Technical Approach

C.4 Technical Approach Content

C.4.1 Describe in detail the State proposal for establishing and providing for the ongoing administrative functions of operating a high risk pool program. The description should describe how the State proposes to make the high risk pool program operational, including all sub-contracting relationships that may be included in the implementation plan and a proposed timeline for the implementation of the high risk pool program that includes the first date on which the program will accept enrollments and the first date on which the program will provide coverage for enrollees.

Arkansas Blue Cross has administered the Arkansas Comprehensive Health Insurance Program (CHIP) program since its inception in the late 1990s, administered through BlueAdvantage Administrators (BlueAdvantage). BlueAdvantage, a wholly-owned subsidiary of Arkansas Blue Cross and Blue Shield, is the state's largest third-party administrator and offers unmatched experience and expertise in the administration of large account business and complex health plans, meaning we have more than 10-years experience administering high-risk pool programs. Through our long tenure with CHIP, we will continue to work closely with the CHIP Board to ensure that we are able to meet the needs of the Federal High Risk Pool (FHRP) by:

- Working closely with the CHIP Board to establish all procedures and guidelines necessary for the effective administration of the program;

- Assign a dedicated service team to the FHRP account to handle such functions as membership, premium billing, customer

service, and claims processing. This dedicated operations approach will allow us to effectively administer this account and respond timely, accurately, and effectively to the needs of FHRP participants and the CHIP Board.

Subcontractors:

BlueAdvantage has reviewed and understands the scope of work to be performed by the Plan Administrator and agrees to perform those duties as outlined in the Solicitation for State Proposals to Operate Qualified High Risk Pools. BlueAdvantage, the prime sub-contractor and an Insurer, subcontracts additional services as outlined below. Information related to these BlueAdvantage subcontractors can be found in Exhibit A "FHRP – Subcontractor List." This list also includes CHIP subcontractors.

Timeline:

TASK	DATE
RFP Release	June 1, 2010
Proposal Due Date	June 1, 2010
Contract Awarded	July 1, 2010
Accept Enrollees	August 1, 2010
Provide Coverage	September 1,2010

If the State operates another high risk pool, describe how the State will segregate funding and expenditures for the two programs and track enrollees separately across all benefits and services.

BlueAdvantage will establish the FHRP account structure with a distinct "carrier" code which allows all records associated with the account to be segregated and reported separately from our other business. This includes but is not limited to membership/eligibility, billing, premium/funding, benefits administration, claims processing etc.

All BlueAdvantage staff and other direct expenses related to the administration of this program are assigned dedicated cost centers. Arkansas Blue Cross and Blue Shield (Arkansas Blue Cross) uses a cost allocation/accounting system called the Standard National Accounting Program (SNAP), which provides for the full allocation of all direct costs at the time the expense is incurred. Indirect expenses such as overhead, facilities and equipment, as well as general and administrative expenses, are allocated to the appropriate cost center monthly.

SNAP is a user-controlled, table-driven accounting system for cost, budget, and general ledger accounting functions. The cost accounting segment of SNAP serves as the base module, editing all of the financial data needed for cost accounting and general ledger, allocating all administrative and indirect expenses, and building and/or maintaining user-inputted tables for cost and general ledger reporting. The system provides for allocation of administrative expenses to various business units called cost centers, which can be rolled up into a variety of business products called lines of business. A specific line of business will be established for FHRP.

To ensure segregation, CHIP's subcontractors, as identified on Exhibit A, have all opened separate billing files regarding services to be performed for the FHRP. Accordingly, all subcontractor bills submitted to CHIP will clearly delineate when such services are performed for or on behalf of the FHRP. In turn, this will allow CHIP to submit only appropriate and proper administrative costs to HHS for reimbursement. CHIP itself will utilize a wholly separate bank account for the administration of the FHRP, than that utilized for CHIP's state high risk pool.

If the proposal is to delegate the operation to a nonprofit entity, the State should clearly indicate if it proposes that HHS contract with the State (that will subcontract with the nonprofit) or proposes that HHS contract directly with the nonprofit high risk pool. If the State proposes that HHS contract directly with the nonprofit high risk pool, provide copies of all governing authorities of the nonprofit entity, including statutes, regulations, governance, and plan of operation.

The State of Arkansas proposes that HHS contract directly with CHIP so as to avoid the legislative appropriation process for getting monies to CHIP for its administrative services and costs (Refer to Exhibit B). Copies of all governing authorities, including statutes (Exhibit C), articles of incorporation (Exhibit D) and bylaws (Exhibit E) are enclosed herewith.

C.4.2 In response to the questions below, describe how the State will design a high risk pool program that will meet the basic requirements to operate the program as described in A.4.2 of the Statement of Work.

1) Describe the eligibility criteria that the qualified high risk pool will use to determine if individuals are eligible to enroll in the proposed high risk pool program.

A.4.2

1) Eligibility for Individuals to Enroll in High Risk Health Insurance Pool Programs – The Contractor shall develop eligibility criteria for participation in a high risk pool subject to the approval of HHS. Generally, HHS anticipates Contractors will develop criteria that include all of the requirements included in A.4.2.1.a and A.4.2.b Subject to the approval of HHS, the Contractor shall develop

eligibility criteria meeting some or all of the elements included in A.4.2.1.c. That is an individual:

a) Is a citizen or national of the United States or lawfully present in the United States;

Applicants will be required to submit a SSN on their application. Additionally, Contractor will sign up for access to the Systematic Alien Verification for Entitlements (SAVE) Program. The SAVE Program is a program that the state of Arkansas currently utilizes to verify whether a person is a resident and/or legally present. "The SAVE Program is an inter-governmental initiative designed to aid benefit-granting agencies in determining an applicant's immigration status, thereby ensuring that only entitled applicants receive Federal, state, or local public benefits and licenses. The program is an information service for benefit-granting agencies, institutions, licensing bureaus, and other governmental entities." U.S. Citizenship and Immigration Services, About the SAVE Program, http://www.uscis.gov/portal/site/uscis/menuitem.eb1d4c2a3e5b9ac89243c6a7543f6d1a/?vgnextoid=e112feb9a2ca8210VgnVCM100000082ca60aRCRD&vgnextchannel=e112feb9a2ca8210VgnVCM100000082ca60aRCRD (accessed May 25, 2010).

The SAVE Program maintains eligibility requirements to participate and those eligibility criteria include: 1) that the agency be a Federal, state, or local government agency or licensing bureau; and 2) that the agency provide a public benefit, license or otherwise be authorized by law to engage in an activity for which the verification of immigration status is appropriate.

Eligibility criteria regarding citizenship for FHRP is defined on the FHRP Application (Exhibit F), this includes the Eligibility Worksheet and Enrollment Form, Outline of Coverage and covered in more detail within the Policy (both currently being drafted. If needed as part of this Solicitation, we can provide).

b) Has not been covered under creditable coverage for a continuous 6-month period of time prior to the date on which such individual is applying for coverage in the high risk pool program.

Creditable coverage criteria for FHRP is defined on the FHRP Application (Exhibit F) and covered in more detail within the Policy (currently being drafted. If needed as part of this Solicitation, we can provide).

c) Meets the pre-existing condition requirement established for a qualified high risk pool. HHS anticipates that Contractors will use methods to define pre-existing condition that include, but are not limited to:

i) Evidence of denial of coverage.

A letter of denial or refusal to issue coverage will be addressed within the application process and will require that the supporting documentation be submitted along with the completed application.

ii) Evidence that coverage is available only with an exclusionary rider.

If the applicant has existing coverage with an exclusionary rider, this will be addressed within the application process and will require that the supporting documentation be submitted along with the completed application.

iii) The presence of certain medical conditions specified by the State and approved by HHS.

This method of determination will not be used for FHRP. Only options "i and ii" above will be implemented in the program.

2) Describe the coverage and benefits to be offered by the qualified high risk pool. At a minimum, the response to this question must address the benefits elements contained in A.4.2 of the Statement of Work and include all benefit plan variations that may be proposed by the State.

A.4.2 (cont.)

2) Benefits Requirements – The qualified high risk pool may offer one or more benefit plans, provided that they are actuarially consistent with the statutory requirement that the issuer's share of the costs is not less than 65 percent of the total costs of the benefit. Contractors may propose the benefit and coverage structure to be used by the qualified high risk pools within the limits of their allotments.

Included as Exhibit G is the Schedule of Benefits for the $1,000 deductible plan. This benefit option will be offered applicants applying for health coverage in FHRP.

The Policy defining the benefit coverage and the Outline of Coverage is currently being drafted. If needed as part of this Solicitation, we can provide.

The current plan structure does include a Lifetime Maximum.

Maximum Lifetime Benefit means the maximum amount of benefits that FHRP will pay for Covered Expenses under this Policy and any previous or

subsequent CHIP Policy issued to you. The Maximum Lifetime Benefit is reflected in subsection C. of SECTION III—SUMMARY OF BENEFITS. In calculating the Maximum Lifetime Benefit, FHRP includes:

1) Covered Expenses we pay for In-Network Providers, Out-of-Network Providers and Prescription Drugs or Devices; and

2) Covered Expenses we paid under a previous FHRP Policy held by you, your current FHRP Policy and any subsequent FHRP Policies we issue to you.

3) How will the qualified high risk pool comply with the requirements to cover pre-existing conditions described in A.4.2.3?

A.4.2 (cont.)

3) A qualified high risk pool must provide to all eligible individuals that it enrolls in a qualified high risk pool, health coverage that does not impose any pre-existing condition exclusions with respect to such coverage, and may not deny enrollment based on a pre-existing condition.

The benefit option offered in FHRP will not be subject to pre-existing conditions nor will claims be subject to review and/or denial based on any pre-existing condition.

4) Describe how the qualified high risk pool will derive its premiums, including a description of its methodology in determining the standard risk rate.

A.4.2 (cont.)

4) The premiums charged under the high risk pool may not exceed 100 percent of the premium for the applicable standard risk rate that would apply to the coverage offered in the State or States. The qualified high risk pool shall determine a standard risk rate by considering the premium rates charged for similar benefits and cost-sharing by other insurers offering health insurance coverage to individuals in the applicable State or States. The standard risk rate shall be established using reasonable actuarial techniques. A qualified high risk pool may not use other methods of determining the standard rate, except with the approval of the Secretary. Premiums charged to enrollees in the qualified high risk pool may vary on the basis of age, by a factor not greater than 4 to 1.

See generally (Exhibit H) THRP Estimates (Final 2010-06-01).doc dated June 1, 2010 and (Exhibit I) THRP Attestation (Final 2010-06-01).doc dated June 1, 2010.

5) Describe the cost sharing structure of the benefit package(s) proposed to be offered by the qualified high risk pool that complies with the requirements outlined in A.4.2.~~7~~ 5.

A.4.2 (cont.)

5) The qualified high risk pool's average share of the total allowed costs of the required benefits must be at least 65 percent of such costs. The out-of-pocket limit of coverage for cost-sharing for the required benefits may not be greater than the applicable amount described in section 223(c)(2) of the Internal Revenue Code of 1986 for the year involved.

See page 2 of Exhibit I THRP Attestation (Final 2010-06-01).doc dated June 1, 2010.

6) If applicable, describe the provider network(s) proposed to be used by qualified high risk pool enrollees and demonstrate that the network(s) has a sufficient number and range of providers to ensure that all covered services are reasonably available and accessible in those networks.

A.4.2 (cont.)

6) A qualified high risk pool may specify the networks of providers from whom enrollees may obtain services. The qualified high risk pool must demonstrate to HHS that it has a sufficient number and range of providers to ensure that all covered services are reasonably available and accessible to its enrollees.

BlueAdvantage is able to provide an aggressive provider network arrangement. Arkansas Blue Cross directly contracts with all participating providers in the TrueBlue PPO which covers the state of Arkansas. We have contracts with all acute care hospitals in Arkansas and contracts (both direct or through the national BlueCard® program) with hospitals in contiguous counties in bordering states. More than 85 percent of all hospitals and physicians throughout the United States contract with Blue Cross and Blue Shield Plans. The BlueCard program allows members to receive the same health care benefits of their local Blue Plan while traveling or living out of their Plan's area.

In total, more than 9,400 health professionals and 116 hospitals participate in the TrueBlue PPO. This comprehensive network includes a full complement of ancillary providers under contract and meets and exceeds

consumer demand for provider choice. Network directories are updated daily and are available on-line or in print. Over 1.4 million members access the TrueBlue PPO network.

7) Describe the appeals and reconsiderations process that the qualified high risk pool proposes to make available to enrollees in the high risk pool program as per the description of section A.4.2.~~10~~ 7.

A.4.2 (cont.)

7) A qualified high risk pool shall establish and maintain procedures for individuals to appeal eligibility and coverage determinations. Minimally, the appeals procedures must provide enrollees and potential enrollees the right to a timely redetermination by the qualified high risk pool or its designee of a determination concerning eligibility or coverage, and the right to a timely reconsideration of a coverage redetermination by an entity independent of the qualified high risk pool or the entity designated to make that redetermination.

The following language below will be implemented within the Policy (currently being drafted. If needed as part of this Solicitation, we can provide).

a. If a claim for benefits is denied either in whole or in part, you will receive a notice explaining the reason or reasons for the denial. You may request a review of a denial of benefits for any claim or portion of a claim by sending a written request to the FHRP Appeals Coordinator, in care of BlueAdvantage Administrators, 320 W. Capitol Avenue, Suite 500, Little Rock, Arkansas 72201 or P.O. Box 1460, Little Rock, Arkansas 72203. Your request must be made within sixty (60) days after you have been notified of the denial of benefits.

b. In preparing your request for review, you or your duly authorized representative will have the right to examine documents pertinent to your claim. You or your duly authorized representative may submit, with your request for review, any additional information relevant to your claim and may also submit issues and comments in writing. A complete review will then be made of all information relating to your claim. You will receive a final decision in writing within sixty (60) days after the receipt of your review request, except where special circumstances require extensive review. A final decision will be sent to you after no longer than one hundred twenty (120) days.

c. If you are still not satisfied at this point, you have the right to file an appeal with the Grievance Committee of the Board of Directors of the Arkansas Comprehensive Health Insurance Pool within 30 days of the final decision of the FHRP Appeals Coordinator. The Grievance Committee shall act on the grievance within 60 days of the receipt of the grievance unless a later date is agreed to by you and the Grievance

Committee. You may make a final appeal to the full FHRP Board within 30 days of the determination of the Grievance Committee. You have the right to request a hearing before the Board upon request. The Board will act on your appeal within 30 days of receipt unless a later date is agreed to in writing by you and the Board.

d. Appeals to the Grievance Committee and Board as set forth in subparagraph (c) above must be addressed as follows:

FHRP
c/o John K. Harriman, Attorney
Mitchell, Williams, Selig, Gates & Woodyard, PLLC
P.O. Box 419
Little Rock, AR 72203

Procedures regarding our Utilization Review appeal process can be found in Exhibit J – Managed Care Functions.

C.4.3 Describe the qualified high risk pool's proposed eligibility determination and enrollment standards as outlined in Section A.4.3.

A.4.3 The Contractor shall perform all eligibility determination and enrollment functions.

1) The Contractor shall develop and utilize an eligibility determination process that will assure that only individuals eligible for coverage (as described in A.4.2.1) receive benefits from the program.

A.4.2

1) Eligibility for Individuals to Enroll in High Risk Health Insurance Pool Programs – The Contractor shall develop eligibility criteria for participation in a high risk pool subject to the approval of HHS. Generally, HHS anticipates

Contractors will develop criteria that include all of the requirements included in A.4.2.1.a and A.4.2.b Subject to the approval of HHS, the Contractor shall develop eligibility criteria meeting some or all of the elements included in A.4.2.1.c. That is an individual:

a) Is a citizen or national of the United States or lawfully present in the United States;

Applicants will be required to submit a SSN on their application. Additionally, Contractor will sign up for access to the Systematic Alien Verification for Entitlements (SAVE) Program. The SAVE Program is a program that the state of Arkansas currently utilizes to verify whether a person is a resident and/or legally present. "The SAVE Program is an inter-governmental initiative designed to aid benefit-granting agencies in determining an applicant's immigration status, thereby ensuring that only entitled applicants receive Federal, state, or local public benefits and licenses. The program is an information service for benefit-granting agencies, institutions, licensing bureaus, and other governmental entities." U.S. Citizenship and Immigration Services, About the SAVE Program, http://www.uscis.gov/portal/site/uscis/menuitem.eb1d4c2a3e5b9ac89243c6a7543f6d1a/?vgnextoid=e112feb9a2ca8210VgnVCM100000082ca60aRCRD&vgnextchannel=e112feb9a2ca8210VgnVCM100000082ca60aRCRD (accessed May 25, 2010).

The SAVE Program maintains eligibility requirements to participate and those eligibility criteria include: 1) that the agency be a Federal, state, or local government agency or licensing bureau; and 2) that the agency provide a public

benefit, license or otherwise be authorized by law to engage in an activity for which the verification of immigration status is appropriate.

Eligibility criteria regarding citizenship for FHRP is defined on the FHRP Application (Exhibit F), Outline of Coverage and covered in more detail within the Policy (both currently being drafted. If needed as part of this Solicitation, we can provide).

b) Has not been covered under creditable coverage for a continuous 6-month period of time prior to the date on which such individual is applying for coverage in the high risk pool program.

Creditable coverage criteria for FHRP is defined on the FHRP Application (Exhibit F) and covered in more detail within the Policy (currently being drafted. If needed as part of this Solicitation, we can provide).

c) Meets the pre-existing condition requirement established for a qualified high risk pool. HHS anticipates that Contractors will use methods to define pre-existing condition that include, but are not limited to:

FHRP Pre-Existing Condition is: 1) a condition which has manifested itself within the six (6) month period immediately preceding the effective date of your Policy in such a manner as would cause an ordinary, prudent person to seek diagnosis, care or treatment; or 2) medical advice, care or treatment was recommended to or received by you within the six (6) month period immediately preceding the effective date of your Policy.

i) Evidence of denial of coverage.

A letter of denial or refusal to issue coverage will be addressed within the application process and will require that the supporting documentation be submitted along with the completed application.

ii) Evidence that coverage is available only with an exclusionary rider.

If the applicant has existing coverage with an exclusionary rider, this will be addressed within the application process and will require that the supporting documentation be submitted along with the completed application.

iii) The presence of certain medical conditions specified by the State and approved by HHS.

This method of determination will not be used for FHRP. Only options "i and ii" above will be implemented in the program.

2) As part of the enrollment application process, the Contractor will obtain the name, address, date of birth and Social Security number of a person applying for coverage.

The FHRP applicant's information (name, address, date of birth and Social Security number) will be captured on the FHRP Application (Exhibit F).

3) The Contractor shall implement a process to confirm that the enrollee is a citizen or national of the United States or an alien lawfully present in the United States. The Contractor shall submit to HHS for approval a plan for verifying citizenship in accordance with the Affordable Care Act.

Applicants will be required to submit a SSN on their application. Additionally, Contractor will sign up for access to the Systematic Alien Verification for Entitlements (SAVE)

Program. The SAVE Program is a program that the state of Arkansas currently utilizes to verify whether a person is a resident and/or legally present. "The SAVE Program is an inter-governmental initiative designed to aid benefit-granting agencies in determining an applicant's immigration status, thereby ensuring that only entitled applicants receive Federal, state, or local public benefits and licenses. The program is an information service for benefit-granting agencies, institutions, licensing bureaus, and other governmental entities." U.S. Citizenship and Immigration Services, About the SAVE Program, http://www.uscis.gov/portal/site/uscis/menuitem.eb1d4c2a3e5b9ac89243c6a7543f6d1a/?vgnextoid=e112feb9a2ca8210VgnVCM100000082ca60aRCRD&vgnextchannel=e112feb9a2ca8210VgnVCM100000082ca60aRCRD (accessed May 25, 2010).

The SAVE Program maintains eligibility requirements to participate and those eligibility criteria include: 1) that the agency be a Federal, state, or local government agency or licensing bureau; and 2) that the agency provide a public benefit, license or otherwise be authorized by law to engage in an activity for which the verification of immigration status is appropriate.

4) The Contractor shall develop and operate an enrollment process that ensures eligible individuals timely access to benefits under the qualified high risk pool and that enrollment is maintained per the eligibility criteria established by the qualified high risk pool. The Contractor shall submit a description of the enrollment process to HHS for approval. HHS anticipates that, in general, the enrollment process proposed by the Contractor will provide that an individual eligible for enrollment who submits a complete enrollment request by the 15th day of a month must have coverage take effect by the 1st

day of the following month, except in exceptional circumstances that are subject to HHS approval.

On page 6 of the FHRP Application (Exhibit F) under "Effective Date" it reads "Subject to availability of the plan's enrollment limitation, an individual eligible for enrollment who submits a complete enrollment request by the 15th day of a month will have an effective date of the 1st day following the month. A complete application includes all required information and documentation required to complete processing". This is also addressed within the Policy (currently being drafted. If needed as part of this Solicitation, we can provide).

5) The Contractor shall develop and operate a disenrollment process. The Contractor shall submit a description of the disenrollment process to HHS for approval. HHS anticipates that the disenrollment process will include provisions that include, but are not limited to, policies for disenrolling an individual if the monthly premium is not paid on a timely basis; when an individual no longer resides in the qualified high risk pool's service area; when an individual obtains other creditable coverage; and, in the case of a death of the individual.

The disenrollment language below will be implemented within the Policy (currently being drafted. If needed as part of this Solicitation, we can provide).

WHEN THIS COVERAGE ENDS

Your thirty-day right to terminate. You may cancel this Policy within thirty (30) days after receiving it by returning the Policy to us or by completing a Change Request Form. If

you decide to cancel, any unearned premiums paid will be refunded.

Immediate termination without notice. This Policy will terminate automatically without notice on the date of your death, or if Arkansas law requires immediate cancellation.

Termination by FHRP upon 30 days' notice. FHRP may, at its option, terminate this Policy thirty (30) days after FHRP makes any written inquiry to you concerning eligibility or place of residence to which you do not reply.

Termination at the end of current monthly coverage period in which eligibility ends. This Policy will terminate automatically without notice at the end of the current monthly eligibility period for which you have paid premium, if during the monthly coverage period any insured person:

a. requests coverage to end;
b. is no longer a resident of Arkansas;
c. does not pay in full the required premium under this Policy, in which event the liability under this Policy shall be limited to benefits incurred under this Policy for the monthly coverage period for which premiums have been paid and the Insured Person remained eligible for coverage under this Policy;
d. has received a total of [$1,000,000] in FHRP benefits during his or her lifetime;
e. has committed a fraudulent insurance act as defined by the Arkansas Insurance Code, such as knowingly providing false evidence on an insurance Application;
f. we determine for any other reason under this Policy or by law that the Insured Person is no longer eligible for CHIP coverage;
g. has, obtains *or is eligible for* coverage substantially similar to or more comprehensive than this Policy under

a Group Health Plan, Part A or B of Medicare, a Medical Assistance Program or any Health Insurance Coverage (*except that* the Resident Eligible Person may maintain this Policy for the period of time he or she is satisfying a pre-existing condition waiting period under the Health Insurance Coverage or the Group Health Plan or any other coverage intended to replace this Policy);

h. becomes a resident of a public institution; or

i. has all or part of the premium paid for or reimbursed under any government sponsored program or by any government agency or health care Provider, except as an otherwise qualifying full-time employee, or dependent of such employee, of a government agency or health care Provider, or by one of the following in connection with a group health plan:

   i) person's current employer;

   ii) if there person is retired, by the person's former employer; or

   iii) if the person is a dependent of an employee or retiree, by the current or former employer of the employee or retiree; or

j. person has previously terminated plan coverage unless twelve (12) months have elapsed since termination of coverage.

Refusal to renew all Policies of the same form. We may refuse to renew your Policy if we refuse to renew all other Polices of the same form, and such nonrenewal is permitted or required under applicable law or regulation.

C.4.4 Describe the customer service functions and standards that will be employed by the qualified high risk pool program. The description should

include the qualified high risk pool's proposal for the staffing, hours of operation and service levels that the qualified high risk pool will provide to enrollees in the qualified high risk pool.

Included as Exhibit K is a description of the functions and standards for BlueAdvantage Customer Service.

A.4.4.2 – Capability to provide customer service and plan enrollment information in languages other than English

CHIP's Plan Administrator possesses the capability to provide customer service and plan enrollment information in Spanish, which is the largest anticipated minority population to be served by the FHRP in Arkansas.

C.4.5 Describe the technical support center to respond to health care and pharmacy providers for information that will be employed by the qualified high risk pool. The description should include the qualified high risk pool's proposal for the staffing, hours of operation and service levels that the qualified high risk pool will provide.

For Members:

CVS Caremark will provide call center services for FHRP. CVS Caremark provides customer service 24 hours a day, 7 days a week, through the following channels:

- Personal online access at CVS Caremark's Web site, available via My BluePrint
- Teams of representatives available 24/7 to help answer any questions
- Interactive voice response service, using phone keypad or speech recognition.

CVS Caremark is committed to longstanding industry leading customer service; therefore your calls will be serviced from their Richardson, Texas facility, recognized for customer satisfaction excellence through the prestigious J.D. Power Certified Call Center Program. J.D. Power recognizes CVS Caremark's call center operations and acknowledges them as providing An Outstanding Customer Service Experience – so your members will receive the same high quality service from each and every call center location. Customer Care Representatives have access to all retail, mail service, and paper claims data and use the same online system as CVS Caremark's retail network pharmacies and mail service pharmacies. The following information is available online:

- Member profile
- Utilization history
  - Record of all past prescriptions filled at the CVS Caremark Mail Service Pharmacy, or any network retail pharmacy
  - Notes from the pharmacist recorded at time of fill
- Complete FHRP Group Health plan design information
  - Covered drugs
  - Brand and generic copays
  - Coinsurance amount, if applicable
  - Member and dependent eligibility
- Pharmacy location(s) access by zip code
- Claims status and procedures (mail and retail)
- Location of a mail service prescription in the dispensing process
- Explanation of Benefit payments (when CVS Caremark reimburses)
- Explanation of Benefit denials (when CVS Caremark reimburses)
- Literature fulfillment information, including the status of any literature being mailed to a member

Additionally, Customer Care Representatives have access to a member-specific Comment History screen. The narrative information entered then becomes a permanent part of the member's record and provides a resource which can be audited if necessary. All Customer Care Representatives and CVS Caremark's Account Management teams are able to access the screen for future service inquiries.

CVS Caremark's representatives also have access to an online reference manual where FHRP plan related information is kept current and stored. Here, representatives will see sample communications provided to members, information regarding new initiatives, procedures specific to the FHRP membership, and other reference material.

Customer Care Representatives refer to their training, experience, and established online procedures when handling specific inquiries. If an inquiry is of a clinical nature, or if the caller specifically requests, the call will be transferred to a Clinical Care Services pharmacist. CVS Caremark's telecom system provides for easy transfer of calls from the representative to the pharmacist. They continually monitor the call queue for Clinical Care Services, and staffing adjustments are made as needed. All call transfers are warm transfers (i.e., the Customer Care Representative informs the pharmacist of the nature of the call, connects the caller, and introduces the pharmacist prior to releasing the call). Once the pharmacist has answered the caller's clinical questions, the call normally ends. Should the caller have remaining inquiries, the pharmacist may transfer the call back to a Customer Care Representative.

Customer Care Service Pharmacists are available Monday through Friday from 6:00 a.m. to 8:00 p.m. (CST) and on Saturday from 6:00 a.m. to 12:00 p.m. (CST). Pharmacists are available for emergency inquiries 24 hours a day, 7 days a week. The caller is referred to an after-hours call service that will page the pharmacist for a call back to the member within one hour. A Customer Care Representative will follow up with the member to ensure that a Clinical Pharmacist returned the call.

For Pharmacists:

A major component of pharmacy support is CVS Caremark's Pharmacy Help Desk, which provides pharmacists with access to Customer Care Representatives 24 hours a day, 7 days a week, including holidays.

Managed within CVS Caremark's Customer Care Operations division, the Pharmacy Help Desk is outsourced primarily, with a senior company manager on site to ensure the quality of service provided. If necessary, they can redirect calls to company representatives for overflow or redundancy purposes. Their centralized Command Center monitors call volume in a real-time environment to ensure that adequate service levels are maintained.

CVS Caremark's member Customer Care unit is aligned with their Pharmacy Help Desk to help ensure that members, pharmacists, and physicians receive consistent, accurate, and timely assistance with inquiries. CVS Caremark's Customer Care Center includes a Retail Customer Care team that works with and supports over 64,000 network pharmacies by troubleshooting point of service online claim transmissions. Retail Customer Care Representatives utilize view access to retail pharmacy electronic transactions to assist with eligibility, rejected claim resolution, and clarification of

all adjudicated claims. The retail Customer Care Representatives also provide triage support of inquiries regarding pharmacy payment, network enrollment, or other general contract support, providing the retail pharmacist with a single point of contact.

Pharmacists can dial CVS Caremark's toll-free number to select options from the Retail Services Interactive Voice Response menu for assistance. Those options include eligibility, rejected claim re-processing, and network questions. All pharmacy inquiries are authenticated prior to the release of any Protected Health Information (PHI). These services are available 24 hours a day, 7 days a week.

CVS Caremark's Pharmacy Help Desk is led by a Management team that is in constant communication with their Account Services unit, their Customer Care unit, and other supporting areas – which results in greater consistency and availability of the most up-to-date information.

C.4.6 Describe the qualified high risk pool's system for billing, collecting, and accounting for premiums.

FHRP policyholders elect to either have premiums drafted monthly from a bank account or pay quarterly by check. Premium billings are produced monthly for Monthly Bank Drafts as well as Quarterly members based on current membership and finance records maintained in AMISYS. Policyholders set up on the quarterly billing cycle are mailed a printed invoice and return envelope at least ten days prior to the due date. Policyholders set up on the monthly bank draft (Electronic billing cycle have premiums withdrawn from their bank account on the 5th day of the month (or the next

business day if the 5th falls on a weekend or holiday). A printed invoice is not sent to members whose premiums are paid by bank draft.

BlueAdvantage sends manual billings to policyholders with delinquent accounts, insufficient funds, or returned personal checks and performs a follow-up on manual bills approximately three weeks after the mail date. If BlueAdvantage receives a partial payment (i.e., one month's premium received for a quarterly billing cycle), they return the payment to the policyholder with a letter stating that partial payments are not accepted.

If a policyholder is cancelled due to non-payment of premiums, BlueAdvantage mails a Certificate of Creditable Coverage to the policyholder as a notice that their policy is no longer active. If a refund of premiums is due, BlueAdvantage mails a refund check to the member.

For policyholders who elect quarterly billing, the majority of payments will go to a lockbox where coupons are delivered daily by courier and data is transmitted daily. Payments received in person, or mailed directly to BlueAdvantage, are placed in a secure area for the finance department to retrieve daily.

BlueAdvantage records and posts all payments into AMISYS and reconciles them to the banking daily deposit each day. BlueAdvantage reconciles the bank account and AMISYS on a monthly basis.

C.4.7 If the qualified high risk pool intends to develop and implement utilization and care management as part of the qualified high risk pool coverage,

describe the utilization and care management processes that the qualified high risk pool proposes to use.

Included as Exhibit J is a description of the key managed care functions for BlueAdvantage.

C.4.8 Describe the system for processing and paying for health and prescription drug claims that will be implemented by the qualified high risk pool. The description should include the basis for payment rates and the timeliness of payments to providers. The description should also include the point of sale claim system that will be utilized for prescription drug claims.

The skills of registered pharmacists, combined with CVS Caremark's technologically advanced online adjudication system, make for the most efficient point-of-service pharmacy benefit. Our standard online DUR, plan design, and safety edits complement and enhance the clinical expertise of our registered pharmacists. Equipped with these tools, they can dispense drugs more cost effectively and with greater safety.

Because all CVS Caremark retail network pharmacies are online, they can transmit claims electronically for verification of plan design and DUR. Our online claims adjudication system is available 24 hours a day, 7 days a week, every day of the year. In addition, our network pharmacies can transmit claims through any of the switching companies (e.g., Relay Health (formerly known as Per-Se or NDC Health); Emdeon (formerly known as WebMD or Envoy); QS1, etc) or by maintaining a direct link to our data center.

<u>Member Identification</u>

A member simply presents a prescription to the network pharmacist, along with his/her ID card. Since eligibility is verified online, the ID card serves only as a convenient reference to the member's plan information for the pharmacist.

Recording of Prescription Data

The pharmacist inputs the following information prior to transmitting the claim to CVS Caremark for adjudication:

- Plan ID
- Days' supply
- Member number
- NDC number
- Relationship code
- Compound
- Gender
- Ingredient cost
- Date of birth
- Total price
- Date of service
- Prescriber ID
- Rx number
- DAW code
- New/refill number
- Usual and customary
- Metric decimal quantity.

Data Transmission

The pharmacist transmits network claims to our system based on member eligibility, drug coverage, drug interactions, and copay/coinsurance specifications – all according to plan parameters. Using an established electronic data transfer network and available 24/7, the system is designed specifically to handle prescription drug claims.

Claims Adjudication

Our system applies each claim against the client's plan parameters for a specific member. When the claim is processed, the system applies hundreds of edits within seconds, to verify the following:

- The claim is from a participating pharmacy
- The member (or dependent) is eligible
- The drug meets plan parameters
- The appropriate quantity and days' supply of the medication were dispensed
- The claim is priced accurately
- The claim has not been duplicated or previously paid.

To help ensure complete safety before the medication is dispensed, the system alerts the pharmacist immediately to the results of the drug utilization review edits. In addition, it transmits the member's copay/coinsurance amount to the pharmacy within seconds.

Prescription Dispensing

Following adjudication, the pharmacist receives a message confirming that the claim has been approved or rejected. If the claim has been approved, the pharmacist's terminal designates it as payable, and the price and copay appear on the pharmacist's terminal as determined by the system. Once the claim has been adjudicated, the member submits the applicable copay and receives the medication, along with a receipt indicating the prescription number, the date, and the amount paid.

Rejected or Denied Claims

A claim that has not been submitted properly by the pharmacy is rejected. Each electronic data transfer claim that is rejected carries an electronic message with the reason for the rejection.

Pharmacy Reimbursement Frequency

We reimburse each of our network pharmacies weekly, based on the contracts we hold with those pharmacies and in accordance with all state laws and regulations.

C.4.9 Describe the qualified high risk pool's proposed efforts to conduct outreach and marketing for the high risk pool program.

Marketing efforts will be focused through two primary channels of communications. First, information concerning the FHRP will be published in newspaper of general circulation throughout the state of Arkansas. Second, flyers will be sent to life and health agents within the state informing them of the criteria and availability of the pool. Lastly, the FHRP will have a website presence which

consumers will be able to access through a link posted in CHIP's current website. Additional marketing and outreach may be utilized or employed on an "as needed" basis. The administering insurer also will attend monthly agent meetings to provide information as well as coordinating with the Workforce agency in the State of Arkansas to provide information relating to FHRP.

C.4.10 Describe the process the qualified high risk pool proposes to use to identify and report to HHS instances in which health insurance issuers or group health plans are discouraging high-risk individuals from remaining enrolled in their current coverage in compliance with A.4.10.

In its application (a copy of which is attached herewith as Exhibit F), CHIP will utilize and employ all of the three (3) methods listed below to identify and report to HHS instances where health insurance issuers or group health plans are discouraging high-risk individuals from remaining enrolled in their current coverage in instances in which such individual subsequently are eligible enroll in the qualified high risk pool. In addition, as is the practice in CHIP, the current state high risk pool, in an effort to ensure that each enrolled individual continues to meet eligibility criteria, a Residency Affidavit will be sent out annually for policyholders to complete and return.

1) Questions to identify applicants (or their family members) that are employed, may have, or have had, access to other coverage including employment based group health coverage, or are getting assistance in the payment of premiums for the qualified high risk pool from employers or other sources.

2) Questions asking applicants to identify their most recent health coverage and the reasons for leaving or losing that coverage.
3) Requirement that enrollees report changes in their employment status (or that of a family member) during the course of enrollment.

C.4.11 Describe the procedures that qualified high risk pool proposes to implement to prevent, detect, and report incidences of waste, fraud, and abuse.

CHIP will utilize a layered system to address the above-referenced items. First, our application has been designed in a manner to prevent abuses, waste and fraud as it relates to the pool. Second, regular Board meetings will be utilized so that the accounting, actuarial, administrative and legal team can discuss and ascertain potential inconsistencies or other irregularity which could indicate fraud or other wasteful activities. The CHIP Board is made up of 7 member representatives, four (4) of which have a vast knowledge of the insurance industry by being current or former representatives of insurance companies and health maintenance organizations licensed to do business in the State of Arkansas. Third, we utilize annual financial and claims audits to help identify abuses, fraud, or other wasteful activity. Every effort will be made, within the law, to recover monies wrongfully spent in relation to FHRP. Furthermore, CHIP will immediately report all significant instances of waste, fraud or abuse to HHS. When necessary, we will also utilize the AID Fraud Unit.

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C.4.12 Describe the system for routine monitoring and identification of compliance risks.

CHIP will implement routine monitoring and identification of compliance risks to detect and prevent fraud and other wasteful behavior. Such procedures will include internal monitoring and audits to evaluate the high risk pool program, including any sub-contractors utilized by the program, in terms of compliance with HHS requirements. These same procedures will be utilized to insure that CHIP is and remains in compliance with all applicable laws and regulations, including the Patient Protection & Affordable Care Act, P.L. 111-148 of 2009, HIPAA Privacy Regulations 45 C.F.R. §164.502(e); 160.103; 164.504(e), Gramm Leach Bliley Act of 1999, Arkansas Insurance Department Rule & Regulation 74. The administering insurer will perform internal monitoring and audits to evaluate the compliance of the FHRP, including maintenance of security and audit procedures to account for all premium payments received and self-monitoring claim adjudication performance through internal audits for performance against standards in contracts, including: enrollment cards issuance, claims processing, customer service, administrative efficiencies, overpayment collection and fraud investigation, subrogation and appropriateness of lump sum claims. The Board shall have the right to audit, upon commercially reasonable notice, all records maintained by the Administering Insurer that relate to services provided to FHRP by the Administering Insurer and all functions under the Contract. The Administering Insurer shall provide the Board or its designee with access to all such records for audit purposes during normal working hours. CHIP subcontracts with legal counsel, an actuarial firm, an accounting firm and an auditing firm. Contained within the subcontracting

agreements are clauses that require those subcontractors to meet state required licensing and any and all federal requirements applicable to the subcontractors. CHIP will hold regular Board meetings that allow review of all CHIP activity. A checks and balances system is in place whereby checks paid to sub-contractors are reviewed and signed by two (2) Board members. Additionally, information is captured on the FHRP application to ensure that any agents involved in the application process are licensed in compliance with state law.

C.4.13 Describe the system the qualified high risk pool proposes to implement to coordinate benefits as described in A.4.13.

A.4.13 The Contractor shall develop and implement a system for coordinating benefits for health and prescription drug claims with other payers as needed, such as Workers' Compensation.

If BlueAdvantage has reason to believe that a FHRP policyholder has or obtains other coverage, BlueAdvantage will mail a Coordination of Benefits (COB) Questionnaire or Medicare Questionnaire, as applicable, to the policyholder requesting verification of coverage, type of coverage, and effective date of coverage.

If it is deemed that coverage should be coordinated with the FHRP policy, the COB information is loaded into AMISYS and claims are coordinated based on FHRP policy guidelines. If it is deemed that coverage should not be coordinated with the FHRP policy, the policy may be rescinded or retro-terminated to the original effective date or the effective date of the other policy, as appropriate.

If the policy is terminated, a letter is mailed to the policyholder explaining the termination of coverage and refunds are requested from providers on any paid claims after the termination date. If applicable, premium refunds are mailed to the policyholder.

Claims involving possible subrogation are considered based on a pay and pursue basis. BlueAdvantage uses an external vendor, Health Care Recoveries, Incorporated, to investigate and recoup refunds on subrogated claims. BlueAdvantage sends the vendor a weekly paid claims data tape, which the vendor edits against software that looks at the diagnosis, procedures, accident flags, etc. BlueAdvantage takes the lead in resolving and approving subrogation claims and consults the CHIP Board as necessary.