31 What was your percentage of turnover for claims examiners in 2011 and 2010 at the claim office(s) that would be assigned to this account.

Answer: The percentage of turnover for claim examiners in 2011 was 5.0% and 7.3% in 2010.

Attachments:

5.2.6.1.32 Which of the following descriptions would best characterize your claim adjudication process?

Answer: 1: System-based adjudication with claims specialist oversight

Detail:

Options:

1. System-based adjudication with claims specialist oversight
2. Claim specialist adjudication with system-based claim tracking
3. Primarily claim specialist adjudication and tracking
4. Other: [Text]

Attachments:

5.2.6.1.33 What security measures are in place to ensure that reimbursements are issued to the proper party?

Answer: 3: Other: [Our claims system automatically links the member, the plan, the provider, the network, any applicable referral and the fee arrangements. The system automatically calculates benefits on the basis of the negotiated arrangement or, for non-network providers, according to Nonparticipating Provider Reimbursement policy such as percent of Medicare, state-mandated rate and percent of Fair Health, etc. and other guidelines.

The claims system employs automated claim review software to identify and adjust for unbundling of services and duplicate claim billings. We also use additional software, known as the Aetna Standard Table to identify diagnoses and procedures designated as inappropriate according to our clinical policy.

]

Detail:

Options:

1. Assignment signature required
2. Network provider automatically assigned
3. Other: [Text]

Attachments:

5.2.6.1.34 Will you accept liability for claim processor negligence? Fraud?

Answer: 1: Yes

Detail: When we suspect fraud, we create a case and assign a Special Investigations Unit (SIU) investigator. Internal investigations involving employees, agents or vendors are the responsibility of the Investigative Services Unit located in Hartford, CT.

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

Our internal controls include the following:

- Password and procedural limitations within the claims system

- Security edits built into the claims system
- A series of miscellaneous audits designed to target areas with the potential for abuse (e.g., unassigned payments, overrides, etc.)
- A toll-free compliance alert line which provides employees access 24 hours a day, seven days a week to report known or suspected acts of employee misconduct
- Confirmation letters to randomly selected payees

Options:

1. Yes
2. No

Attachments:

5.2.6.1.35 Can you use an identifier other than the SSN?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

5.2.6.1.36 If an identifier other than SSN is used, is there an additional charge? If so, please indicate on the rate sheet.

Answer: 2: No

Detail: There is no additional charge. Our standard non-SSN identifier will be used.

Options:

1. Yes
2. No

Attachments:

5.2.6.1.37 Explain whether you offer direct deposit of participant benefit reimbursement.

Answer: Direct deposit is not available for member reimbursement for the dental plan. We provide this service for our FSA administration.

Attachments:

5.2.6.2 UCR Management

5.2.6.2.1 Confirm that your negotiated provider reimbursements are the lower of a discount amount or UCR and members or the plan will not be billed for amounts above UCR?

Answer: Our contracts include a provision that requires the negotiated discount for non-covered services. Certain state laws prohibit dental carriers from requiring participating dentists to accept

DPPO discounted rates for non-covered services. While we cannot contractually require participating dentists in these states to provide services at discounted rates regardless of plan coverage, we encourage them to voluntarily do this.

Attachments:

5.2.6.2.2 Describe how you would implement the plan documents UCR requirements, including how you collect claim charge data to assess UCR. Identify any parties with whom you share this data to verify statistical appropriateness or to ensure adequate claim data for Alaska is available for analysis.

Answer: For Reasonable & Customary (R&C) based on the benefit determinations, we consult an external database. We use FAIR Health Benchmarks database produced by the non-profit entity FAIR Health.

COLLECT DATA

We obtain information from FAIR Health, Inc. Health plans send FAIR Health copies of claims for services they received from providers. The claims include the date and place of the service, the procedure code and the provider's charge. They combine this information into databases that show how much providers charge for most services in any zip code.

CALCULATION OF PORTION WE PAY

We use the 80th percentile to calculate how much we pay for out-of-network services. Payments at the 80th percentile means 80 percent of the charges in the database are the same or less for that service in the particular zip code. If charges are not enough (less than 9) for services in a particular zip code, we may use the derived charges data. This charge is based on the charges of comparable procedures, multiplied by a factor that takes into account the relative complexity of the procedure that was performed.

Attachments:

5.2.6.2.3 Describe any difficulties you would have in implementing the plan's UCR requirements, including any additional charges that would be required.

Answer: We base payment for services or supplies received from network providers on the contract between us and that provider. Our recognized amount is applied to services or supplies that member chooses to receive out-of-network. Payment for out-of-network services will be based on our payment policies.

Attachments:

5.2.6.2.4 How often do you update your UCR profiles?

Answer: We use the FAIR Health database for our reasonable & customary (R&C) reimbursement amounts. FAIR Health database updates are released twice per year. Aetna's systems are updated following those releases.

Attachments:

5.2.6.2.5 Are UCR allowances applied to all services?

Answer: If an allowable charge is not included in the profile, we use 85 percent of the provider's charge as the PPO fee allowance.

Attachments:

5.2.6.2.6 Can the UCR percentage be changed at the State's request?

Answer: We can support the State's current 90th UCR percentile. The State may opt for the following recognized amount level alternatives: 50th, 60th, 70th, 75th, 80th, 95th or 95th percentile. These alternate recognized amount level percentiles will not affect automatic system calculation. Additionally, we can accommodate a \$5 or \$10 corridor within which we would not reduce charges.

Attachments:

5.2.6.2.7 Describe whether you are willing to disclose UCR to plan members upon request.

Answer: We provide relevant data about specific recognized charges available by ADA code for a particular geographic area upon request from you, a provider or a member.

Attachments:

5.2.6.2.8 Are UCR profiles calculated based on the most recent 6 months of claims charge data? If not, explain what period of time you use to calculate UCR data.

Answer: Our recognized charge is applied based on the date of service. FAIR Health is updated two times per year and thus applies to 6-months of claims.

We will work closely with the State to ensure your plan's actual reimbursement for out-of-network services are consistent with your intent. We remain committed to controlling health care costs for our members and customers. We believe we are able to do so using FAIR Health database.

Attachments:

5.2.6.2.9 Do you maintain separate UCR profiles for the State of Alaska?

Answer: For out-of-network charges in all 50 states, Aetna consults the Fair Health Benchmarks database. There are 491 number of codes.

Attachments:

5.2.6.2.10 Do Alaska UCR profiles reflect the differences between the rural and urban areas of the State?

Answer: Our payment is based on the zip code where the service is provided. It is based on 3-digit zip code.

Attachments:

5.2.6.2.11 Please describe the geographic areas for which you maintain UCR profiles by zip code, including the geographic factors used in determining groups that determine UCR.

Answer: Aetna uses the FAIR Health zip code based expense area groupings for reasonable and customary determinations. These groupings consist of a single or multiple three digit zip codes for the State. If multiple zip codes need to be grouped to create a large enough pool of provider charges the groupings are based on cost similarity and geographic proximity. State lines are not crossed. There are 491 zip code areas.

Attachments:

5.2.6.2.12 Is the claims charge data collected to assess UCR for Alaska limited to providers in Alaska?

Answer: The FAIR Health database consists of provider charge data collected at the zip code level from more than 150 major contributors, including commercial insurance companies and third-party administrators.

Attachments:

5.2.6.2.13 Describe any recommendation you would have to change the plan's UCR methodology.

Answer: We suggest that UCR discussed within the overall network fortification discussions we will have with the State. Our goal is to support the State in the handling of the overall Alaska network and modify UCR accordingly to steer utilization to in network providers.

Attachments:

5.2.6.2.14 Describe how you calculate reimbursement when UCR data is not sufficient in a geographic area.

Answer: Our payment is based on the zip code where the service is provided or the provider's usual charge, whichever is less. UCR charges are determined by collecting the claims submitted for each procedure, defined by the procedure code, in a geographic area. The highest and lowest charges are ignored and the charge that allows 90% of all the claims to be paid in full is set as the UCR charge for that procedure. The geographic area is determined by where the procedure is performed.

INSUFFICIENT DATA

If data is insufficient to determine UCR charge, the claims administrator may consider items such as the following:

- Prevailing charges in a greater geographic area
- Complexity of the service or supply
- Degree of skill needed
- Type of specialty of the provider
- range of services or supplies provided by a facility

Attachments:

5.2.6.2.15 For purposes of appeal, UCR data and underlying calculations may have to be made available to members and the Division upon request. Describe how you would implement this requirement and any difficulties you anticipate in complying with this requirement.

Answer: Upon request, and with appropriate releases, the methodology around how we determine UCR is sent to members and could be sent to the division.

Attachments:

5.2.6.3 Explanation of Benefits (EOB)

5.2.6.3.1 Provide a copy of your company's electronic EOB.

Answer: 1: Attached

Detail:

Options:

1. Attached
2. Not Attached

Attachments: [Aetna Dental EOB.pdf](#)

5.2.6.3.2 Describe your process and timing for printing and mailing or otherwise distributing explanations of benefits to members and providers.

Answer: Members who register for Aetna Navigator®, our secure member website, can view the status of a medical, dental or pharmacy or flexible spending account (FSA) claim for themselves or a covered dependent, 24 hours a day, 7 days a week. They can check to see if a claim is completed, in process, or if more information is needed.

In addition, members may download personal claims safely and securely to a computer or disk for use in planning for health care expenses, tax reporting and record keeping.

MEMBERS

We mail member EOBs for the same family, in the same envelope, whenever possible. Any personal health information that is protected under privacy laws is masked or not included on the EOB. In addition, a member can request a privacy restriction if desired by contacting member services.

We mail the EOBs on a consistent day of the week based on the state of residence of the member. We use an every 21-day mailing schedule; however, we may send EOBs out at 7 days or 14 days to comply with any state regulations. EOBs will go out daily, and not age, when there is a member payment or request for additional information from the member. We produce EOBs in Erlanger, KY by an off-site print vendor.

Our claims system will suppress in-network EOB production if benefits are assigned and the member's liability is zero, or if the member's liability consists of a copayment only.

Members can also view EOBs on Aetna Navigator®, our secure member website at www.aetnavigators.com.

PROVIDERS

We age and bulk in a schedule provider EOBs and checks, whether for network or non-network providers. This allows delivery within 24 days of the claim received date. We send the majority on either a weekly or biweekly schedule, and on a consistent day of the week determined by state location of the provider. A provider EOB accompanies each provider draft. The EOB breaks down the payment by patient and gives pertinent information about the payment and non-covered expenses.

Attachments:

5.2.6.3.3 Describe your method to provide the electronic communication of the adjudicated claim to the member.

Answer: Members can elect to suppress paper EOBs and receive electronic EOBs only. Members that elect paper suppression will receive an e-mail notification to their e-mail address regarding the EOB transaction.

Members who register for Aetna Navigator can view the status of a medical, dental or pharmacy or flexible spending account (FSA) claim for themselves or a covered dependent, 24 hours a day, 7 days a week. They can check to see if a claim is completed, in process, or if more information is needed.

In addition, members may download personal claims safely and securely to a computer or disk for use in planning for health care expenses, tax reporting and record keeping.

Attachments:

5.2.6.3.4 Identify how your EOB's provide sufficient information to explain claim processing, including display of annual individual and family maximums met, payee – including date paid and check number, and any applicable benefit maximums met by an individual, per claim.

Answer: Our member EOB provides a payment summary of paid benefits by Aetna as well as what the member may owe. There is also a section that gives a breakdown of how a claim was paid. Details include:

- Amount billed
- The member rate
- Any amount that is pending or not payable and any remarks that may explain why
- Amount applied to the deductible
- What the member's plan paid
- Any amount the member may owe

Attachments:

5.2.6.3.5 Does your claims system have the capability to show, on the EOB, the negotiated and actual charge?

Answer: 3: Both

Detail:

Options:

1. Negotiated
2. Actual
3. Both

Attachments:

5.2.6.3.6 Explain your process for ensuring member and provider EOBs correctly reflect the processing and payment of benefits prior to sending them to members and providers. Provide a sample copy of both a provider and a member EOB.

Answer: We audit EOBs internally on a monthly basis for accuracy. There are also routine quality reviews performed by the business team. We handle any findings promptly with an action plan.

We process and communicate the status of claims and payment of benefits as follows:

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

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

- Benefits are assigned and member's liability is zero
- Benefits are assigned and member's liability consists of a copayment only (applicable for pharmacy)
- Incomplete claims - For claims that are missing information (e.g., accident details, diagnosis and other coverage information), claim processors will attempt to contact the provider or employee for the additional information. If we are unable to obtain the missing information, we send the employee an EOB acknowledging receipt of the claim, explaining the reason for the delay and/or requesting the necessary information. We will only pend the expense in question.
- Denied claims - We send employees and providers an EOB explaining the reason for the denial. The EOB describes the appeals process in the event the employee/provider does not agree with our determination.

Attachments: [Aetna Dental EOB.pdf](#)
[Aetna Dental EOB Provider.pdf](#)

5.2.6.3.7 Describe how you ensure the line-by-line EOB remarks correctly reflect the reason for denial or reduction of any line item charge.

Answer: We have a committee, dedicated to overseeing the process of creating or revising EOB remark codes. The committee meets weekly. It has representation from a cross functional population of the various business areas, including legal counsel. Their goal is to ensure they create and approve a remark that is clear, easy to understand and explains the reason for denial or reduction. There are also separate efforts underway to review existing codes to ensure they adhere to the same standards. A monthly EOB audit performed also chooses random selections of EOBs to examine remarks for the same set of standards.

In addition, our claim system supports this process with built-in edits. We have four mechanisms in place to promote coding and EOB accuracy:

- We update all of our systems with all new, termed and revised codes as documented by industry code set owners for set effective dates.
- We provide extensive processor training.
- Our quality audit program identifies coding problem areas and then provides retraining as needed.
- We use Flash Code software to improve the accuracy of our coding for surgical, medical and dental procedures and diagnoses.

Flash Code automatically translates descriptive terminology into the appropriate diagnostic or procedural coding and vice versa. Our processors can access this feature as they process claims. For example, a processor can determine the appropriate code if:

- A code is not on the claim form
- A code is invalid (e.g., mammogram for male patient) or incomplete
- A code conflicts with the written description

This helps to ensure the proper coding of claims, and in turn, the correct EOB remarks are assigned.

Attachments:

5.2.6.3.8 Explain what accumulator fields and service limits are currently available to be printed on your EOBs, for example: year to date individual and family deductible met and dental benefit paid to date as applicable.

Answer: We standardly display applicable plan deductible and out of pocket limits on member EOBs. We allow specialty benefit displays if requested by the State.

Attachments:

5.2.6.3.9 Provide your EOBs Flesch-Kincaid readability score.

Answer: We redesigned the member EOB in October, 2011. The components of the EOB are at a 5th and 8th grade readability level.

Dalbar rated our member EOB against other member EOBs in the industry. It received their communications seal as well as ranked in the top 5. Our EOB rated best in class for clarity.

Attachments:

5.2.6.3.10 Describe how you respond to EOB improvement recommendations made by providers and members.

Answer: We take EOB improvement requests into consideration and measure them for feasibility. If we determine a change is necessary, we use a standard process for implementing code changes.

Attachments:

5.2.6.3.11 Does your claims system have the capability to customize EOB messages? If there is an additional cost, please indicate the cost on the rate sheet.

Answer: Yes. The State has the option to customize EOB messages at no additional charge. Our business and legal departments must approve custom EOB messages and/or message campaigns. We recommend that messages be as short as possible (maximum of 3 lines) and have a recommended stop date (i.e., 3 or 6 months in the future). The 3 lines have a maximum of 140 characters per line including spaces and punctuation. There is no additional charge for customization of the notes section of the EOB.

Attachments:

5.2.6.3.12 Do you have the ability to customize financial and service limit information that appears on your EOBs? If there is an additional cost, please indicate this cost on the rate sheet.

Answer: Yes. The State can customize the label headings on EOBs at no additional charge.

Attachments:

5.2.6.3.13 What percentage of claims are auto-adjudicated for contracted Alaska providers? For non-contracted?

Answer: We do not track the auto-adjudication rate by contracted or non-contracted Alaska providers; we track the overall office auto-adjudication rate.

Attachments:

5.2.6.3.14 Describe your organization's success in increasing auto adjudication rates for Alaska providers.

Answer: We define automatic claim adjudication as benefit determination through the claims system without processor intervention.

We continue to focus on increasing our automatic adjudication rates. To accomplish this, we continually review the types of claims and benefit designs that could increase our automatic adjudication rates. We also work with the State on your plan designs and identify benefits that would impede automatic adjudication. In general, auto-adjudication rates at or above 85 percent are considered very efficient, taking into account the value of cost containment programs and the impact of customer benefit choices including the extent of customization of the plan design.

Attachments:

5.2.6.3.15 Indicate whether monetary adjustments (whether they are provider write-off or member responsibility) are shown on your EOBs so members are not required to manually calculate the adjustment amount themselves.

Answer: Yes. Monetary adjustments are shown on the EOB. A member does not have to make any manual calculations to determine their share of the costs.

Attachments:

5.2.6.3.16 Do you charge clients for issuance of duplicate EOBs/claims?

Answer: No, there is no charge for duplicate EOBs. Members can request additional copies of EOBs anytime by contacting member services.

If Aetna is the medical administrator, the State's health concierge will be available to assist members with this request. Additionally, members can view and print detailed claim information anytime by using the secure member website.

Attachments:

5.2.6.3.17 Does your claims system have a common database for edits, pricing, production of EOBs and reporting?

Answer: Yes. The data in our claim system is integrated online. This allows our eligibility areas to view claims information as needed. This information is in a read-only format and can only be updated by authorized viewers. Our claim system automatically feeds to reporting so that the State and your account team has the most accurate information possible in support of your plan.

Attachments:

5.2.6.4 Coordination of Benefits (COB)

5.2.6.4.1 Describe your current COB administrative procedures to ensure all dental claims are paid consistently in the correct order of benefit determination.

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

- During enrollment, many of our customers collect information about other coverage and share it with us.
- During the precertification process, our nurses ask about other coverage.
- Due to the cooperative nature of our relationship with network providers, hospitals and physicians routinely obtain other coverage information and submit it with the claim.
- In addition to the normal "other coverage" questions on our claim form, we ask if any other family members are employed and specific details.
- We send mailers to members with more than one dependent and members who turn 65.
- Registered plan members can provide us with updated COB information at any time using the Requests and Changes feature of Aetna Navigator, our secure member website.
- We exchange data with CMS (Medicare) regarding member eligibility and enrollment information. We exchange data on a quarterly basis. We update our verification files based on this information.

All claims submitted are screened for COB, even those where the member's current eligibility file does not indicate other coverage.

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

still do not obtain a response we would pay, pend, or deny the claim based on state regulation.

When other coverage information is obtained, we update the online family eligibility record to indicate primary/secondary/tertiary status. The system automatically presents a COB edit during claim processing when the eligibility file indicates that other coverage is primary. The notice includes details about the other coverage, which family members the other plan covers, the carrier, type of coverage and date of the last update.

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

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

Attachments:

5.2.6.4.2 Define the process, including who in your organization is responsible, for follow-up on possible COB opportunities.

Answer: Our COB approach is to determine the order of benefits for coordination prior to payment. We investigate any other primary benefits before issuing benefits.

Our claim processors handle claims with COB. We train them in both COB identification and investigation. We also identifying COB claims through our system-automated processes.

COB PROCESS

When other coverage is possible, we pend the claim online. We send an EOB to the member requesting specific details. If the member does not respond within 45 days of sending the original mailer, we send a follow-up mailer requesting the additional information. If we still do not obtain a response we pay, pend or deny the claim based on state regulation. If the information we receive does not seem plausible, we contact the provider or member to inquire about other coverage.

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

- Details about the other coverage
- Family members the other plan covers
- Carrier
- Type of coverage (e.g., medical only, medical-dental, etc.)
- Date of the last update

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

Attachments:

5.2.6.4.3 Explain the edits used in your system to identify potential COB cases on a continual basis.

Answer: All claims submitted are screened for COB, even those where the member's current eligibility file does not indicate other coverage. The system supports COB administration in several ways:

- The system has an online edit to warn the processor when accessing any family member's record for

claims processing.

- The system notice or COB database includes details about the other coverage, such as:
 - Family members covered
 - Carrier
 - Date last updated
 - Pertinent facts about the other coverage such as effective date
- Depending on your plan or state legislation, the system automatically picks the type of COB administered.
- The system calculates the COB benefits and updates the member's claim records with some processor intervention. (Exception: Manual processing is required if you choose to offer the COB carve-out method.)
- Electronic and paper claims have a field to indicate with a yes or no whether the claim is a result of a work-related condition or injury. Our claims system will present an edit if the answer to this question is yes. In addition, there are diagnosis codes that the claims system will edit to determine if work related. For claims with these diagnosis codes, the system logic will present the processor with an edit indicating "claim may be accident/workmen's comp related". On a prepayment basis, processors will review these claims which have an indication of potential occupational injuries or conditions. We deny claims identified as work-related. In addition, we add an online notice in the claims system to flag future related claims. If we suspect a work-related injury due to the diagnosis and time of occurrence, we pend the claim and request additional information from the employee, you and/or the provider.

Attachments:

5.2.6.4.4 Describe how you would fulfill the annual validation to identify other health/dental insurance coverage requirement.

Answer: We have an annual validation process (AVP) in addition to a variety of ongoing ways to identify when members have other coverage. Our COB administration starts with the collection and maintenance of accurate information about other coverage. We exchange data with CMS (Medicare) regarding member eligibility and enrollment information. We exchange data on a quarterly basis. We update our verification files based on this information.

In addition, we have a variety of methods for gathering COB information on an annual and ongoing basis, including:

- During enrollment, the State may wish to collect information about other coverage and share it with us.
- During the precertification process, our nurses ask about other coverage.
- Due to the cooperative nature of our relationship with network providers, hospitals and physicians routinely obtain other coverage information and submit it with the claim.
- In addition to the normal "other coverage" questions on our claim form, we ask if any other family members are employed and specific details.
- We send mailers to members with more than one dependent and members who turn 65.

- Registered plan members can provide us with updated COB information at any time using the Requests and Changes feature of Aetna Navigator, our secure member website, at www.aetnanavigator.com.

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

Attachments:

5.2.6.4.5 Confirm whether you are able to handle internal coordination when a claimant is covered under more than one State benefit plan such as being covered as the member and also as a dependent.

Answer: Confirmed. We add a special handling indicator and notice on the member's file to indicate internal COB applies. We have detailed workflows for the processors on handling of these claims.

Attachments:

5.2.6.4.6 Describe your use of computer edit checks or triggers to initiate COB application.

Answer: Our claims system includes edits that identify when a member is eligible for other coverage, such as age limit edits for Medicare, to trigger COB. In addition, our claim system edits consider the following as potential indicators of other coverage to initiate COB:

- Large bills submitted as paid
- Photocopied bills
- Indication of other party payment on the bill
- Auto accidents (i.e., potential no-fault insurance)
- Workers' compensation

Attachments:

5.2.6.4.7 Is COB history stored online?

Answer: Yes. Our eligibility file provides a field that allows documentation of a member's other coverage including:

- Name of the other carrier
- Policy number
- Effective date of the other coverage
- Order of benefit determination.

Attachments:

5.2.7 Quality Control (use tables provided in Attachment G4)

5.2.7.1 Please explain in detail how you will evaluate and report to the State your performance under the Contract. Specifically, identify and describe, by function, how each aspect of the work set forth in Section 1.04 of the RFP instructions relative to the Dental Claims Administration and Managed Network component will be evaluated for effectiveness and efficiency. For each function, please provide the following evaluative information:

- A detailed description of each performance standard you will utilize to evaluate each functional component for effectiveness and efficiency.
- The benchmark measurement for each identified performance standard for each functional component.

- The frequency of reporting to the State your evaluation of each identified performance standard for each functional component based on the standards and benchmarks you utilized to determine effectiveness and efficiency.
- Which standards you are willing to subject to penalty for failure to meet.
- Whether the evaluation of each standard will be conducted by your organization or will be conducted by an independent external organization.

Answer: We will offer Performance Guarantees in the following areas: Implementation, Account Management, Plan Sponsor Services, Claim Administration, Network Management, Member Satisfaction, Member Services, and Navigator.

Our Performance Guarantee document and Attachment I4 outlines the details and measurements of the Performance Guarantees.

Performance Guarantee reporting can occur quarterly, and reconciliation will occur annually.

Aetna will evaluate the outcomes of the guarantees.

Attachments:

5.2.7.2 Are you willing to put fees at risk for network expansion if needed?

Answer: Yes, we are willing to put fees at risk for a DPPO Recruitment guarantee.

Attachments:

5.2.7.3 Are you willing to guarantee savings in this proposal? If so, please explain.

Answer: We are willing to propose a Discount Guarantee with fees at risk.

Attachments:

5.2.7.4 Are you willing to place fees at risk for meeting certain performance standards and guarantee outcomes under the Contract?

Answer: Yes

Attachments:

5.2.7.5 Confirm you will not charge the State for claim payments not authorized by the State's plans when such payments were erroneously authorized by Contractor's employees, subcontractors or joint venturers, including pre-authorizations issued by Contractor's employees, subcontractors or joint venturers, causing the State's plans to incur costs for non-covered services.

Answer: Confirmed.

Attachments:

5.2.7.6 When are performance penalties paid out?

Answer: Penalties are paid/applied annually.

Attachments:

5.2.7.7 Can tracking and reporting of the performance standards be based on State-specific data?

Answer: Certain performance standards are available as case specific; other performance standards are only available at the site level, etc.

Attachments:

5.2.7.8 Please confirm that you will permit and cooperate with internal audits on any aspect of the administration of the program, as the State determines to be necessary and appropriate. State personnel or outside auditors that the State selects may perform these audits, including audits that may take place after the end of the contract period.

Answer: Confirmed. We agree with your right to audit and would like to discuss the logistics of any audit if selected as the successful bidder.

Attachments:

5.2.7.9 Please confirm that you will provide claims, payment documentation and other necessary information required for the State to complete its annual health funds audits.

Answer: Confirmed. We agree with your right to audit and would like to discuss the logistics of any audit if selected as the successful bidder.

Attachments:

5.2.7.10 Do you agree to fund an implementation audit, prior to effective date, up to \$50,000 to be performed by a firm of the State's choosing?

Answer: Agree.

Attachments:

5.2.7.11 Please indicate whether or not you agree with the following statements regarding Audits.

	Agree
You will allow auditing of your operations as they relate to the administration and servicing of this account.	1: Agree
Your organization will not charge for services rendered in conjunction with the audit.	1: Agree
If problems are discovered, follow-up audits will be paid by your organization.	1: Agree

Detail: Confirmed. In regard to items 1 and 2, we agree with your right to audit and would like to discuss the logistics of any audit if selected as the successful bidder. In regard to item 3, Aetna can agree to bear the expense of reasonably tailored follow-up audits.

Attachments:

5.2.7.12 Do you use a statistically significant sample for internal audits?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

5.2.7.13 Do you have a dedicated internal audit staff?

Answer: 1: Yes

Detail:

Options:

1. Yes
2. No

Attachments:

5.2.7.14 With what frequency is the claims processing function audited by an external auditing firm?

Answer: 4: Other: [We engage our external auditor on an annual basis.]

Detail:

Options:

1. Daily
2. Weekly
3. Monthly
4. Other: [Text]

Attachments:

5.2.7.15 With what frequency is the claims processing function audited internally?

Answer: 1: Daily

Detail:

Options:

1. Daily
2. Weekly
3. Monthly
4. Other: [Text]

Attachments:

5.2.7.16 Are audits performed on a pre- or post-disbursement basis?

Answer: 3: Both

Detail:

Options:

1. Pre-Disbursement
2. Post-Disbursement
3. Both

Attachments:

5.2.7.17 How are claims selected for audit?

Answer: 1: Random by system

Detail: This question limits us to one selection. Claims are selected for audit using all methods above: random selection, set percent per day, set number per approver per day/week, diagnosis, and dollar amount.

Options:

1. Random by system
2. Set percent per day
3. Set number per approver per day/week
4. Diagnosis
5. Dollar amount
6. Other. Please specify: [Text]

Attachments:

5.2.8 Appeals

5.2.8.1 Describe your method for processing appeals for certification review, claim review and/or billing appropriateness.

Answer: We provide a nationally standardized process for resolving member complaints and appeals which enhances our ability to handle them in a consistent and timely fashion.

We adopt the requirements of an individual state and these supersede the nationally standardized process. Our law department makes the final determination when there is any question as to the applicability of a law.

Our customer service representatives (CSRs) respond to most issues when members call our customer service department. If the issue cannot be resolved during the call, the CSR researches the inquiry and follows up with the member.

Members who are not satisfied with the CSR's response may file an oral or written complaint or appeal. Our complaint and appeal process is outlined below:

Complaints

The definition of a complaint is any oral or written expression of dissatisfaction/concern, other than an appeal, by a member or a member's authorized representative regarding services provided by Aetna, a network health care professional or a vendor. Complaints include, but are not limited to:

- Quality of administrative service provided by a participating health care professional
- Quality of administrative service provided by Aetna
- Use of his/her protected health information
- A plan benefit, billing, eligibility or contract provision that does not involve a request to review a denied claim or service

We resolve standard complaints within 30 days, and expedited complaints within 5 business days.

Level I Appeals

A Level I appeal is a verbal or written request by a member, or a member's authorized representative, requesting a change in an initial determination decision. Appeals include, but are not limited to:

- Claim payment
- Plan interpretation
- Benefit determinations
- Eligibility

To begin the appeals process, the member or the member's authorized representative submits a verbal or written request asking for a change in the initial determination decision. The member may send the appeal to the address shown or call the toll-free number listed on the notice of adverse benefit determination.

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

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

We resolve expedited appeals within 36 hours, and post service appeals within 30 days.

Written notice of a denied appeal includes:

- a. A statement of the reviewer's understanding of the pertinent facts of the appeal (description of the health care service/claim)
- b. Evidence or documentation used for the basis of the decision
- c. An explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the member's medical circumstances (as applicable)
- d. The specific rule, guideline, protocol or other similar criterion that was relied upon in making an adverse determination (as applicable)
- e. A statement that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the member upon request (as applicable)
- f. The specific plan provisions on which an adverse benefit determination is based
- g. A list of the titles and qualifications of the individuals participating in the review of the appeal (those individuals involved in the decision making process). Specific names available upon request
- h. A statement that the member is entitled to receive, upon request and free of charge, reasonable access to and copies of, all documents, records and other information relevant to the member's appeal
- i. A description of the next review level, including time frames and how to file (as applicable)
- j. The following statement: "If you do not agree with the final determination on review, you have the right to bring a civil action under Section 502(a) of ERISA."
- k. The following statement:
ASC (self-insured): "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your Plan Administrator or your local U.S. Department of Labor Office."

Level II Appeals

If the member or authorized representative is not satisfied with the outcome of the Level I appeal decision, they may submit an oral or written request, for further review, within 60 days of receipt of a

Level I decision. For clinical appeals, a practitioner who typically treats the condition, performs the procedure, or provides the treatment under review and was neither involved in the original denial of coverage determination or Level I appeal, performs the second level review. Administrative denials, such as contractual or benefit exclusions, limitation or exhaustion not requiring clinical judgment, have only one level of appeal.

If a Level II appeal is denied, the written notice includes all specific reasons for the denial, including the clinical rationale, reference to applicable plan provisions, dental information reviews and any other applicable appeal procedures that may be available.

Tracking

The Complaints and Appeals Tracking System (CATS) was developed to support our national process. The goals of this system are administrative consistency, centralized data collection, business accountability, a consistent workflow process and generation of standard reports. CATS stores the necessary data relating to a complaint or appeal for tracking, resolution and reporting purposes. This centralized data collection enables us to increase customer service, customer satisfaction and promotes regulatory compliance.

CATS provides a single system to capture, track, route and resolve all member, provider and customer complaints and appeals. The application is web based and allows for paperless routing of appropriate documents.

Attachments:

5.2.8.2 Explain how you use staff dental professionals and/or outside consultants to review disputed claims for dental necessity and billing appropriateness.

Answer: Our Customer Resolution Team is responsible for all member appeals.

Our professional dental consultants review requests for services and specialty care referrals. Based on their dental knowledge and experience, along with documentation submitted by the provider, the consultants review requests for appropriateness and eligibility according to the plan provisions.

Our dental consultants hold active dental licenses, many in multiple states. We have general dentists, oral surgeons and periodontists on staff. They provide clinical review for all utilization management review sites. Key requirements of our dental consultants include at least 10 years of clinical experience and that they remain actively licensed in their states, which requires on average 30 hours of continuing education every 2 years.

Attachments:

5.2.8.3 Describe how you retain dental consultants that represent various specialties for use in pre-authorization and claims resolution.

Answer: We employ approximately 15 dental consultants and 24 dental consultant assistants nationally, as both full- and part-time members of our staff. Our dental consultants have a minimum of 10 years of private practice experience. Dental consultant assistants are predominantly registered dental hygienists and certified dental assistants.

Attachments:

5.2.8.4 Describe your multi-level appeals process for administrative and clinical denials.

Answer: Level I Appeals

A Level I appeal is a verbal or written request by a member, or a member's authorized representative,

requesting a change in an initial determination decision. Appeals include, but are not limited to:

- Claim payment
- Plan interpretation
- Benefit determinations
- Eligibility

The member or authorized representative has 180 days after receipt of a coverage decision to file an appeal. We resolve expedited appeals within 36 hours, and post service appeals within 30 days.

Level II Appeals

If the member or authorized representative is not satisfied with the outcome of the Level I appeal decision, they may submit an oral or written request, for further review, within 60 days of receipt of a Level I decision. For clinical appeals, a practitioner who typically treats the condition, performs the procedure, or provides the treatment under review and was neither involved in the original denial of coverage determination or Level I appeal, performs the second level review. Administrative denials, such as contractual or benefit exclusions, limitation or exhaustion not requiring clinical judgment, have only one level of appeal.

If a Level II appeal is denied, the written notice includes all specific reasons for the denial, including the clinical rationale, reference to applicable plan provisions, dental information reviews and any other applicable appeal procedures that may be available.

Attachments:

5.2.8.5 Describe how you will meet the State's appeal process requirements and confirm you will be able to provide copies of all claim and appeal documents to the State for appeals that reach the State's level.

Answer: Confirmed. We will perform Level I and II appeals and will send out a complete packet of all documentation used in making the original claim and appeal determinations when fiduciary responsibility shifts to the State's level.

Attachments:

5.2.8.6 Confirm that you will participate, if needed, in administrative hearings resulting from denial determinations.

Answer: Confirmed. We will defend any lawsuit originating during or after completion of the first two levels of appeal. After all levels of appeal and the External Review option, if applicable, are exhausted, there is a Voluntary Appeal process available through the State. The State becomes responsible for defense of any lawsuit originating from the Voluntary Process.

Attachments:

5.2.8.7 Provide the percentages of total claims processed monthly that are appealed for other clients of similar size to the State.

Answer: Approximately 0.04% of dental claims we receive are appealed.

We do not track appeals by client size.

Attachments:

5.2.8.8 Of your total denials, provide the percentage of services that are generally overturned on appeal.

Answer: In 2011, we overturned approximately 32% of decisions as a result of an appeal. We upheld approximately 68% of the decisions.

Attachments:

5.2.8.9 Do you have a dedicated appeals staff?

Answer: Yes. We have an internal Customer Resolution Team (CRT) who are dedicated to appeals resolution.

Attachments:

5.2.8.10 Confirm the State will have a single point of contact for appeals related inquiries.

Answer: Confirmed. The State's Plan Sponsor Liaison (PSL) is the single point of contact for appeals related inquiries. The PSL serves as an extension of the State's account management team. They are located in the customer service center and act as a single point of contact for the State to assist you in resolving escalated issues. Your PSL will work with the appeals team and other Aetna resources to obtain all of the necessary information surrounding inquiries.

Attachments:

5.2.8.11 Please provide copies of all appeal decision notices you use.

Answer: We have provided a sample of our appeal decision notice, as requested.

Attachments: [Aetna Appeal Letter Sample.doc](#)

5.2.8.12 Describe other services you offer prior to or during appeal.

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

CRTs are comprised of complaint and appeal analysts who are responsible for all member appeals.

The State will also have a health concierge who can assist members with the appeal process, as well as local service representatives within our Anchorage and Juneau offices.

Attachments:

5.2.9 Data Analysis

5.2.9.1 Data Collection

5.2.9.1.1 Do you utilize a data warehouse for reporting and claim and trend analysis?

Answer: Yes.

Attachments:

5.2.9.1.2 Describe your organization's data warehousing and population health analytical services, including software used.

Answer: One of our most differentiating assets, our vast data warehouse, consists of 18 terabytes of integrated claim, membership, product and provider information.

The data warehouse is larger and more sophisticated than standard database management systems available in the marketplace. It is sourced by numerous operational systems such as:

Enrollment/eligibility
Claims administration
Provider applications

Patient management applications

The data warehouse encompasses the following product lines:

Medical
Pharmacy
Dental
Vision
Disability
Behavioral Health

From this data warehouse we execute numerous data analytic, reporting, trending, predictive modeling and data mining processes and activities.

Attachments:

5.2.9.1.3 What resources do you provide from a health data analyst perspective to support your clients?

Answer: We can provide you with all the data and information needed, in the way you need it, to effectively monitor your programs, address your issues, and help you make benefits strategy decisions. As a start, you receive immediate access to Aetna Health Information Advantage, a rapid and flexible Web-based decision support tool that houses your health benefits data. It includes standard and ad hoc reports. Your account manager is available to assist you with these reports at any time. We also provide printed communications to help you understand how to interpret and use our reports. In addition, Aetna Health Information Advantage includes an on-line help facility, which demonstrates how to use the features and content, and Aetna Informatics® contacts are available to assist you.

Attachments:

5.2.9.1.4 If yes, please provide the name of the warehouse and indicate if the State will have access to data and reporting. If there is an additional cost, please indicate the cost on the rate sheet.

Answer: Yes, the State will have access to data and reporting at no additional cost. Aetna Health Information Advantage reporting tool produces the information you need when you need it. Our reporting system is fast, flexible and customizable. It can help you make benefits and plan decisions quickly and confidently. Aetna Health Information Advantage will take your benefits and plan performance to the next level.

Industry leading analytical tools

Aetna Informatics® combines data, systems and people to give you answers to questions you did not know to ask. Our seasoned experts use our world-class data warehouse and cutting-edge technologies to pull together reports for you. You get information that is easy to understand and recommended actions to help you craft a better benefits package for your unique population.

Flexible reporting options

We can provide you with all the data and information needed, in the way you need it, to effectively monitor your programs, address your issues, and help you make benefits strategy decisions. As a start, you receive immediate access to Aetna Health Information Advantage, a rapid and flexible Web-based decision support tool that houses your health benefits data. It includes standard and ad hoc reports, giving you all the fundamental information you need when you need it. You can also choose other levels of reporting and services for a fee.

Integrated data for a holistic view

Our experts take different data types from various sources and organize them on a member-centric basis. This means we can link an individual member's data across many different sources. This total information content is then available for analysis. It is a holistic view of an individual person. This approach to data allows for a clear understanding of problems. It helps us pinpoint actions to recommend for your group. Aggregating data, on the other hand, stops short of this level detail. It limits your ability to have even a basic understanding of any problem or issue.

Our tool can help you see:

- Total cost of your health benefits
- How well your medical and other programs work together
- Impact of your benefit design

It can also help you:

- Draw stronger conclusions about member choices and incentives
- Isolate cause and effect of activities on overall health care costs
- Achieve insights into outcomes of programs across a variety of measures
- Increase your ability to conduct offset analyses

With our tools you can better analyze your current situation and customize the perfect health benefits solution — based on actual experience — for your workforce, taking into account your budget and benefits strategy.

Attachments:

5.2.9.1.5 Explain whether your organization will release detailed claims data to a central data warehouse for non-AlaskaCare health plan related analysis. Indicate if you are paid to provide this data.

Answer: One of our primary responsibilities is the protection and confidentiality of member information. In keeping with this requirement and at no charge, we provide information to a variety of external organizations as follows:

- We provide summarized information in support of national initiatives to monitor and manage quality of care. Examples of these include HEDIS measures at the Aetna Plan level to NCQA or hospital patient safety measures to the Leapfrog Group. We also participated in the some of the early pilot rounds of data submission for Care Focused Purchasing, a national initiative with participation from many large health plans.
- We contribute claims data to a national file used to develop UCR (usual, customary and reasonable) fee schedules for providers. This claims file does not include any member information.
- We have at times provided de-identified claims data to research organizations in support of beneficial member studies. All parties who participate in these studies are fully compliant with HIPAA regulations.
- We provide claims data to state and federal regulatory bodies when required.

We occasionally sell pharmacy dispensing information to certain drug companies. We agreed to this

after careful consideration of the use and intent for primarily furthering health care knowledge. These data are fully de-identified and HIPAA compliant.

Attachments:

5.2.9.2 Reporting

5.2.9.2.1 Please confirm the Contractor will provide the State or its authorized representatives with the following reports at the designated frequencies in a format compatible with Microsoft Excel or Access. Please identify what information is contained in each report. Please attach a sample of each report.

Report Plan Frequency

Claims Processing Accuracy All Plans Combined Quarterly

Claim Turnaround Time All Plans Combined Monthly

Statistical Summary By Plan Monthly

-- Covered lives

-- Billed fees/charges

-- Paid claims

-- Transactions

Provider Summary By Plan Annually

Claim Payment Summary By Bargaining Unit

& Retirement System Monthly

-- Transactions and claim dollars

-- Type of service

Utilization Summary By Plan Quarterly

-- Type of service

-- Claimant

-- Place of service

-- In-network versus out-of-network

--Network cost savings

-- Denials and appeals

Cost Trends By Plan Annually

Cost Containment Trends By Plan Annually

Audit Data – Claim Details for all below

-- Checks Cleared By Plan & Benefit Type Monthly

By Group & Retirement System

-- Incurred but not paid By Plan Annually

-- Outstanding checks By Plan Annually

-- Lag reports By Plan Annually

Performance Standard Verifications By Standard Annually

Appeals Statistics By Plan Quarterly

Answer: Confirmed. We provide the reports listed above through quarterly Aetna Health Information Advantage utilization reports, annual accounting reports, performance guarantee reports, and our monthly banking and claim reports. We also provide appeal reports upon request.

UTILIZATION REPORTS

Aetna Health Information Advantage is the ideal tool for benefits managers, placing valuable information right at their fingertips. Aetna Health Information Advantage, an information application software tool created by Aetna Informatics, makes performance experience data available through the Internet. We encrypt the information so it remains secure.

We will also provide the following reports at no additional cost to the State:

RENEWAL ACCOUNTING PACKAGE

This package includes a complete, detailed accounting of the policy period. We provide this after the policy period is complete. It includes an analysis of actual paid fees, claims and employees. It also details any charges incurred through out the policy period, and if applicable performance guarantee results.

BANKING REPORTS

These reports perform monthly bank reconciliation and track appropriate funding liability limits. A monthly funds request and receipt report provides a summary of the funds requested as well as a record of the funds received for paid claims in a one-month period. The funds summary report provides a control/suffix breakdown of the recorded claim dollars included in the wire transfers. Additional reports allow the customer to check the monthly status of paid claims charged against a plan's liability limits, depending on the funding arrangement.

CLAIM REPORTS

We provide you with monthly claim reports, in a Microsoft Access format 10 business days following the end of the reporting period. The electronic reports summarize claim activity by line of coverage, along with providing detailed claim information for each employee as well as claim totals for

employees and dependents by Medicare status.

PERFORMANCE GUARANTEES (including claim turnaround time and processing accuracy statistics, as applicable)

We provide reporting for results on a quarterly basis at no additional cost. We reconcile performance guarantees annually.

APPEAL REPORTS

Upon request, and with appropriate confidentiality releases in consort with our corporate confidentiality policies, we provide a quarterly, case-specific complaint and appeal report. The standard complaint and appeal report profiles case resolution statistics and is intended for plan administration purposes only. We release the report two to three weeks after the close of the quarter.

Attachments: [Appeal SAMPLE Standard quart report 3Q05.xls](#)

[Actionable Information Report Sample.pdf](#)

[Aetna Accounting Exhibits Sample.xls](#)

[Aetna Banking Report Sample.pdf](#)

[Aetna Claim Report Sample.xls](#)

[Performance Guarantee Results Sample.doc](#)

[Self Insured Dental Utilization Report Sample.xls](#)

5.2.9.2.2 Please confirm that when requested to do so by the State, reports can track claims separately by benefit type (e.g., dental, orthodontia).

Answer: Confirmed.

Attachments:

5.2.9.2.3 Other than those listed above, provide a list and detailed description (including frequency) of the reports provided on a standard basis (at no additional cost). Attach samples.

Answer: As described above, Aetna Health Information Advantage is comprised of interactive data analysis capabilities and preformatted reporting.

Interactive data analysis can be performed on topics such as Key Measures, Dental Trend, and Membership. These topics are called “Modules” and are produced at the customer level by funding arrangement and product type on an incurred basis with a 2-month claim lag. These modules offer a high level view of the current data as well as book of business and prior year comparisons. Each module can be drilled down into more detailed reporting and graphs allowing users to group and refine how they look at the data with options such as time period, products, age, gender, region, etc. as well as geographic and provider related options.

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

The preformatted Dental Standard Report package includes the following exhibits:

- Key Statistics - Dental
- Trend Analysis by Dental Cost Category
- Dental Provider Network Experience (applies to PPO product only)
- Dental - Costs Sharing Analysis
- Demographics for Dental Membership

- Top 25 Services by Dollar
- Savings and Benefit Payment Distribution
- Utilization by Procedure Group

The standard report package can also be run by various time periods, account structure, product combinations and incurred versus processed.

In addition to the product-specific standard reports, we offer a Summary by Product package which provides key information for all dental product lines in one package.

ACTIONABLE INFORMATION REPORTS

Your Aetna account team uses the Actionable Information Report during the annual plan review meeting. The report provides a clear, easy-to-understand summary of plan performance, key clinical findings and cost drivers.

Unlike many of our competitors, we provide a complete set of adjusted book of business benchmarks. This annual report automatically flags any variance from those benchmarks. Armed with this information, you and your account team can discuss ways to adjust your health and wellness programs and communications to sustain or improve results.

The report runs on an incurred basis with a two-month lag. We recommend at least 12 months of your incurred data to compare to the benchmark. With two full years, we can compare your data year-over-year and to the benchmark.

The report displays clinical metrics into separate content areas. This helps us rapidly identify areas where different products, programs and services can have an impact on affordability and quality.

Attachments: [Actionable Information Report Sample.pdf](#)
[Aetna Utilization Reports Sample.zip](#)

5.2.9.2.4 Are you able to accommodate requests for ad-hoc or customized reporting (including utilization information) at no cost to the State? If there is an additional cost, please indicate the cost on the rate sheet.

Answer: Yes. Customized reports are available upon request from Aetna Informatics. We assign a business consultant to respond to tailored information and analytic needs. We will provide the State with 50 prepaid hours for ad hoc reporting and other analytic projects. Additional hours are available for an additional fee. Once the prepaid hours are exhausted, we charge \$200 per hour for report generation/programming and \$350 per hour for analytic/consulting services.

Attachments:

5.2.9.2.5 If you are able to accommodate ad- hoc or customized reporting, what is the normal turnaround time to fulfill such request.

Answer: We prepare and deliver most ad hoc reports within three to five business days.

Attachments:

5.2.9.2.6 Are you able to provide reporting based on account code structure to allow the State to see trends in claim activity information by different organization units?

Answer: Yes. We will set up an account code structure to allow the State to view trends by each organization unit. This will be addressed in the set up process to establish the necessary structure to support the State's reporting needs.

Attachments:

5.2.9.2.7 Describe any custom reporting and data dashboards you have created for your clients, be specific and how they integrated into the full suite of services being proposed.

Answer: We offer online reporting through Aetna Health Information Advantage and our Actionable Information Reporting.

Aetna Health Information Advantage

As described above, Aetna Health Information Advantage places valuable information at your fingertips. Aetna Health Information Advantage allows the State to perform interactive data analysis on topics such as key measures, trend and membership. Each module can be drilled down into more detailed reporting and graphs allowing users to group and refine how they look at the data with options such as time period, products, age, gender, region, provider specific detail, etc.

The standard preformatted report package can also be run with variations on time periods, account structure, product combinations, network service area, large claimant threshold and claim basis (incurred versus processed). We update our data monthly.

Actionable Information Report

The Actionable Information Report provides a clear, easy-to-understand summary of plan performance, key clinical findings and cost drivers.

The report displays clinical metrics into separate content areas. This helps us rapidly identify areas where different products, programs and services can have an impact on affordability and quality.

We compare your population's numbers against our own benchmarks to see where the plan is coming in too high or right on target. The report is color coded to make it simple. Green means that item is within normal range. The report also shows year-over-year trend for ongoing monitoring of your Aetna benefits. This helps us spot recent health and behavior changes in your population so we can act on it quickly, before it becomes too costly.

The report does not just report the problem. It is actionable because we also provide ways to improve your situation.

Attachments:

5.2.9.2.8 Are reports available via the web to the client?

Answer: Yes.

Attachments:

5.2.9.2.9 Indicate functions of your Web-based reporting product available to the client staff.

**Answer: 1: Send Eligibility Updates,
2: Extract Enrollment Information,
3: Run Standard Eligibility Reports,
4: Run Ad Hoc Reports,
5: Full Query Capability,
6: Run Premium Reports**

Detail:

Options:

1. Send Eligibility Updates
2. Extract Enrollment Information
3. Run Standard Eligibility Reports
4. Run Ad Hoc Reports
5. Full Query Capability
6. Run Premium Reports
7. Other: [Text]

Attachments:

5.2.10 Financial

5.2.10.1 Subrogation

5.2.10.1.1 Do you charge for subrogation?

Answer: 2: No

Detail:

Options:

1. Yes
2. No

Attachments:

5.2.10.1.2 If you answered Yes to the previous question, please indicate the charge for subrogation on the rate sheet.

Answer: ---

Attachments:

5.2.10.2 Banking

5.2.10.2.1 Provide a sample of your administrative fee invoice.

Answer: 1: Attached

Detail:

Options:

1. Attached
2. Not Attached

Attachments: [Aetna Fee Invoice Sample.pdf](#)

5.2.10.2.2 Describe your process for printing checks, including whether they are produced daily, weekly, monthly or other. Describe whether the timing is different for members than for providers and your process for replacing a lost check when notified by a member or provider that they did not receive the check.

Answer: We mail member EOBs and checks daily when there is a member payment or request for additional information from the member. We produce EOBs in Erlanger, KY by an off-site print vendor.

We age and bulk in a schedule provider EOBs and checks, whether for network or non-network

providers. This allows delivery within 24 days of the claim received date. We send the majority on either a weekly or biweekly schedule, and on a consistent day of the week determined by state location of the provider. A provider EOB accompanies each provider draft. The EOB breaks down the payment by patient and gives pertinent information about the payment and non-covered expenses.

Members can contact their health concierge and member services if they did not receive a check. We will work with the member to replace the lost check as soon as possible.

Attachments:

5.2.10.2.3 Describe whether the timing for printing checks is different for members than providers and your process for replacing a lost check when notified by a member or provider that they did not receive the check.

Answer: EOBs will go out daily, and not aged when there is a member payment or request for additional information from the member. Members can contact their health concierge and member services if they did not receive a check. We will work with the member to replace the lost check as soon as possible.

We age and bulk provider EOBs and checks, whether for network or non-network providers. This allows delivery within 24 days of the claim received date. We send the majority on either a weekly or biweekly schedule, and on a consistent day of the week determined by state location of the provider.

Attachments:

5.2.10.2.4 What measures are in place to ensure that reimbursements are issued to the proper party?

Answer: We have end to end quality measures in place to ensure payment accuracy. In addition to an extensive array of system controls, we perform the following prepayment audits:

- Trainee Audit - Initially, the business unit provides mentors/auditors to audit 100 percent of claims processed by trainees. As each trainee's results reach an acceptable level in a category, the percentage of claims reviewed decreases.
- Draft Authority Limit Audit - Each individual in the service center has a specific draft authority limit. Supervisory or management personnel review claims above that limit.
- Prepayment Review - We audit all claims equal to or greater than \$7,000. The quality auditors report to our National Customer Operations (NCO) Claim Quality department.
- Itemized Bill Review - For certain large inpatient facility claims from network facilities, we offer Itemized Bill Review (IBR), an additional feature of our National Advantage Program (NAP). We have partnered with a vendor to review these claims for billing errors prior to claim adjudication. IBR reviews inpatient facility bills with submitted expenses of \$20,000 or more incurred at a network facility (excluding per diem arrangements). We pay the claim based on standard billing practices and in accordance with the facility's contractual arrangements. The State must participate in NAP in order to elect IBR.

We perform the following audits on a post-payment basis:

- Stratified Quality Audit - Using an industry accepted stratified audit methodology, the population of processed claims are segregated into dollar categories (strata) based upon the amount paid. A sampling of claims is randomly selected from within each strata. Results are extrapolated over the entire population based upon the weight of each strata to the population.

- **Daily Processor Audit** - Our auditing staff audits claims through a system-generated, random selection process. We examine claims for payment, procedural or coding errors. We audit a minimum of 20 claims per processor each month. The quality auditors report to our NCO Claim Quality department.
- **Auto-adjudicated Claim Audit** - Our Quality Assurance Policy includes a monthly audit of auto-adjudicated claims at the office level (204 claims per claim office key, per quarter, if available) with a maximum of 10,000 audits per quarter at the enterprise level.
- **Auditor Re-audit** - Auditors are subject to a re-audit of their work based on a stratified sample. This audit validates the accuracy of the auditors and compliance with the audit program. Overall results are reported for Pay Incidence, Pay Dollar and Total Claim Accuracy.
- **Bank-Cleared Claim Draft Audit** - Our corporate office oversees our automated check auditing system that monitors each bank-cleared check.
- **Corporate Audit** - Any of our service centers may be subject to an audit by our Corporate Audit department on an unscheduled, unannounced basis to evaluate the effectiveness of controls over processes and procedures.

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

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

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

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

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

In addition, we are also subject to SOX and SSAE 16 SOC 1 review.

Attachments:

5.2.10.2.5 Explain whether you offer direct deposit of participant benefit reimbursements and identify for which benefits covered by this proposal the direct deposit service is available.

Answer: Member direct deposit is not available for member reimbursement at this time for the dental plan. Direct deposit is an offering for our FSA and DCAP.

Attachments:

5.2.10.2.6 Describe your ability for accepting electronic fund transfers for member payment of premiums for COBRA/Direct Bill participants.

Answer: Participants may pay their monthly premiums by mailing a check or money order to PayFlex. As an alternative, participants can submit electronic payments to PayFlex through the participant web portal. Both one-time and recurring EFT options are available. When the one-time EFT option is used, the participant enters his/her checking or savings account type, account number, transit routing number and financial institution name. An EFT transaction for the full amount of premium due is automatically initiated as part of the next EFT processing schedule. When the recurring EFT option is used, the participant enters his/her checking or savings account type, account number, transit routing number and financial institution name. An EFT transaction for the full amount of premium due is automatically initiated on the 8th of each month, or on the next business day thereafter. Recurring EFT instructions remain in place until the participant changes them online.

Attachments:

5.2.10.2.7 Please confirm you will establish a separate bank account on the State's behalf.

Answer: Confirmed.

Attachments:

5.2.10.2.8 Please confirm that you will set up the State's account structure based upon their requirements.

Answer: Confirmed.

Attachments:

5.2.10.2.9 Please confirm you will process claims and issue checks from the bank account you established on the State's behalf.

Answer: Confirmed.

Attachments:

5.2.10.2.10 Please confirm you will request an electronic transfer of funds from the State at regular intervals on a "checks cleared" basis and that the request will be by active employee claims and retiree claims; retiree claims will be split by medical and DVA expenses as well as by retirement system.

Answer: Confirmed. We have assumed daily.

Attachments:

5.2.10.2.11 Please confirm you will provide the State with a monthly report reconciling the account balance, claims drafts and electronic transfers.

Answer: Confirmed.

Attachments:

5.2.10.2.12 Do you require that self-funded plans use a specific bank for funding claims? If yes; indicate name of bank.

Answer: Yes. We use a joint benefit payment clearing account (i.e., a Single Account Multiple Participant or SAMP account) at Bank of America or Citibank Delaware. The State subscribes to this account by signing a banking agreement that we forward to our bank.

The State is identified as payer to show that benefit payments go directly from the State to employees. We are shown as the State's agent.

Attachments:

5.2.10.2.13 For self-funded plans, confirm that no imprest balance is required.

Answer: Confirmed.

Attachments:

5.2.10.2.14 What is the frequency for ACH transfers for claim funding?

Answer: We request funds from the State's designated bank when recorded claims total at least \$20,000 and on the first banking day of each month. We assume that based on the number of members, the State will be funding claims on a daily basis.

Attachments:

5.2.10.3 Direct Bill

5.2.10.3.1 Confirm you are able to bill and remit to the State premiums due on a monthly basis for any retiree whose retirement warrant is insufficient to pay the elected coverage, including divorced and widowed spouse continuing long term care coverage, when the member enrolls in the Direct Bill program. This question assumes the State will direct the Contractor as to the retiree's coverage elections. The State retains eligibility determination responsibility for Direct Bill.

Answer: Confirmed.

Attachments:

5.2.10.4 COBRA

5.2.10.4.1 Confirm you are able to administer COBRA continuation for members who must pay premium directly.

Answer: Confirmed.

Attachments:

5.2.10.4.2 Describe your ability for accepting electronic fund transfers for member payment of premiums for COBRA.

Answer: Aetna/PayFlex:

As a recognized leader in account administration, PayFlex Systems USA, Inc. was recently acquired by Aetna to offer the PayFlex Spending Account and COBRA administration solutions to their clients as well as continuing to provide on a stand-alone basis as well. The transaction was completed on October 3, 2011, making PayFlex a wholly owned subsidiary of Aetna and operating as an independent subsidiary.

Electronic Fund Transfers:

Participants may pay their monthly premiums by mailing a check or money order to PayFlex. As an alternative, participants can submit electronic payments through the participant web portal. Both one-time and recurring EFT options are available. When the one-time EFT option is used, the participant enters his/her checking or savings account type, account number, transit routing number and financial institution name. An EFT transaction for the full amount of premium due is automatically initiated as part of the next EFT processing schedule. When the recurring EFT option is used, the participant enters his/her checking or savings account type, account number, transit routing number and financial institution name. An EFT transaction for the full amount of premium due is automatically initiated on the 8th of each month, or on the next business day thereafter. Recurring EFT instructions remain in place until the participant changes them online.

Attachments:

5.2.10.4.3 Please indicate in the chart below your ability to provide the listed COBRA administration service. If there is an additional cost, please indicate the cost on the rate sheet.

Duties of Service Provider	Response
Notify each Qualified Beneficiary of the right to continue coverage	Yes
Accept directly from the client, Qualified Beneficiary (QB), or representative of a QB notice of a Qualifying Event (QE), second QE or SSA disability determination	Yes
Prepare and distribute COBRA election forms	Yes
Bill each COBRA participant on a monthly basis	Yes
Accept COBRA premium payments from participants and remit to the client on a weekly basis	Yes
Determine if COBRA participant has paid the required COBRA premium amount on time	Yes
Provide notice of nonpayment or insufficient payment to a COBRA participant	Yes
Provide monthly accounting to the client of all COBRA premium payments	Yes
Accept and respond to notice of QEs	Yes
Furnish records and information to the client as needed	Yes
Provide special messages to COBRA participants upon notice from the client	Yes
Distribute required open enrollment materials, SPDs, or other mass mailing per notice from the State	Yes
Maintain required backup documentation for all COBRA notices, forms, etc. per ERISA	Yes
Monitor and advise the client of state/federal continuation requirements	Yes
Implement procedures and methods to confirm a COBRA participant's continued eligibility for COBRA coverage	Yes
Inform the client of COBRA elections	Yes
Notify QB of any available conversion privilege	Yes
Distribute notices of unavailability of COBRA coverage	Yes
Distribute notices of termination of COBRA coverage	Yes
Record and monitor COBRA elections and terminations	Yes
Notify the client when an individual ceases to be eligible for COBRA coverage	Yes
Provide customer service via phone and web	Yes
Receive, process and enter open enrollment elections from COBRA participants	Yes

Detail:

Attachments:

5.2.10.4.4 Please attach a flowchart of payment processes between your company and the client.

Answer: 1: Attached

Detail:

Options:

1. Attached
2. Not Attached

Attachments: [A_ 5.2.10.4.4 COBRA Process Flow Chart.pdf](#)

5.2.10.4.5 How long after receiving premium payments from COBRA participants, will you forward the payments to the client? To the extent any 'float' will accrue, indicate how it will be tracked, reported and credited.

Answer: On the 10th of each month or such day of the month as determined by The State, monthly Premium Remittance Register reports are produced and made available on the Employer Portal. Notification of availability will also be sent to The State contact via e-mail. The remittance includes all monthly premium amounts satisfied prior to the current remittance period OR all satisfied monthly premium amounts less the 2% administration fee and less our administration fees. Remittance is made via check or EFT directly to The State.

If payments are made directly to carriers, the same schedule applies. Monthly Premium Remittance Register reports are produced for each carrier payment and sent to the individual carriers.

If our fees exceed the amount of premium remittance collected in any month, our standard payment terms for outstanding fees owed are net 10 days.

Attachments:

5.2.10.4.6 Describe your quality control process for invoicing.

Answer: We support a standard monthly billing cycle. Additional billing cycle options are yearly, quarterly, semi-monthly (direct billing only) and weekly (direct billing only).. Two types of premium billing options are available:

* Premium payment coupons that are sent to the participant at the start of the plan year (or point of COBRA election).

* Premium notices that are sent to the participant each month on a date that The State can define (default is the 15th of each month).

Monthly premium calculation is automated by the platform and is based on the participant's election, rates and coverage levels provided by The State as part of the implementation process. In the case of a mid-month coverage effective date, the first month's premium amount is prorated. In the case of a retroactive benefit change, the first month's premium includes all retroactive months.

All COBRA premium payments are collected at our secure Distribution Center within the Omaha, Nebraska headquarters location. Checks are scanned and deposited into a PayFlex bank account via a file process. Checks are retained for 90 days and then securely destroyed by shredding. The premium amount, check number (if applicable) and month of premium payment are posted to the participant account in the COBRA platform. Premium payments are entered within 2 business days of receipt unless additional research is required. A daily bank reconciliation process is used to ensure the accuracy of payment processing and bank deposits. As part of this process, we receive daily bank files and perform a reconciliation of transactions posted to our COBRA platform to actual cash activity at the bank. Any discrepancies are resolved.

Premiums are due on the first day of each month and are considered paid on time if the mail receipt date/EFT payment date is on or before the 30-day grace period end date. The COBRA platform automatically rejects any premium that is received by us after the grace period has expired. These late payments are returned to the participant and notification of COBRA termination is sent to the participant and appropriate carrier(s).

Attachments:

5.2.10.4.7 By which method do you send each of the following (regular mail, certified, etc.)?

	Response
COBRA initial	Notices are delivered to participants via First-Class mail. Initial Rights

	Response
notification	Notices also include “proof of mailing.”
Qualifying event notice	Notices are delivered to participants via First-Class mail. Qualifying Event packages also include “proof of mailing.”
Correspondence	Notices are delivered to participants via First-Class mail.

Detail: Participants may also elect to receive notices via email by electing the eNotify™ option on the participant portal. The eNotify™ option is available once the QE notice has been sent to the participant.

Note: The QE Notice, Initial Notice and Termination Notice are not sent via eNotify™

Attachments:

5.2.10.4.8 What payment options are available for participants?

Answer: 6: Check Online,
7: Automatic Debit,
8: Check by Mail

Detail: Participants may pay their monthly premiums by mailing a check or money order. As an alternative, participants can submit electronic payments through the participant web portal. Both one-time and recurring EFT options are available. When the one-time EFT option is used, the participant enters his/her checking or savings account type, account number, transit routing number and financial institution name. An EFT transaction for the full amount of premium due is automatically initiated as part of the next EFT processing schedule. When the recurring EFT option is used, the participant enters his/her checking or savings account type, account number, transit routing number and financial institution name. An EFT transaction for the full amount of premium due is automatically initiated on the 8th of each month, or on the next business day thereafter. Recurring EFT instructions remain in place until the participant changes them online.

Options:

1. Credit by Phone
2. Debit by Phone
3. Check by Phone
4. Credit Card Online
5. Debit Card Online
6. Check Online
7. Automatic Debit
8. Check by Mail

Attachments:

5.2.10.4.9 Confirm you will provide eligibility for this group to other contractors as appropriate.

Answer: Confirmed.

Attachments:

5.3 State Objectives

5.3.1 Plan Design

5.3.1.1 Please describe how you can assist the State with identifying and implementing possible plan enhancements that would support the states objectives as identified in Section 1.0 of the RFP.

Answer: The State of Alaska has clearly articulated a vision and objectives that will transform health care delivery in the State. The vision and objectives require the State to partner with an organization that is innovating and evolving at a rapid rate to fully support the short and long term objectives. Aetna is an organization that can support the objectives and continue to bring forth approaches and solutions critical to the State of Alaska's future success through four key pillars:

INNOVATION, DESIGN AND PERFORMANCE EXCELLENCE- Aetna is the administrator for 643 national account customers, 318 public and labor organizations, 197,467 Medicare customers, 1,257,110 Medicaid members, and 17,818,931 commercial members. This portfolio of customers is the result of continuously innovating and supporting our customers.

We have a culture of innovation at Aetna and have developed multiple areas of the organization to support organizational improvements from all of our employees. This ranges from innovation at every level of the organization to our Emerging Business Unit focused on developing critical customer solutions. This innovation has resulted in on-going enhancements in how we are improving our operations to both streamline the administrative processes and enable design solutions to support our customers. This begins with the simple measures of having our clinical policies be included in our network contracts and our claim system tied to those same policies. Our network and any custom network solutions are fully integrated into our claim system to streamline the payment process. Our leadership has empowered all Aetna employees to identify methods to improve our operations to deliver the highest quality program to our plan sponsors and members.

Our innovation, design and performance excellence enables us to support the following State of Alaska objectives:

- Embedding clinical decision support tools into daily practice
- Using information technology to support patient education, patient care planning, coordination of care, and monitoring of compliance
- Comprehensive collection, analysis and utilization of data to inform and guide policy and plan design decisions
- High accuracy in claims processing
- Quality customer service

CONSUMER ENGAGEMENT - The age of the consumer is here and Aetna fully recognizes this as a key area to cost management. We are creating the critical support for the member with the personnel and technology to provide information and advocacy through the method sought by the member. We truly believe that the support the State of Alaska requires to transform health care is through One Member at a Time. Our Health Concierge Service model, which is a component of our medical proposal, is the My AlaskaCare Single Point of Contact. The My AlaskaCare SPOCs are specially trained personnel with the tools to be the member advocate and truly the “Concierge” role across the full benefit program continuum. Our technology is the other mechanism that puts the power of transparency, clinical decision support and provider directories (in and out of network) at the member's fingertips via web and mobile phones. For the State of Alaska, the My AlaskaCare SPOC and web and mobile tools are a key cornerstone to supporting your members both in and out of Alaska. It supports the advocacy and member experience across Aetna and all of the State of Alaska benefit programs essential to delivering upon State of Alaska objectives.

Our consumer engagement enables us to support the following State of Alaska objectives:

- Encouraging patients to engage in the management of their own health
- Providing them with resources and skills to obtain appropriate health care services
- Using information technology to support patient education, patient care planning, coordination of care, and monitoring of compliance

EVIDENCE-BASED MEDICINE - Aetna has not wavered from using evidence-based medicine to manage our customers' benefit programs on both a self-funded and fully insured basis. This begins with our disciplined approach to developing clinical policies based on evidence-based medicine. Our Clinical Policies are often used by TPAs and other insurance carriers, because of the disciplined approach and rigor around the on-going review process. Our Care Engine technology is the Clinical Decision Support the State of Alaska is seeking by ensuring evidence-based medicine is applied to all medical and pharmacy claims. The application of evidence-based medicine includes our dental program that leverages our Dental Medical Integration grounded on dental care that drives medical costs.

Our evidence-based medicine enables us to support the following State of Alaska objectives:

- Designing the delivery system to ensure the provision of effective, efficient clinical care
- Embedding clinical decision support tools into daily practice
- Using information technology to support patient education, patient care planning, coordination of care, and monitoring of compliance
- Increasing overall value through cost reduction and improved health outcomes and improved quality of health care
- Comprehensive collection, analysis and utilization of data to inform and guide policy and plan design decisions

PROVIDER COLLABORATION - Our network management is built on sound principles beginning with evidence-based medicine approach to our clinical policies to our reimbursement approach in Alaska. Our experience in core network management and breadth of our book of business will further support the necessary network development in the State.

Our provider collaboration enables us to support the following State of Alaska objectives:

- Designing the delivery system to ensure the provision of effective, efficient clinical care
- Embedding clinical decision support tools into daily practice
- Using information technology to support patient education, patient care planning, coordination of care, and monitoring of compliance
- Increasing overall value through cost reduction and improved health outcomes and improved quality of health care
- Comprehensive collection, analysis and utilization of data to inform and guide policy and plan design decisions

Our experience across these four cornerstones in Alaska and the lower 49 will allow us to support the State of Alaska's objectives across each of the RFP components. When integrating each of the RFP components, we can deliver a fully integrated comprehensive solution that will support the goals and objectives, which includes delivering the cost controls so critical to the future of the State of Alaska benefit program.

We further define our dental value proposition as working with our customers to design plans and provide services to meet their needs at almost any price point. Our broad product spectrum and flexible plan designs, along with large provider networks and competitive prices, make us a leading choice for dental benefits. We offer a variety of dental plan designs, including fixed copayment plans and coinsurance plans, which allow our customers various options for a healthier tomorrow as their business needs grow and change.

We believe in the importance of oral health in influencing overall health. Research shows that effective disease management programs can promote healthy outcomes and reduce health care costs.

However, the matters of the mouth are often overlooked when it comes to disease management. We are trying to change that. Through integrated medical and dental data, we are in a unique position to help evaluate and share, with our members and their doctors, disease patterns that may have otherwise gone unnoticed. We are sending the message that regular dental care is pivotal in the management of our members' overall health.

The State of Alaska will appreciate our:

Innovative technology resources for customers, members and providers
Excellent customer service through our dedicated dental service centers
A value proposition that only Aetna is uniquely positioned to deliver
Professional and focused account managers

We are one of the premiere dental benefits carriers in the industry and your business matters to us. With over 50 years of experience in the dental marketplace, we offer the widest array of products of any carrier today. Whether the State of Alaska is looking for the advantages of a managed dental plan or the option to choose any licensed dentist in the country for covered services, one of our products can be a valuable part of That State of Alaska's benefits package.

The focus of Aetna Dental is customer service excellence. We created dedicated dental service centers to consistently achieve our goals of excellence. What does this emphasis on customer service mean? Member satisfaction.

We currently handle more than 85 percent of incoming dental claims electronically. This enables us to review any claim at any time for processing in one of our three dental service centers. A dedicated team of dental consultants and dental consultant assistants provide review of claims across all time zones to meet customer needs. In addition, dental consultants are available to review complaints and appeals requiring immediate attention for a prompt benefit determination.

We set the standard in dental service with one phone number, one system and one location for all dental products. Our quality efforts extend to all aspects of our dental products including:

- Network recruiting
- Utilization management
- Provider profiling and reporting
- Member education and outreach
- Claims/member service
- Customer reporting
- Administration

Attachments:

5.3.2 Policy Development

5.3.2.1 Please describe how you can support the State in policy development through the use of data driven analysis and best practice recommendations. Please include any additional resources your organization can provide.

Answer:

On a national basis, we remain focused on fostering compliance with the Affordable Care Act (ACA). We will continue to help our customers with the implementation of ACA. We will continue to advocate for workable regulations and needed legislative changes to avoid the unintended

consequences of higher costs and needlessly complicated requirements on our customers. We will work with public policy leaders and legislators to fix the serious issues that continue to plague our health care system.

A significant element of policy development is the understanding of health care delivery and the variation by geography. The Account Team and advisory teams covering clinical and Alaska care delivery are a critical element to the policy development process. This team will leverage national and regional resources in the areas of clinical policy development, government affairs, Accountable Care Solutions, Primary Care Medical Home Enablement, Medicaid and Medicare program administration, health care reform, transparency and alternative payment approaches (e.g., reference based pricing and case rates) to name a few. Overall, we have the infrastructure and resources to support the State's policy development as well as a determination of pilot opportunities.

Our process will be to work with the State on developing the areas of policy development including the goals in specific areas. The team will leverage our national resources to identify best practices and approaches to impact the State's goals. Our sessions with the State will leverage the clinical and Alaska specific expertise to uncover opportunities. In addition, we will have participation by our subject matter experts to address emerging solutions in the market and address policies to support deployment of those solutions.

Once areas are identified we will work with our internal resources for the analysis of the data available. We will leverage our resources that handle our internal evaluation processes including data analytics, review of evidence, and understanding of provider and member impact. In addition, our data is made more robust by expertise we have in the establishment of Accountable Care Organizations and Patient Centered Medical Home enabled delivery systems.

We have supported organizations in the review and development of policies for their own organization as well as State legislation. While we do not provide legal advice, we have resources to support review and make recommendations on the type of changes that can change care delivery. Our role in health care reform emphasizes our desire to impact cost and quality in the health care delivery. The State of Alaska is in a unique position to drive health care delivery through policies that support the change. Our Alaska experience combined with the national resources can support the development of policy for the State of Alaska program only as well as for the State.

We envision a key component of the policies to be a potential demonstration of projects that explore changes to care delivery in the State. Our robust experience with Accountable Care Organizations and Patient Centered Medical Homes will be valuable in not only developing solutions, but guiding set up of changes in the delivery system.

Attachments:

5.3.3 Innovation

5.3.3.1 Briefly describe the four most important ways you propose to assist the State in controlling health costs in Alaska now and in the future.

Answer: There is a close connection between the mouth and the body. Research shows that up to 90 percent of whole-body illnesses can show their first signs in the mouth. Additionally, gum disease may impact a healthy pregnancy. It demonstrates the linkages across programs and optimizing interactions across all of a customer's programs.

The four most important ways we can support the State in controlling health care costs in Alaska now and in the future, aligns to our four pillars. Overall, we believe the State must align with an organization that materially takes the State beyond a transactional administrator and to an organization

supporting its strategic direction. The State of Alaska has clearly outlined a vision and objectives that require an organization that provides the infrastructure, tools and resources to support the development and deployment of its strategy.

Aetna is uniquely situated due to its role in providing insurance coverage in Alaska today and the sophisticated customer base operating in Alaska and the lower 49. Our experience in Alaska and the lower 49 with government and commercial customers supports the State's strategies both now and in the future. The four most important ways we support the State are:

- **CONSUMER ENGAGEMENT** - Consumer engagement is not only one of the State's objectives, but a critical area of Aetna's strategic direction. This is a demand from our customers operating in Alaska and lower 49 as well as an area critical for Aetna under the Accountable Care Act. The ability to control costs is highly dependent on consumer engagement and alignment to supporting members through the optimal method for that member. In some instances, the only interaction with the member can be through the dental program.

Consumer Engagement is one member at a time and a key cornerstone of our solutions for the State and controlling costs. Our proposed solutions and development are focused on both personnel and technology to address the various mediums members want and need to engage. We provide the critical level of advocacy and support that helps the member navigate their State of Alaska benefit program:

- o It begins with the My AlaskaCare Single Point of Contact, which is through our Health Concierge Service model under our medical proposal. This model is our next level of customer service that transforms health care from a transactional service to full advocacy for your members. This team is designed to respond to all member inquiries and personalize each call, but more importantly act as the advocate across the full benefit offerings by the State of Alaska. This team is specially trained and tested to ensure they are fully qualified to support the member through every facet of the health care delivery system and across all of the State of Alaska's benefit program and vendors.

Health Care is very complex and the My AlaskaCare Single Point of Contact will support the member in navigating the delivery system and truly being the health care advocate. This team is trained to listen to verbal queues from each call and take the member call "personally." A simple way to think about it is a Concierge will communicate the time the parade starts just like any Service Representative, but will then take it to the next level and support the member in determining how they will get there, the time it will take, other logistical challenges and even schedule the transportation if necessary. As we think of the complexities of health care and supporting the State in achieving its objectives, this level of service and advocacy is essential.

- o **On-line and Mobile Tools** - Another critical facet of consumer engagement is providing members with tools to support dental care decisions. Aetna has robust tools to support the member's dental decisions and condition look up. Our tools are designed to support our customers and members with the information critical to their needs.

- o **Experts** - Between all of the Aetna companies, we have experts covering all facets of the mental, physical and clinical elements of consumer engagement. Our proposed annual strategy and deployment process reflect the complexities associated with member adoption of change and the critical time investment needed to develop the solutions that your State of Alaska members will embrace. We will provide the necessary expertise to develop solutions that both support the State of Alaska's objectives and will be embraced by your members through a consumer-oriented roll out. This support addresses all elements of design and incentives.

- **EVIDENCE-BASED MEDICINE** - Aetna has placed extensive rigor on integrating evidence-based

medicine throughout our operations. This is also a part of our dental program through our dental medical integration.

Our industry-leading Dental Medical/IntegrationSM (DMI) program recognizes this connection and provides a coordinated care approach and enhanced benefits for our at-risk members who are not receiving dental care. We offer the program at no additional cost to customers who have both Aetna medical and dental plans. We support members through a combination of proactive identification, member outreach and education, and enhanced benefits.

Member identification

We automatically identify and enroll members for the program. Our claim system automatically scours medical and dental claims to look for members who are pregnant or have diabetes, heart disease and/or cerebrovascular disease. We then review these members and identify those who have not been to the dentist in the past 12 months. As we have both medical and dental claims information, this process is seamless and allows us to reach out members who need the most support.

Member education and outreach

Once identified, we send an initial educational postcard to the member. We encourage members to call one of our Dental Care Coordinators to get help choosing a dentist, making a dental appointment, and enrolling in the program's enhanced benefits.

If the member does not see the dentist within four months after receiving our initial educational postcard, a Dental Care Coordinator follows up with a phone call. We make two outreach phone calls during normal business hours. If we cannot reach the member, we send them a follow up postcard.

Enhanced benefits

The DMI program offers enhanced benefits to encourage at-risk members to get the care that they need. We cover specific services at 100 percent, with no deductible, including:

- One extra visit for a routine cleaning
- A dental debridement to remove any thick or hard deposits on teeth
- Dental office use of antibacterial agents to treat periodontal disease (not applicable to pregnant women)
- Periodontal maintenance

Our Dental/Medical IntegrationSM (DMI) program focuses on improving member quality of life, and ultimately, reducing costs and increasing productivity. We do this by:

- Targeting those who are at-risk and not receiving dental care
- Increasing member awareness of good dental health
- Motivating members to seek appropriate care through enhanced benefits
- Supporting members' healthy decisions through outreach

A strong scientific foundation

There is a strong connection between oral health and overall well-being. Our research shows that individuals with certain conditions, such as diabetes, coronary artery disease, cerebrovascular disease, and pregnant women, may benefit the most from the earlier dental and periodontal care that is more

likely in an integrated program.

Our DMI program was founded on this scientific evidence to provide a coordinated care approach and enhanced benefits for members who need it the most.

Positively impacting costs

Our DMI program aims to avoid future costs, risks and adverse outcomes that can negatively impact a member's well-being. As we target members with certain chronic conditions, we can produce both dental and medical cost savings.

Studies have shown:

- Individuals with diabetes, coronary artery disease, and cerebrovascular disease, who received dental care earlier, lowered the risk or severity of their respective conditions, which reduced their overall medical costs.¹
- Women who received preventive dental care had fewer birth complications than those who did not.²

In addition, you may save administrative costs when you use one carrier for both medical and dental coverage.

Increasing productivity

Employees miss millions of hours of work each year for dental-related illnesses or dental visits, and that number increases for parents who miss time for their children's dental

- **PROVIDER SOLUTIONS** - We can support the development of a comprehensive network solution for the State of Alaska. This will require an organization to partner with the State on the design and delivery needed to expand the network. We have the resources to leverage all of our learnings in the lower 49 surrounding breadth of the network to achieve critical results for the State..

- **OPERATIONAL EXCELLENCE** - Operations is often an overlooked facet of the cost management for an organization. As both an administrator and insurance carrier, we fully understand the importance in market leading operations and the impact this has on all facets of cost management and the consumer experience. A key area of operations is our on-going enhancements to our processes and clinical programs. We learn and build to align with the needs of our customers who need programs to both manage cost and quality, but enable the critical attraction and retention. Our National Account and Public Sector customers demand the level of service that Aetna delivers. Our proposed Health Concierge service model is the infrastructure for the My AlaskaCare Single Point of Contact and has won JD Powers award for service. The State will not only benefit from this development, but will be a driver of the development through the areas you are seeking with your objectives.

Operations brings everything together in a fashion that translates to an overall impact. We commit to working with the State to continuously measure and determine opportunities for improvement. Our resources and analytics will provide the State with critical information to make informed decisions and achieve the strategic objectives. We recognize success in achieving those objectives relies on a partner that continuously evolves and brings market leading approaches to the table. We commit to being that partner and bringing forth solutions specific to Alaska.

Attachments:

5.3.3.2 Please provide a white paper with information on innovative steps your organization is prepared to implement in order to assist the State is achieving its vision as stated in Section 1.0 of the RFP. Include any programs or innovations that have proven successful with other similar clients. Focus on cost containment and cutting edge health care support, as well as integration with other key vendor partners.

Answer: 1: Attached

Detail:

Options:

1. Attached
2. Not Attached

Attachments: [5.3.3.2 - Innovation White Paper.doc](#)

5.3.4 Performance Incentives

5.3.4.1 In accordance with Section 5.2 of the RFP, please describe in detail any proposals you are including with your cost proposal relative to fee increments for accomplishing state objectives as outlined in Section 1.0 of the RFP such as:

- a. Cost Containment Fee Increment. An annual fee increment in an amount to be proposed by the Offeror to be awarded if cost growth per member declines xx% from the prior fiscal year and claims processing accuracy audits show claims processing accuracy exceeds 98% for the fiscal year.
- b. Cost Reduction Fee Increment. An annual fee increment in an amount to be proposed by the Offeror to be awarded if overall claims costs are less than xx% from the prior fiscal year and claims processing accuracy audits show claims processing accuracy exceeds 98% for the fiscal year.

Note that these are examples and the State is willing to review other proposed performance incentives.

Answer: Aetna will guarantee the savings that result from negotiated arrangements with providers participating in our Dental Preferred Provider Organization (DPPO). The maximum adjustment will not exceed \$0.50 PEPM, or conversely an additional charge to the State of \$0.25 PEPM. Additionally, in no event, will fees be adjusted by more than 35% due to results of the discount-based performance guarantee and all service-based performance guarantees combined.

Actual Discount vs. Target Fee Adjustment Maximum Fee Adjustment
> 30% The State's additional charge (Incentive to Aetna) \$0.25 PEPM
26% - 30% No adjustment NA

< 26% Please see Attachment B for Aetna payout slopes. \$0.50 PEPM

Please see our Dental Discount Guarantee documents for additional information regarding this Performance Incentive.

Aetna will also offer a trend-based Incentive guarantee that allows Aetna to earn additional fees, if the State's DPPO plan trend reduces during the first plan year (from July 1, 2013 to June 30, 2014). If

Aetna meets this guarantee, the State will pay (Aetna will “earn back”) the corresponding fees as described below:

Actual Claims PEPY vs. Target The State's Additional Charge
(Aetna's “Earn Back”)

The State's DPPO plan trend reduces by 1 percentage point. \$0.10 PEPM

The State's DPPO plan trend reduces by 2 percentage points. \$0.30 PEPM

Please see our Dental Trend Based Earn Back Guarantee document for additional information regarding this Performance Incentive.

Attachments: [CONFIDENTIAL Trend Based Earn Back Guarantee.docx](#)
[REDACTED Trend Based Earn Back Guarantee.doc](#)

5.4 Cost

5.4.1 Fees

5.4.1.1 Confirm you have submitted a cost proposal based upon an administrative fee charge on a per Employee and per Retiree per month basis.

Answer: Confirmed.

Attachments:

5.4.1.2 Confirm you have completed the rate table, and included any additional costs identified within the questionnaire.

Answer: Confirmed.

Attachments:

5.4.1.3 Confirm that your rates are guaranteed for at least 3 years

Answer: Confirmed.

Attachments:

5.4.1.4 Do you charge additional fees for educational materials, etc.? If there is an additional cost, please indicate the cost on the rate sheet.

Answer: 1: Yes

Detail: Standard materials are included.

Options:

1. Yes
2. No:

Attachments:

5.4.1.5 Are all program communications (print materials and on-line text/exhibits) included in your fees? If there is an additional cost, please indicate the cost on the rate sheet.

Answer: 1: Yes

Detail: SPD printing and mailing are excluded from our quoted fees.

Options:

1. Yes
2. No

Attachments:

5.4.1.6 If you are awarded the contract, please confirm that you will provide a one-time implementation credit to assist with transition expenses (such as employee communication). Please confirm the amount of the implementation credit on the rate sheet.

Answer: 1: Confirmed

Detail: We have provided a combined Implementation/Communication allowance in our proposed fees.

Options:

1. Confirmed
2. Not Confirmed

Attachments:

5.4.1.7 Please confirm your rates are proposed for the State's required guarantee period.

Answer: 1: Confirmed

Detail:

Options:

1. Confirmed
2. Not Confirmed

Attachments:

5.4.1.8 You understand that any response except "Yes" within this section may result in an adjustment to the pricing terms and fees you input in other sections within this RFP and/or may disqualify your offer from being considered.

Answer: Understand

Attachments:

5.4.1.9 Dental Claims Administration and Managed Network Pricing Tables

Please confirm you have completed the Excel worksheets in Attachment F4 and provided the completed worksheets as an attachment in section 5.5 Response/Required Documents. Detailed instructions are provided in the worksheet.

Answer: 1: Confirmed

Detail:

Options:

1. Confirmed
2. Not Confirmed

Attachments:

5.4.2 Discounts/Network

5.4.2.1 Dental Active and Retiree Network Claims and Disruption Worksheets

Please confirm you have completed the Excel worksheets in Attachment J3 & J4 and provided the completed worksheets as an attachment in section 5.5 Response/Required Documents. Detailed instructions are provided in the worksheet.

Answer: 1: Attached

Detail: The follow worksheets are considered trade secret, proprietary and confidential. As stated in our proposal response, they should not be publically released:

-CONFIDENTIAL_Attachment_J1_-
_Medical_Active_Network_Claims_and_Disruption_Worksheet.xlsx
-CONFIDENTIAL_Attachment_J2_-
_Medical_Retiree_Network_Claims_and_Disruption_Worksheet.xlsx
-CONFIDENTIAL_Attachment_J3_-
_Dental_Active_Network_Claims_and_Disruption_Worksheet.xlsx
-CONFIDENTIAL_Attachment_J4_-
_Dental_Retiree_Network_Claims_and_Disruption_Worksheet.xlsx

We have also included a redacted version of each file, with the confidential information removed. Only redacted files, may be released in an open records requested.

We have included a separate file with a password to open the full confidential files. This password should only be shared on a need to know basis, and should not be released publically.

Options:

1. Attached
2. Not Attached

Attachments:

5.5 Response Documents - Dental

5.5.1 Please complete an attach the following file labeled "Attachment F4 - Dental Claims Administration and Managed Network Pricing Tables and Example.xlsx"

Attachment [Attachment F4 - Dental Claims Administration and Managed Network Pricing Tables and Example.xlsx](#)

Answer: 1: Attached

Detail: We have also included a redacted version of each file we consider confidential, with the confidential information removed. Only redacted files, may be released in an open records requested.

We have included a separate file with a password to open the full confidential files. This password should only be shared on a need to know basis, and should not be released publically.

Options:

1. Attached
2. Not Attached

Attachments: [Attachment F4 - Dental Claims Administration and Managed Network Pricing Tables and Example.xlsx](#)
[DPPO Plan Design - Economy.xlsx](#)
[DPPO Plan Design - Premium.xlsx](#)
[DPPO Plan Design - Standard.xlsx](#)
[DPPO Plan Design- Retirees.xlsx](#)
[Dental Fee Exhibit.xlsx](#)
[Dental Financial Assumptions.docx](#)

5.5.2 Please complete an attach the following file labeled "Attachment I4 - Dental Claims Administration and Managed Network Implementation and Performance Guarantees.xlsx"

Attachment [Attachment I4 - Dental Claims Administration and Managed Network Implementation and Performance Guarantees.xlsx](#)

Answer: 1: Attached

Detail: We have also included a redacted version of each file we consider confidential, with the confidential information removed. Only redacted files, may be released in an open records requested.

We have included a separate file with a password to open the full confidential files. This password should only be shared on a need to know basis, and should not be released publically.

Options:

1. Attached
2. Not Attached

Attachments: [Attachment I4 - Dental Claims Administration and Managed Network Implementation and Performance Guarantees.xlsx](#)
[CONFIDENTIAL Dental Discount Guarantee Attachment A.docx](#)
[REDACTED Dental Discount Guarantee Attachment A.doc](#)
[CONFIDENTIAL Dental Discount Guarantee Attachment B.xlsx](#)
[REDACTED Dental Discount Guarantee Attachment B.doc](#)
[CONFIDENTIAL Trend Based Earn Back Guarantee.docx](#)
[REDACTED Trend Based Earn Back Guarantee.doc](#)
[Performance Guarantees.docx](#)

5.5.3 Please complete an attach the following file labeled "Attachment J3 - Dental Active Network Claims and Disruption Worksheet.xlsx"

Answer: 1: Attached

Detail: The follow worksheets are considered trade secret, proprietary and confidential. As stated in our proposal response, they should not be publically released:

-CONFIDENTIAL_Attachment_J1_-
_Medical_Active_Network_Claims_and_Disruption_Worksheet.xlsx
-CONFIDENTIAL_Attachment_J2_-
_Medical_Retiree_Network_Claims_and_Disruption_Worksheet.xlsx
-CONFIDENTIAL_Attachment_J3_-
_Dental_Active_Network_Claims_and_Disruption_Worksheet.xlsx
-CONFIDENTIAL_Attachment_J4_-
_Dental_Retiree_Network_Claims_and_Disruption_Worksheet.xlsx

We have also included a redacted version of each file, with the confidential information removed. Only redacted files, may be released in an open records requested.

We have included a separate file with a password to open the full confidential files. This password should only be shared on a need to know basis, and should not be released publically.

Options:

1. Attached
2. Not Attached

Attachments: [CONFIDENTIAL Password for J.1 J.2 J.3 J.4.docx](#)
[CONFIDENTIAL Attachment J3 -
Dental Active Network Claims and Disruption Worksheet.xlsx](#)
[REDACTED Attachment J3 - Dental Active Network Claims and Disruption Worksheet.xlsx](#)

5.5.4 Please complete an attach the following file labeled "Attachment J4 - Dental Retiree Network Claims and Disruption Worksheet.xlsx"

Answer: 1: Attached

Detail: The follow worksheets are considered trade secret, proprietary and confidential. As stated in our proposal response, they should not be publically released:

-CONFIDENTIAL_Attachment_J1_-
_Medical_Active_Network_Claims_and_Disruption_Worksheet.xlsx
-CONFIDENTIAL_Attachment_J2_-
_Medical_Retiree_Network_Claims_and_Disruption_Worksheet.xlsx
-CONFIDENTIAL_Attachment_J3_-
_Dental_Active_Network_Claims_and_Disruption_Worksheet.xlsx
-CONFIDENTIAL_Attachment_J4_-
_Dental_Retiree_Network_Claims_and_Disruption_Worksheet.xlsx

We have also included a redacted version of each file, with the confidential information removed. Only redacted files, may be released in an open records requested.

We have included a separate file with a password to open the full confidential files. This password should only be shared on a need to know basis, and should not be released publically.

Options:

1. Attached
2. Not Attached

Attachments: [CONFIDENTIAL Password for J.1 J.2 J.3 J.4.docx](#)
[CONFIDENTIAL Attachment J4 -
Dental Retiree Network Claims and Disruption Worksheet.xlsx](#)
[REDACTED Attachment J4 - Dental Retiree Network Claims and Disruption Worksheet.xlsx](#)

5.6 Reference Documents - Dental

5.6.1 Attachment G4 - Dental Claims Administration and Managed Network Scoring Methodology.docx

Document: [Attachment G4 - Dental Claims Administration and Managed Network Scoring Methodology.docx](#)

5.6.2 Attachment H4 - Dental Claims Admin and Managed Network Scoring Methodology Example and Discounted Allowed Charges Example.xlsx

Document: [Attachment H4 - Dental Claims Admin and Managed Network Scoring Methodology Example and Discounted Allowed Charges Example.xlsx](#)

5.6.3 Attachment J6 - Dental Disruption Scoring Example.xlsx

Document: [Attachment J6 - Dental Disruption Scoring Example.xlsx](#)

6 Response Documents - All Coverages

6.1 Please complete an attach the following file labeled "Attachment B - Offeror Information and Certification.docx"

Attachment [Attachment B - Offeror Information and Certification.docx](#)

Answer: 1: Attached

Detail: Please find Attachment B, and supporting information, attached.

Options:

1. Attached
2. Not Attached

Attachments: [1.a Signed Attachment B - Offeror Information and Certification.pdf](#)

[1.b Attachment B - Offeror Information and Certification.docx](#)

[2. Subcontractor Commitment Letters.zip](#)

[3. Minimum Qualification Question 2.1.1.2 Response- CONFIDENTIAL.doc](#)

[3. Minimum Qualification Question 2.1.1.2 Response- REDACTED.doc](#)

[4. State of Alaska Business Licence.pdf](#)

[5. State of Alaska Certificate of Authority.pdf](#)

[6. Legal Clarifications \(Deviations\).doc](#)

[7. Plan Clarifications.xlsx](#)

[8. Confidentiality Request.docx](#)

6.2 In the attached file labeled "Attachment C - General Provisions.docx", please identify those terms, if any, you object to and attach your response.

Attachment [Attachment C - General Provisions.docx](#)

Answer: 1: Attached

Detail:

Options:

1. Attached
2. Not Attached - no objections

Attachments: [6. Legal Clarifications \(Deviations\).doc](#)

6.3 In the attached file labeled "Attachment D - Indemnity and Insurance.docx", please identify those terms, if any, you object to and attach your response.

Attachment [Attachment D - Indemnity and Insurance.docx](#)

Answer: 2: Not Attached - no objections

Detail:

Options:

1. Attached
2. Not Attached - no objections

Attachments:

7 Reference Documents - All Coverages

7.1 Attachment A - Standard Agreement Form for Professional Services.docx

Document: [Attachment A - Standard Agreement Form for Professional Services.docx](#)

7.2 Attachment E - Notice of Intent to Award a Contract.docx

Document: [Attachment E - Notice of Intent to Award a Contract.docx](#)

7.3 Attachment K1 - Census - Active.xls

Document: Can't find reference to document

7.4 Attachment K2 - Census - Retiree.xlsx

Document: Can't find reference to document

7.5 Attachment K3 - DCR Active Data as of 06302011.xlsx

Document: [Attachment K3 - DCR Active Data as of 06302011.xlsx](#)

7.6 Attachment K4 - Active and Retiree Census Structure.xlsx

Document: Can't find reference to document

7.7 Attachment L1 - Active - Medical Enrollment and Claims Paid.pdf

Document: [Attachment L1 - Active - Medical Enrollment and Claims Paid.pdf](#)

7.8 Attachment L2 - Active - Vision Enrollment and Claims Paid.pdf

Document: [Attachment L2 - Active - Vision Enrollment and Claims Paid.pdf](#)

7.9 Attachment L3 - Active - Dental Enrollment and Claims Paid.pdf

Document: [Attachment L3 - Active - Dental Enrollment and Claims Paid.pdf](#)

7.10 Attachment L4 - Retirees- Medical Enrollment and Claims Paid.pdf

Document: [Attachment L4 - Retirees- Medical Enrollment and Claims Paid.pdf](#)

7.11 Attachment L5 - Retirees- Audio - Vision Enrollment and Claims Paid.pdf

Document: [Attachment L5 - Retirees- Audio - Vision Enrollment and Claims Paid.pdf](#)

7.12 Attachment L6 - Retirees- Dental Enrollment and Claims Paid.pdf

Document: [Attachment L6 - Retirees- Dental Enrollment and Claims Paid.pdf](#)

7.13 Attachment L7 - Monthly Utilization by Plan Summary - Oct '10 - May '12 - FINAL.XLSX

Document: [Attachment L7 - Monthly Utilization by Plan Summary - Oct '10 - May '12 - FINAL.XLSX](#)

7.14 Attachment L8 - Pharmacy Supplemental Utilization and Plan Design Reference.pdf

Document: [Attachment L8 - Pharmacy Supplemental Utilization and Plan Design Reference.pdf](#)

7.15 Attachment M1 - Medical Claims Processed Appeal Volume.pdf

Document: [Attachment M1 - Medical Claims Processed Appeal Volume.pdf](#)

7.16 Attachment M2 - Dental Claims Processed Appeal Volume.pdf

Document: [Attachment M2 - Dental Claims Processed Appeal Volume.pdf](#)

7.17 Attachment M3 - Call Volume reports.xlsx

Document: Can't find reference to document

7.18 Attachment M4 - Claims, calls and appeals.pdf

Document: Can't find reference to document

7.19 Attachment M5 - Employee Assistance Program Statistics.xlsx

Document: [Attachment M5 - Employee Assistance Program Statistics.xlsx](#)

7.20 Attachment N - Proposed Terms and Conditions.docx

Document: [Attachment N - Proposed Terms and Conditions.docx](#)

7.21 Attachment O - PEC Scoring Sheets.docx

Document: Can't find reference to document

7.22 Attachment P - PEC Worksheet Guide.docx

Document: Can't find reference to document

7.23 Attachment Q - PEC Evaluator's Guide.doc

Document: [Attachment Q - PEC Evaluator's Guide.doc](#)

8 Questions and Answers

8.9

Question: 1. We have identified several data items that are critical to developing a proposal on equal footing with an incumbent, and are including them in our questions. Will you consider responding to bidder questions you get in early prior to the 12/14 response date? Specifically, will you provide requested data that is currently available to an incumbent prior to 12/14?

Answer:

8.10

Question: 2. In order to provide pharmacy pricing and guarantees, a detailed claim file is required. This data is commensurate with the information the incumbent will utilize to price the pharmacy. Can the State provide a file with the following detailed pharmacy claim data:

- Claim Information by Drug dispensed for a 12 month period (note period)
- Average employee counts and members for claim information provided
- Date of Service
- National Drug Code (NDC) = 11 digit number
- NABP (Pharmacy) Number
- Quantity Dispensed
- Days Supply
- Retail/Mail Indicator
- Brand/Generic Indicator

Answer:

8.11

Question: 3. Is a top conditions report available for the actives and retirees? If not, is a report available with charges by MDC for the actives and retirees?

Answer:

8.12

Question: 4. Is a network report available that provides the current network utilization achieved by the State split by active and retiree?

Answer:

8.13

Question: 5. Can the retiree enrollment and claims be split by Non-Medicare and Medicare?

Answer:

8.14

Question: 6. Can we get a place of service indicator on the medical claim repricing file(s)? If not, can we get a key for either the Provider Type or Provider Specialty column so we can determine if that claim is Inpatient, Outpatient, or Physician?

Answer:

8.15

Question: 7. Can the State provide any preliminary results of the wellness program that addresses utilization split by active and retiree coverage?

Answer:

8.16

Question: 8. Can the State provide current EAP utilization split by Active and Retiree including Critical Incident Stress Debriefing and training hours?

Answer:

8.17

Question: 9. Based on the example in the network disruption exhibits, it appears that the network reimbursement levels are not utilized in the scoring. Is this a correct assumption? If not, how is repricing utilized in the RFP process?

Answer:

8.18

Question: 10. How should an organization represent any economies of scale if awarded multiple components of the RFP (for example, if an organization would offer better pricing for being awarded both medical and health care management, medical and pharmacy, medical and dental, all four together)?

Answer:

8.19

Question: 11. Is an organization to assume the performance based incentives as outlined in the State Objectives are accepted by the State? If not, how will the State determine if incentives are accepted?

Answer:

8.20

Question: 12. For the point of contact question (2.1.3.2 #7) are you looking for the point person for RFP process or once the business is awarded?

Answer:

8.21

Question: 13. Does the state have any office space available in its facilities to accommodate health plan resources?

Answer:

8.22

Question: 14. Please confirm that all Health Care Management services are to be offered to actives, Pre-Medicare retirees and Medicare retirees with no variation across these populations.

Answer:

8.23

Question: 15. Please advise if a non-officer individual with the authority to bind a contract will be sufficient to sign all applicable RFP documents?

Answer:

8.24

Question: 16. You state in section 1.12 that "Confidential material, including trade secrets and proprietary data, contained in proposals may be held confidential if the Offeror requests in writing that the Procurement Officer do so, and if the Procurement Officer agrees in writing to do so." Are we to make this request directly in our proposal response? Can you confirm that the bidder would be informed, and allowed to appeal, before any confidential information is made public (assuming the Procurement Officer does not formally agree)?

Answer:

8.25

Question: 17. Proposal Tech 2.1.1.2- You ask that we meet the minimum criteria in section 2.7- do you really mean section 2.8?

Answer:

8.26

Question: 18. Proposal Tech 2.2.1.6- Can you confirm you want a listing of each and everyone one of our national (non-Alaska) providers (which would be a very large file), or would you prefer a summary by specialty?

Answer:

8.27

Question: 19. As you know, it is standard practice for us to have a Non-Disclosure Agreement in place prior to release of the negotiated rates (as required in Attachments J1, J2, J3 and J4). Can Buck Consulting and the State of Alaska please sign our Non Disclose agreement? Can you also let us know who to provide a copy of this agreement to? (We were unable to upload it in the "Ask Question" Section.)

Answer:

8.28

Question: 20. Regarding question 4.1.3.2 "Identify and describe how all aspects of the work for each function identified below will be organized and staffed", Could the state provide definitions regarding items

E. Participation

F. Effectiveness

H. Quality Control

i. Performance Guarantees

I. Data Analysis

i. Data Collection

ii. Reporting

J. Financial

Answer:

8.29

Question: 21. Regarding question 4.1.8.11 "Explain how you can coordinate with an external weight management program, such as Weight Watchers At Work", could the state provide more information about current use of external weight management programs? What types of integration would be useful for the State's program?

Answer:

8.30

Question: 22. Regarding question 4.1.5.5 “Please list the dates in which your eligibility and claims systems were reviewed and validated against the updated HIPAA regulations”, could the state clarify the intent and relevance for Healthcare Management?

Answer:

8.31

Question: 23. Regarding question 4.1.7.2 “Does your automated data processing capability include the ability to interface with the State's health reporting eligibility system when fully operational”, could the state please provide more detail around the State's reporting eligibility system?

Answer:

8.32

Question: 24. Regarding question 4.2.2.2.11 “Is there an extra fee for customization? If there is an additional cost, please indicate the cost on the rate sheet”, please define what the State is anticipating for customization or are we to purely outline all potential permutations.

Answer:

8.33

Question: 25. What is the state's current incentive program for members? Do the incentives apply to all populations including Medicare?

Answer:

8.34

Question: 26. Does the state currently have a Nurseline and if so can you provide the current participation rates?

Answer:

8.36

Question: 27. Can the State provide an overview of the current utilization management and case management programs in place today and identify any variation by Pre Medicare and Medicare? Is the current utilization in these areas available for the past 12 months split by active, Pre-Medicare and Medicare?

Answer:

8.37

Question: 28. For RFP question 2.1.4.3 (and 5.1.4.7) please indicate what is meant by run-out or termination communications.

Answer:

8.38

Question: 29. What quantity/frequency of data feeds is the State looking for in RFP question 2.1.7.4 (and 5.1.7.4)? Alternatively, what should all bidders assume?

Answer:

8.39

Question: 30. Are any of the plans currently grandfathered? Are the plans subject to Federal Mental Health Parity? If yes, will the plans maintain their grandfathered status or exemption from Mental Health Parity effective 7/1/2013?

Answer:

8.40

Question: 29. What quantity/frequency of data feeds is the State looking for in RFP question 2.1.7.4 (and 5.1.7.4)? Alternatively, what should all bidders assume?

Answer:

8.41

Question: 31. On attachment F1, under General ASO services, please indicate what is meant by HIPAA Administration. How does this differ from HIPAA certificates that are included under the Other Value Add Services?

Answer:

8.42

Question: 32. For section 2.2.8 of the questionnaire, Quality Control (use the tables provided in attachment G1), is this the correct attachment? Is this section referring to Attachment I1?

Answer:

8.43

Question: 33. Please confirm Attachment K3 is being provided as informational only on the future Defined Contribution Retiree population, and they are not currently enrolled in the plans included in this RFP.

Answer:

8.44

Question: 34. Please provide the current medical administration fees and the services included in those fees. If not represented in the fee, what are the current services and fees for the Wellness program the State recently implemented?

Answer:

8.45

Question: 35. On the Retiree Census, 237 retirees show enrolled in one of 4 LTC plans. Are these retirees also enrolled in a medical plan?

Answer:

8.46

Question: 36. Is a large claim listing (claims over \$75,000) available identifying paid dollars for last 12 months, current member status, diagnosis, and member's enrolled plan?

Answer:

8.47

Question: 37. Does the claim repricing file represent all claims paid under the plans? If not, can a top 25 provider/facility utilization report be made available separately for Actives, Pre Medicare Retirees and Medicare Retirees?

Answer:

8.48

Question: 38. What is the current level of discount savings being achieved today with the incumbent medical vendor split by Active and Retiree?

Answer:

8.49

Question: 39. Under the current pharmacy plan, is Envision the PBM for all retail, mail and specialty prescriptions? If not, please identify how each phase is currently handled?

Answer:

8.50

Question: 40. What is the current frequency of the data sharing between the PBM and the medical administrator? What are expectations beginning 7/1/2013 between the medical administrator and the healthcare management vendors?

Answer:

8.51

Question: 41. The Monthly paid pharmacy claim data didn't include enrollment. Is that available by month for the time periods originally provided?

Answer:

8.52

Question: 42. Can the State provide a key for the groups (35947, 36328, 36327) identified in the claim file?

Answer:

8.53

Question: 43. For the detailed pharmacy claim file, can the State break out the active and retirees? For the retirees, can they be further split by Pre Medicare and Medicare with a Medicare indicator or group structure?

Answer:

8.54

Question: 44. Please define "enrollment" as it applies to the Behavioral Health performance guarantee.

Answer:

8.55

Question: 45. For depression screening, is the State seeking a specific approach or for the bidder to make a recommendation?

Answer:

8.56

Question: 46. How is follow-up defined? Is it with a clinical person or non-clinical? Is it required on non-urgent calls? Telephonic? What happens in the event that a person is hospitalized or otherwise not accessible?

Answer:

8.57

Question: 47. On the Performance Guarantee for EAP Utilization target, the PG reads, "At least 6% of unique participants will assess the EAP service within the reporting period." Do you mean, "access the EAP"? If so, how do you define utilization? For example, EAP face to face visits only, or would a member who called and received referrals for child care count as a "unique member"? What are the State's incentives or communications to support meeting this threshold?

Answer:

8.58

Question: 48. Are we to price the Employee Assistance Program in Attachment F1 Medical Claims Administration and Managed Network Pricing Tables? Please confirm that EAP is only priced in the Health Care Management component and a requirement of that bid.

Answer:

8.59

Question: 49. Attachment F3 provides several EAP session models. Are we to address these models in the EAP cells in Attachment F1?

Answer:

8.60

Question: 50. Do the populations provided in Attachment F1 apply to Attachment F3 (6,670 active employees and 36,532 retirees) membership? Should these be bid as one population or two independent populations with two separate PEPM rates?

Answer:

8.61

Question: 51. Can we get current FSA (Health Care and Dependent Care) actual participation numbers for State of Alaska?

Answer:

8.62

Question: 52. Who is current FSA provider?

Answer:

8.63

Question: 53. What are current vendor's FSA fees?

Answer:

8.64

Question: 54. What are the average number of COBRA members per month?

Answer:

8.65

Question: 55. What are the average number of initial COBRA notices per month?

Answer:

8.66

Question: 56. What are the average number of COBRA Qualifying Event Notices per month.

Answer:

8.68

Question: 57. What is the current COBRA fee?

Answer:

8.69

Question: 58. Is additional information available for all members Can we get an estimate of Active participants for Direct Bill?

Answer:

8.70

Question: 59. What are the current dental fees?

Answer:

8.71

Question: 60. Please provide the adult orthodontia benefit for the Premium plan.

Answer:

8.72

Question: 61. It appears that not all Retiree medical and dental is packaged. How can we tell from the Retiree census which retirees have dental coverage?

Answer:

8.73

Question: 62. It appears that there are about 36K Retirees (subscribers) on the census; however, the average retiree lives for the current 12 month period is approximately 28K. Please explain the discrepancy and if a census is available to align to experience.

Answer:

8.74

Question: 63. What percentage of the Retirees are Voluntary (retiree pay all)?

Answer:

8.75

Question: 64. Can the State provide updated monthly dental experience by plan with enrollment?

Answer:

8.76

Question: 65. If updated experience is not available, can the State elaborate on why there is a discrepancy between the experience and the census that varies by more than 15%:

- a. Economy/Preventive plan—the census lives are 2652. The average lives for the most current 12 months in the experience are 2029.
- b. Premium plan—the census lives are 574. The average lives for the most current 12 months in the experience are 1096.

Answer:

8.77

Question: 66. Please clarify which of the Health Care Management services will be offered to Medicare Prime Retirees

- 1. Wellness Services
 - a. Bio-Metrics
- b. Health Risk Assessment
- c. Lifestyle Coaching
- 2. Incentives
- 3. Nurse Call Line
- 4. Disease Management
- 5. Employee Assistance Program (EAP)
- 6. Web-based services
 - a. Personal Health Record
 - b. Health Risk Assessment
 - c. On-Line Coaching

Answer:

8.79 Posted Amendment 1, which reflects changes to Attachments M3 and M4

8.108

Question: 67. If the State awards RFP components to separate administrators for medical and dental components of the RFP, will the COBRA be handled by a single administrator or multiple?

Answer:

8.109

Question: 68. If the State awards RFP components to separate administrators for medical, pharmacy, health management and dental , are there any expectations for an administrator to pass eligibility or will the State be responsible for all administration of separately awarded contracts?

Answer:

8.110

Question: 69. If the State is seeking a nurseline for active and retiree members, can an administrator elect to have this service offered through the medical component of the RFP as nurseline is more typically aligned to Case Management functions? Will this impact scoring of either RFP component?

Answer:

8.111

Question: 70. Can we get more clarification on the behavioral health benefit for the active and retiree plans? Is this a managed behavioral health plan and how is this currently handled for clinical intake? Does this represent the model that administrators are to duplicate?

Answer:

8.112

Question: 71. What is the exact population covered by the current wellness program and the services utilized to date? What is expected deployment of Health Care Management program over the course of the contract? Please differentiate roll out by actives, retirees and dependents.

Answer:

8.113

Question: 72. What are the State's expectations for Utilization Management and Case Management for the Medicare retirees? Are there different expectations surrounding pre-certification and other provisions?

Answer:

8.114

Question: 73. Does the State continue to use the defined pre-certification list in the booklets or have these been altered in any way? If no changes, can the state provide volume for the past 2 years by each precertification treatment/condition? Are there any other considerations for URC requirements as referenced in question 2.2.7.2.3?

Answer:

8.115

Question: 74. Please provide volume of pre-authorization travel requests and denial ratio for the most recent plan year - July 1, 2011 to June 30, 2012. If available, we would like to see the same measurements for actives and retirees separately.

Answer:

8.116

Question: 75. Is the current administrator using a passive dental network or is it purely an indemnity dental plan?

Answer:

8.117

Question: 76. Please define "welcome kit" from question 4.1.4.2 and the State's expectations on what is included in the kit. Is it the State's expectation that each new employee receive a "hardcopy" communications packet or welcome kit directly from the vendor, or will the vendor be accountable to provide materials to the human resources team for distribution with the State's new employee benefits packets?

Answer:

8.118

Question: 77. If the vendor is expected to mail "welcome kits" directly to new employees please provide the average number of new employees per month or year

Answer:

8.119

Question: 78. If the vendor is expected to mail “welcome kits” directly to new retirees, please provide the average number of new employees per month or year.

Answer:

8.120

Question: 79. Please provide examples of the State's definition of “wellness fee credits” in the Health Care Management Component of the RFP pricing worksheet.

Answer:

8.121

Question: 80. During the bidders conference, the response on Economies of scale indicated to place these in the innovations area. Please clarify how these will be scored for the impact on costs.

Answer:

8.122

Question: 81. During the bidders conference, a question was raised on performance based incentives that we wanted to confirm would be addressed in the question response. How will the State score performance based Incentives?

Answer:

8.123

Question: 82. In regards to question 4.1.8.11 Does the state have a current contract with Weight Watchers or another external weight management company today? If so, does the state's current wellness/disease management vendor have integration processes in place today?

Answer:

8.124

Question: 83. In the financial exhibits, the State has many categories. Is it the State's goal to see pricing for every category possible or how should items be represented when components of standard base pricing? If pricing for each element, can descriptions of what the State is seeking in each component of the exhibit be provided? For example, it is not clear the difference between HIPAA administration and HIPAA Certificates.

Answer:

8.125

Question: 84. In the medical repricing file, there are records that are typically excluded from these analyses. These records are either not considered records (junk records such as unknown provider) or excluded services (matching and non-matching optical facilities, DME, Home Health, Nurse, Holistic, Dietician, Municipalities, etc). We will identify all records as excluded in our response and want to know if Buck will remove all such records from all responses?

Answer:

8.126

Question: 85. If the State is unable to provide a “clean” detailed pharmacy file that is member specific as previously submitted via question format and discussed in the Bidder's conference by December 14, 2012, will illustrative pricing be acceptable for a bidder's submission? How would the State alter its

selection of finalists under this scenario? If the clean file is not available by December 14, would a detailed file be available to all finalists for developing a best and final offer?

Answer:

8.127

Question: 86. In Section 2.8 of the RFP Introduction and Instructions the State's minimum requirements for pharmacy have 75,000 Mail Order Claims requirement. Can the State adjust the minimum requirement to "at least 5 years of experience in processing an average of 50,000 pharmacy mail order claims per month for one group?"

Answer:

8.128

Question: 87. What direction will the Proposal Evaluation Committee be provided to score responses in the 1, 5 and 10 format? If there are extreme variations in the evaluator scoring, how will the State address this variation?

Answer:

8.129

Question: 88. Can the State provide the information contained in the Verisk Quarterly reports split by Medicare and Non-Medicare for the retiree medical plan? If so, please provide.

Answer:

8.130

Question: 89. The Verisk Quarterly reports contain network abbreviations in section 3.1.1. Can the State provide the full names and descriptions for each of the abbreviations?

Answer:

8.132

Question: 90. Can the State provide the place of service for each record in the medical repricing files for the actives and retirees? Alternatively, please provide how each provider type should be classified relative to Inpatient Hospital claim, Outpatient Hospital claim or Physician/Professional claim for purposes of repricing?

Answer:

8.134

Question: 91. Is the state contracting direct with Verisk or this through the administrator? What are associated annual costs?

Answer:

8.138 Added Amendment 2 with information on Attachment L9 - Supplemental Data Exhibits for Pharmacy Benefit Management.xls

8.142 A few of the Offerors have requested that the Questions and Answers be released prior to 12/14/12. Unfortunately, due to the number of questions, this will be not possible. Please look for responses on Friday, December 14th.

8.143

Question: 1. We have reviewed the Pharmacy data provided in Amendment 2. In order to provide the best possible pricing, we would still need the information requested in our bidder questions (#2 and #43). Is it the State's intent to still provide this information, along with the rest of the responses on 12/14/2012?

If the detailed pharmacy data cannot be provided, can the State provide a summary of all claims over the same time period versus top medications only? If summary data is only provided, how will the State address pricing disparities from bidders relative to the incumbent that is using detailed pharmacy data for pricing?

Answer:

8.145 Amendment 3 was uploaded, along with additional Attachments L10 and L11 and a corrected Attachment J5.

8.148 Please note that the responses to Offeror questions will be provided by Friday, December 21st. The State will also release an updated timeline at that point.

8.152 Please note that the RFP timeline will be extended, though specific dates have not been determined. Please note that the State will release the Questions and Answers tomorrow, 12/21.

8.158 Please note that Amendment 5 has been uploaded, including information on the RFP timeline, as well as additional and updated data.

8.159 Please note that Amendment 5 has been uploaded, including information on the RFP timeline, as well as additional and updated data.

8.162

Question: Based on Amendment 4, we understand the State is not willing to sign a non-disclosure agreement during the procurement process. The Amendment indicates that Offerors designating information in their proposals as confidential should submit a second copy of their proposal with that information redacted for inclusion as part of the public procurement file. Are we to make a full second submission of our entire proposal or should only the file with information that would have been covered by a non-disclosure agreement be submitted? Can you clarify how we are to handle?

Answer:

8.166

Question: 1. Everyone on the Active census shows family coverage for medical and dental, please confirm this is correct.

Answer:

8.167

Question: 2. On the active census, 1167 employees show a termination date for Med_Plan1. Are these individuals enrolled in the plan listed in Med_Plan1 column or terminated? In addition, 327 employees show a termination date for Med_Plan2. Are these employees enrolled in the plan listed in Med_Plan2 or terminated?

Answer:

8.168

Question: 3. On the active census, 1043 employees show a termination date for Dental. Are these individuals enrolled in the dental plan listed or terminated?

Answer:

8.169

Question: 4. Please explain the relationship between Med_Plan1 and Med_2.

Answer:

8.170

Question: 5. The census structure worksheet shows there is only one dental plan, however 320 Retirees show enrolled in other dental plans. Can you please explain?

Answer:

8.171

Question: 6. On the retiree census 482 retirees show a termination date for Med_Plan1. Are these individuals enrolled in the plan listed in Med_Plan1 column or terminated? In addition, 498 retirees show a termination date for Med_Plan2. Are these employees enrolled in the plan listed in Med_Plan2 or terminated?

Answer:

8.172

Question: 7. 396 retirees are listed with Med_Cov1 as O, 391 retirees are listed with Med_Cov2 as O, and 386 retirees are listed with Den Coverage as O, however there is not a corresponding category under Tier on the retiree census structure. What tier of coverage is O?

Answer:

8.173

Question: 8. Please explain the relationship between Med_Plan1 and Med_2.

Answer:

8.177 Please note that the Offeror Questions and Answers, as well as Amendment 6 with additional clarification, will be posted either today or tomorrow.

8.178 Please note that Amendment 6, as well as Offeror Questions and Answers, have been posted.

8.179

Question: The State posted a document labeled "Attachment M6 - TPA Contract and Amendments.pdf" (references in response 8.103.6). Can you confirm this is being providing for information purposes only, and does not require a red-line review?

Answer:

8.180

Question: In your response to item 8.162, you reiterate that bidders can submit a second redacted response to remove (and hence protect) confidential information. However, we are unsure of exactly how this will work, since this is an electronic online only submission. Will you create a second only copy wherein we can go in and redact? Are we to submit our initial RFP first, then redact and somehow resubmit? We'd just like more information on the mechanics of how this will be done.

Answer:

8.181

Question: We have reviewed all of the data files provided by the State. The census and pharmacy files contain the member's unique family ID, while the medical file appears to be a different unique ID. Can the state provide the medical file with a consistent family ID as provided in the census and pharmacy file or a methodology to match members across the files?

Answer:

8.185

Question: It sounds like in response to the grandfathered plan question, that it is assumed that plans that are grandfathered are also Mental Health Parity exempt...which is not the case. Plans have to have a separate certification/exemption specific to MH Parity. Please confirm that the St of Alaska plans are also certified exempt from MH Parity.

Answer:

8.188 Please note that Amendment 7 has been posted, in addition to updated Attachments J1 - J4 and new Attachments M7 - M9.

8.189

Question: We are in receipt of Amendment 7 and the associated new claim files. We would like to understand if the new claim files are an exact duplicate of the 2nd set of claim files with only the claim number added or did anything else change. Based on the differences from the 1st set of files and the second, we are trying to understand if we need to recomplete the disruption and repricing that we completed based on the 2nd claim file. Is the final claim repricing file an exact duplicate of the 2nd set of files (every record, column and row excluding the addition of a claim number) or are there changes? If there are changes, can those be identified to avoid the need to redo the entire repricing process?

Answer:

8.191

Question: The State has indicated that all fees be in PEPM format including subrogation fees. It is not standard practice in the market for subrogation vendors to enter into financial terms that are not a percentage of recovery to ensure incentives aligned to maximum recovery. Is it acceptable for a vendor to propose subrogation and COB recovery on a percentage basis to align market practice?

Answer:

8.192

Question: We appreciate the State's clarification on submission of a second file for "confidential" material and understand a Non-Disclosure Agreement cannot be put in place. As such, please confirm that the labeling of each file as "Redacted" and "Confidential" will suffice on the differentiation of the files and enable the appropriate handling of confidential material (In other words, we will submit two copies of the file [the redacted and the regular] for each question that requires a confidential attachment).

Can you also confirm that using the "Confidential Indicator" for the actual questions in Proposal Tech (i.e. for confidential items that do not require an attachment), will automatically exclude that question response from being released for an open records request?

Also, can the State clarify how confidential repricing files will be maintained either exclusively by Buck or if provided to the State how they will be maintained in a confidential location? Will any

individuals not directly involved in the scoring of the confidential repricing files have access to the files or access to the location that the files would be maintained?

Answer:

8.193 Please note that Amendment 8, as well as additional responses to Offeror questions, have been posted.

8.195

Question: We understand and will comply with the State of Alaska's submission requirements of a confidential file and redacted file. In order to meet our requirements surrounding a confidential file, we will password protect the file and will need to know how the State of Alaska would like to receive the password. Are we able to send the associated password to Buck via e-mail or how would the State of Alaska like the password to be delivered to Buck?

Answer: The following answer was extracted from an email
(and as such has not been authenticated):

From: "Melander, Marissa" <Marissa.Melander@buckconsultants.com>
To: Candace Nicholson <nicholsonc_aetna@rfp1.proposaltech.com>
Date: Thu, 7 Feb 2013 22:58:31 +0000

Hi Candace and the Aetna team,

The State requests that you submit the password on the eRFP tool in a separate document.

Thank you!
Marissa

Marissa Melander
720.359.7761

From: Candace Nicholson [mailto:nicholsonc_aetna@rfp1.proposaltech.com]
Sent: Friday, February 01, 2013 12:20 PM
To: Melander, Marissa
Subject: [23650839] Candace Nicholson of Aetna asked about RFP "State of Alaska RFP 2013-0200-1396"

8.196 Please find attached Amendment 9.

8.197 Please note that the Protest of Section 1.14 has been posted.

8.198

Question: Proposal Tech's file limit size of 20MB will not accommodate some of the files required for the State of Alaska proposal. Can the State confirm that we should split up these files to fall below the 20MB threshold and label as File 1, 2, etc. to maintain the order? If this is not the required approach, how would the State want files above the 20MB threshold to be submitted?

Answer: The following answer was extracted from an email
(and as such has not been authenticated):

From: "Melander, Marissa" <Marissa.Melander@buckconsultants.com>
To: Candace Nicholson <nicholsonc_aetna@rfp1.proposaltech.com>
Date: Thu, 7 Feb 2013 23:05:21 +0000

Hi Candace,

We can increase this if you let me know what question you need it increased on.

Thanks!

Marissa Melander
720.359.7761

From: Candace Nicholson [mailto:nicholsonc_aetna@rfp1.proposaltech.com]
Sent: Thursday, February 07, 2013 8:00 AM
To: Melander, Marissa
Subject: [23650839] Candace Nicholson of Aetna asked about RFP "State of Alaska RFP 2013-0200-1396"

8.199 Please note that Amendment 10 and the response to the protest have been posted.

8.200

Question: I am following up on question 8.198 that was submitted. The response was that the file size can be increased for specific questions.

Below are the questions that we will need a file increase size for the state of Alaska bid.

2.5.3 J1 Medical Active Repricing (One Redacted and One Full File- up to 50 MB each)
2.5.4 J2 Medical Retiree Repricing (One Redacted and One Full File- up to 175 MB each)
5.5.3 J3 Dental Active Repricing (One Redacted and One Full File- up to 50 MB each)
5.5.4 J4 Dental Retiree Repricing (One Redacted and One Full File- up to 50MB each)

Please let me know if these changes can be accommodated. Thank you!

Answer: The following answer was extracted from an email
(and as such has not been authenticated):

From: "Melander, Marissa" <Marissa.Melander@buckconsultants.com>
To: Candace Nicholson <nicholsonc_aetna@rfp1.proposaltech.com>
Date: Fri, 8 Feb 2013 21:43:23 +0000

Hi Candace,

The file size has been increased.

Thanks!

Marissa Melander
720.359.7761

From: Candace Nicholson [mailto:nicholsonc_aetna@rfp1.proposaltech.com]
Sent: Friday, February 08, 2013 1:10 PM
To: Melander, Marissa
Subject: [23650839] Candace Nicholson of Aetna asked about RFP "State of Alaska RFP 2013-0200-1396"

The following answer was extracted from an email
(and as such has not been authenticated):

From: "Melander, Marissa" <Marissa.Melander@buckconsultants.com>
To: Candace Nicholson <nicholsonc_aetna@rfp1.proposaltech.com>
Date: Fri, 8 Feb 2013 20:13:06 +0000

They can be – I will get back to you with timing.

Marissa Melander
720.359.7761

From: Candace Nicholson [mailto:nicholsonc_aetna@rfp1.proposaltech.com]
Sent: Friday, February 08, 2013 1:10 PM
To: Melander, Marissa
Subject: [23650839] Candace Nicholson of Aetna asked about RFP "State of Alaska RFP 2013-0200-1396"

8.203 Please note that Amendment 11 was just uploaded.

8.205 Please note that Amendment 12 has been posted.

8.206 Updated version of Amendment 12 was posted.

8.207 Please note that all responses MUST be submitted today by:

1:00 P.M. Alaska Time

2:00 P.M. Pacific Time

3:00 P.M. Mountain Time

4:00 P.M. Central Time

5:00 P.M. Eastern Time

The system will lock at that time and will no longer accept responses.

8.208

8.209 To caveat my last notice, you must hit POST on your response, otherwise the system count it as posted and completed.