ATTACHMENT A-7: Administrative Fees - BAFO #1

Provide the monthly administrative fee per Subscriber (PSPM) broken out by service item. Do not leave the data field blank for any service item line. If there is not a separate allocation for the service item indicate such by inserting "included" in the field. The total PSPM fee should include all administrative fees for all services proposed and for all covered Subscribers. Approximate number of total Plan Non-Medicare Members: **528,648** approximate number of total Plan Subscribers: **333,446**, approximate number of total Plan Medicare Members: 50,177; approximate number of Subscribers: 47,825. Based on June 2022 enrollment (Fees will exclude actual claims payments).

All costs, except actual claim payments for covered Members, must be included below. Unspecified fees and other expenses will not be paid by the Plan.

*Offerors are encouraged to quote additional services not included in the pre-populated list. Additionally, if there are services which if selected by the Plan reduce the monthly administrative fee per Subscriber, list those services and the applicable reduction to the monthly administrative fee. For example, list any savings if electronic EOBs are selected vs. paper EOBs. Include additional documentation for any additional services or discounts as appropriate.

TABLE A-7.1: Monthly TPA Fees

Service Item Per Subscriber Administrative Fee Based on Total Subscribers

	Initial Contract Term			1st Renewal Period	2nd Renewal Period
	01/01/25 -12/31/25	01/01/26 - 12/31/26	01/01/27 - 12/31/27	01/01/28 -12/31/28	01/01/29 - 12/31/29
Standard Services PSPM					
Claims Administration	$ 22.75	$ 22.75	$ 22.75	$ 23.43	$ 24.14
Customer Service	Included	Included	Included	Included	Included
ID Cards	Included	Included	Included	Included	Included
Utilization Review	Included	Included	Included	Included	Included
Medical Management	Included	Included	Included	Included	Included
Network Access	Included	Included	Included	Included	Included
Appeals	Included	Included	Included	Included	Included
Enrollment/EDI Reconciliation	Included	Included	Included	Included	Included
Outbound Data Files	Included	Included	Included	Included	Included
Secure Member Portal	Included	Included	Included	Included	Included
Audits	Included	Included	Included	Included	Included
Standard Reporting	Included	Included	Included	Included	Included
Custom Reporting	Included	Included	Included	Included	Included
Ad Hoc Reporting	Included	Included	Included	Included	Included
Other (list and describe as needed)	Included	Included	Included	Included	Included
Aetna Concierge (Dedicated Customer Service/Claims)	Included	Included	Included	Included	Included
24 Hour Dedicated Nurse Line	Included	Included	Included	Included	Included

Individual ID Cards (custom)	Included	Included	Included	Included	Included
Management	Included	Included	Included	Included	Included
Dedicated Account Manager	Included	Included	Included	Included	Included
Dedicated Account Executive	Included	Included	Included	Included	Included
Dedicated Implementation Manager	Included	Included	Included	Included	Included
Dedicated Provider Call Center	Included	Included	Included	Included	Included
Dedicated Member Services Team	Included	Included	Included	Included	Included
Integration with Stop Loss Vendor	Included	Included	Included	Included	Included
Wellness Allowance (Annual) $1,000,000	Included	Included	Included	Included	Included
Communication Allowance (Annual) $1,000,000	Included	Included	Included	Included	Included
Standard Services Fees - Subtotal	$ 22.75	$ 22.75	$ 22.75	$ 23.43	$ 24.14

TABLE A-7.1 (continued): Monthly TPA Fees					
Service Item Per Subscriber Administrative Fee Based on Total Subscribers					
Additional Services PSPM					
Health Savings Accounts (HSA)	$ 1.25	$ 1.25	$ 1.25	$ 1.29	$ 1.33
Health Reimbursement Accounts (HRA)	$ 2.45	$ 2.45	$ 2.45	$ 2.52	$ 2.60
Assume Claims Fiduciary Liability	Included	Included	Included	Included	Included
Exception processing	Included	Included	Included	Included	Included
1095 Reporting	Included	Included	Included	Included	Included
Various required filings (including New York and Massachusetts surcharge filing, and Michigan Public Act 142 filing)	Included	Included	Included	Included	Included
Telehealth services	Included	Included	Included	Included	Included
Annual OE Plan Vendor testing	Included	Included	Included	Included	Included
Other (list and describe as needed)					
Subrogation (Optional)	$ 0.95	$ 0.95	$ 0.95	$ 0.98	$ 1.01
Additional Services Fees - Subtotal	$ 4.65	$ 4.65	$ 4.65	$ 4.79	$ 4.93

Credit/Savings					
Electronic EOB Adoption	Included	Included	Included	Included	Included
Other					
Subtotal Credits/Savings	Included	Included	Included	Included	Included
Total Cost (PSPM) excludes additional Service Fees outlined for HSA, HRA, Subrogation	$ 22.75	$ 22.75	$ 22.75	$ 23.43	$ 24.14

Monthly Administrative Fees Based on Non-Medicare Lives (Excludes Medicare Primary)

TABLE A-7.1: (continued) Monthly TPA Fees					
Service Item Per Subscriber Administrative Fee Based on Total Non-Medicare Primary Members					
	Initial Contract Term			1st Renewal Period	2nd Renewal Period
	01/01/25 -12/31/25	01/01/26 - 12/31/26	01/01/27 - 12/31/27	01/01/28 -12/31/28	01/01/29 - 12/31/29
Service Item					
Disease Management	Included	Included	Included	Included	Included
Care Coordination	Included	Included	Included	Included	Included
Lifestyle Coaching	Included	Included	Included	Included	Included
Transition of Care	Included	Included	Included	Included	Included
High Utilizer Programs	Included	Included	Included	Included	Included
Complex Case Management	Included	Included	Included	Included	Included
PHM Services via Secure Member Portal	Included	Included	Included	Included	Included
Digital Coaching	Included	Included	Included	Included	Included
Health Risk Assessment	Included	Included	Included	Included	Included
Other (list and describe as needed)					
Behavioral Health Wellbeing	Included	Included	Included	Included	Included
Medication Therapy Management	Included	Included	Included	Included	Included
Opioid Case Management	Included	Included	Included	Included	Included
24/7Nurse Hotline	Included	Included	Included	Included	Included
Total PSPM Additional Services Fee	$ -	$ -	$ -	$ -	$ -

One-time Administration Fees/Credits - TPA Standard Products & Population Health Management

Provide and describe any applicable one-time administrative fees or credits including any applicable conditions, requirements or restrictions related to the charge or credit. Do not leave any data field blank. If there is not a separate one-time charge or credit for the item indicate the fee/credit is not applicable by inserting "N/A" in the field The total should include all onetime administrative fees and credits for all services proposed and for all covered Subscribers/Members.

Specify the expected timing of invoicing for payment of one-time fees and the application of onetime credits, including whether fees will be payable and credits applied in installments .

Offerors may quote additional one-time fees and credits not included in the pre-populated list.

TABLE A-7.2: Onetime Fees/Credits, TPA Standard Products & Population Health Management			
Onetime Fees	**Amount**		**Invoice timing and frequency**
Initial TPA Implementation Credit	$1,000,000		Year 1 only
Single Sign-on Implementations	Included		
Termination Fee 18 month claims run-out	Included		

New Vendor Data Files	Included		
Web customization to support Plan Programs	Included		
Expanded call center hours during OE	Included		
Other (list and describe as needed)			
Total Onetime Credits/Fees	**$1,000,000**		

TABLE A-7.3: Per Participant Fees, Biometric Screenings					
Per Participant Fee for each type of screening performed					
	Initial Contract Term			1st Renewal Period	2nd Renewal Period
	01/01/25 -12/31/25	01/01/26 - 12/31/26	01/01/27 - 12/31/27	01/01/28 -12/31/28	01/01/29 - 12/31/29
Screening Type					
Onsite Biometric Screening 1: Finger Stick, Full Lipid Panel, Blood Glucose or A1c (for diabetics only), Blood Pressure, Height, Weight, BMI Calculation, Waist Circumference, and Counseling	$ 46.40	$ 46.40	$ 46.40	$ 46.40	$ 46.40
Onsite Biometric Screening 2: Finger Stick, Full Lipid Panel, A1c (all), Prediabetes Paper Test (for non-diabetics), Blood Pressure, Height, Weight, BMI Calculation, Body Composition including Waist Circumference or Waist-to-Hip Ratio and other methods, and Counseling	$ 46.40	$ 46.40	$ 46.40	$ 46.40	$ 46.40
Other (list and describe as needed)					
Biometric Screenings Fees - Total					

Is Contractor willing to offer a multi-year fee rate cap for TPA Services?

Yes

If yes, provide cap and explain.

Aetna has offered 3 Year flat fees with 3% escalators in Years 4 and 5.

ATTACHMENT A-8: NETWORK PRICING GUARANTEES - BAFO #1

Indicate the expected improvement on provider reimbursement arrangements by completing the exhibits on the "Guarantees (In State)" and "Guarantees (Out of State)" tabs.

The State Health Plan seeks the most favorable pricing from providers in the selected network and **seeks a contractor that is confident enough in its ability to secure discounts to assume the full risk for any shortfall in the contracted pricing guarantees**. From each bidder, the Plan is seeking (1) discount guarantees, (2) guarantees not to exceed a percentage of the fees charged by Medicare, and (3) guarantees to stay below an overall PMPM trend level. Bidders must provide the guarantee levels requested below and indicate whether they are willing to be at-risk for the full impact of any missed guarantees or a percentage of the full impact (with a minimum of 10% of the amount by which the guarantee was missed). Bidders will be scored on the guarantee levels and the amount placed at-risk. Guarantees can improve from one year to the next but should not become less favorable over time.

At the completion of each plan year, the Contractor shall provide an analysis of its performance against the guarantees. Guarantees will be calculated using claims from active employees and non-Medicare retirees; claims from Medicare retirees are excluded from the calculations.

Network Pricing Guarantees Impact on Projected Costs

Bidders should consider the following when providing their expected improvement in contracted discounts:

- Discount improvements will only be reflected in projected costs to the extent the Vendor is willing to provide shortfall guarantees on a dollar-for-dollar basis. **Discount improvements without guarantees will not be reflected in the projected cost analysis and guarantees not on a dollar-for-dollar basis will only be reflected up to the dollar amount at-risk.**
- The State's expectation is that the following methodology will be used to calculate the average discount for the purposes of the dollar-for-dollar discount guarantee in each of the three contract years. Deviations from this methodology that diminish the value of the guarantee may result in no credit.

Network Discount Guarantee Methodology – for ALL In-Network Claims

- Large claims over $250,000 can be removed from the measurement. While bidders are requested to include all claims regardless of amount in their claims repricing and contracted future discounts, removing large claims over $250,000 will be permitted in the discount guarantee calculation to offset the risk of unforeseen large claims.
- Covered Billed Charges = Total of all facility and professional provider submitted charges minus non-covered charges, ineligible amounts, COB (Coordination of Benefits) and Medicare savings
- Network Savings = Covered Billed Charges minus Cost of Benefits (prior to plan design)
- Achieved Discount % Savings = Network Savings divided by Covered Billed Charges

ATTACHMENT A-8: NETWORK PRICING GUARANTEES (In State) - BAFO #1

Proposer:	Aetna Life Insurance Company
Network:	Broad CPII Network

The State Health Plan seeks the most favorable pricing from providers in the selected network and seeks a contractor that is confident enough in its ability to secure discounts to assume the full risk for any shortfall in the contracted pricing guarantees. From each bidder, the Plan is seeking (1) discount guarantees, (2) guarantees not to exceed a percentage of the fees charged by Medicare, and (3) guarantees to stay below an overall PMPM trend level. Bidders must provide the guarantee levels requested below and indicate whether they are willing to be at-risk for the full impact of any missed guarantees or a percentage of the full impact (with a minimum of 10% of the amount by which the guarantee was missed). Bidders will be scored on the guarantee levels and the amount placed at-risk. Guarantees can improve from one year to the next but should not become less favorable over time.

At the completion of each plan year, the Contractor shall provide an analysis of its performance against the guarantees. Guarantees will be calculated using claims from active employees and non-Medicare retirees; claims from Medicare retirees are excluded from the calculations.

	Initial Contract Term			1st Renewal Period	2nd Renewal Period
	01/01/25 - 12/31/25	01/01/26 - 12/31/26	01/01/27 - 12/31/27	01/01/28 -12/31/28	01/01/29 - 12/31/29
Discount Guarantees					
Inpatient Facility Discount (%) (e.g., 50% discount)					
Fees At-Risk (select from dropdown list)	% of shortfall	% of shortfall	% of shortfall	% of shortfall	% of shortfall
Percentage of Shortfall (if selected from dropdown) **MINIMUM 10%**	20%	20%	20%	20%	20%
Additional Info/Explanation of Calculation of Fees At-Risk	Refer to the explanation provided under the Composite Target Discount section below.				
Outpatient Facility Discount (%) (e.g., 50% discount)					
Fees At-Risk (select from dropdown list)	% of shortfall	% of shortfall	% of shortfall	% of shortfall	% of shortfall
Percentage of Shortfall (if selected from dropdown) **MINIMUM 10%**	20%	20%	20%	20%	20%
Additional Info/Explanation of Calculation of Fees At-Risk	Refer to the explanation provided under the Composite Target Discount section below.				
Professional Fees Discount (%) (e.g., 50% discount)					
Fees At-Risk (select from dropdown list)	% of shortfall	% of shortfall	% of shortfall	% of shortfall	% of shortfall
Percentage of Shortfall (if selected from dropdown) **MINIMUM 10%**	20%	20%	20%	20%	20%
Additional Info/Explanation of Calculation of Fees At-Risk	Refer to the explanation provided under the Composite Target Discount section below.				
Composite Target Discount (%) Combined In and Out of State					
Fees At-Risk (select from dropdown list)	% of shortfall	% of shortfall	% of shortfall	% of shortfall	% of shortfall
Percentage of Shortfall (if selected from dropdown) **MINIMUM 10%**	20%	20%	20%	20%	20%
Additional Info/Explanation of Calculation of Fees At-Risk	Aetna is providing a network discount guarantee covering the active employee and non-Medicare retiree population for Inpatient facility, Outpatient facility and Professional Services by placing up to 25%, (~$22,475,000) of the administrative fees at risk on an annual basis. This guarantee will be reconciled at year end annually on an aggregate basis to the overall aggregate target reflecting the enrolled membership during the policy year. The aggregate target is calculated using the individual components weighted at a market-level utilization rate. The total amount of administrative fees at risk across all guarantees in this document is 45% (~$40,460,000) annually.				
Percent of Medicare Guarantees					
Inpatient Facility Costs (%) (e.g., 135% of Medicare)					
Fees At-Risk	% of overage	% of overage	% of overage	% of overage	% of overage
Percentage of Overage (if selected from dropdown) **MINIMUM 10%**	10%	10%	10%	10%	10%
Additional Info/Explanation of Calculation of Fees At-Risk	Refer to the explanation provided under the Composite Percent of Medicare Guarantee section below.				
Outpatient Facility Costs (%) (e.g., 135% of Medicare)					
Fees At-Risk	% of overage	% of overage	% of overage	% of overage	% of overage
Percentage of Overage (if selected from dropdown) **MINIMUM 10%**	10%	10%	10%	10%	10%
Additional Info/Explanation of Calculation of Fees At-Risk	This is inclusive of all outpatient claims including Specialty Pharmacy. Refer to the explanation provided under the Composite Percent of Medicare Guarantee section below.				
Professional Costs (%) (e.g., 135% of Medicare)					
Fees At-Risk	% of overage	% of overage	% of overage	% of overage	% of overage
Percentage of Overage (if selected from dropdown) **MINIMUM 10%**	10%	10%	10%	10%	10%
Additional Info/Explanation of Calculation of Fees At-Risk	Refer to the explanation provided under the Composite Percent of Medicare Guarantee section below.				
Composite Percent of Medicare Guarantees					
Fees At-Risk	% of overage	% of overage	% of overage	% of overage	% of overage
Percentage of Overage (if selected from dropdown) MINIMUM 10%	10%	10%	10%	10%	10%
Additional Info/Explanation of Calculation of Fees At-Risk	Aetna is providing a Percent of Medicare Guarantee covering the active employee and non-Medicare retiree population for Inpatient facility, Outpatient facility and Professional Services by placing up to 20%, (~$18,000,000) of the administrative fees at risk on an annual basis. This guarantee will be reconciled at year end annually on an aggregate basis to the overall aggregate target reflecting the enrolled membership during the policy year. The aggregate target is calculated using the individual components weighted at a market-level utilization rate. The total amount of administrative fees at risk across all guarantees in this document is 45% (~$40,460,000) annually.				
Trend Guarantee					
Annual PMPM Incurred Medical Cost Trend (%) (e.g., 6%)					
Fees At-Risk		% of overage	% of overage	% of overage	% of overage
Percentage of Overage (if selected from dropdown)		20%	20%	20%	20%

Additional Info/Explanation of Calculation of Fees At-Risk	Trend guarantee begins in Year 2. Guarantee is percent increase over prior year.	Aetna is providing an annual trend guarantee covering the entire active employee and non-Medicare retiree population on an annual basis by placing up to 25% (~$22,475,000) of the administrative fees at risk on an annual basis starting in year 2. Each year an actual claim PMPM will be calculated and compared to the prior year's results. For each full percentage point of trend above the annual guaranteed trend figure Aetna will return 3% of the administrative fees to an annual maximum of 25% (~$22,475,000). The total amount of administrative fees at risk across all guarantees in this document is 45% (~$40,460,000) annually.	Aetna is providing an annual trend guarantee covering the entire active employee and non-Medicare retiree population on an annual basis by placing up to 25% (~$22,475,000) of the administrative fees at risk on an annual basis starting in year 2. Each year an actual claim PMPM will be calculated and compared to the prior year's results. For each full percentage point of trend above the annual guaranteed trend figure Aetna will return 3% of the administrative fees to an annual maximum of 25% (~$22,475,000). The total amount of administrative fees at risk across all guarantees in this document is 45% (~$40,460,000) annually.	Aetna is providing an annual trend guarantee covering the entire active employee and non-Medicare retiree population on an annual basis by placing up to 25% (~$22,475,000) of the administrative fees at risk on an annual basis starting in year 2. Each year an actual claim PMPM will be calculated and compared to the prior year's results. For each full percentage point of trend above the annual guaranteed trend figure Aetna will return 3% of the administrative fees to an annual maximum of 25% (~$22,475,000). The total amount of administrative fees at risk across all guarantees in this document is 45% (~$40,460,000)	Aetna is providing an annual trend guarantee covering the entire active employee and non-Medicare retiree population on an annual basis by placing up to 25% (~$22,475,000) of the administrative fees at risk on an annual basis starting in year 2. Each year an actual claim PMPM will be calculated and compared to the prior year's results. For each full percentage point of trend above the annual guaranteed trend figure Aetna will return 3% of the administrative fees to an annual maximum of 25% (~$22,475,000). The total amount of administrative fees at risk across all guarantees in this document is 45% (~$40,460,000) annually.
Other Guarantees (Encouraged but not Required)					
Explain:	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Fees At-Risk	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Additional Info/Explanation of Calculation of Fees At-Risk	Not Applicable				

Describe your proposed formula for determining the actual performance against expected or quoted pricing guarantees?

Discount Guarantee:
The aggregate guaranteed percentage is calculated using the billed eligible charges by Inpatient Hospital, Outpatient Hospital and Physician/Other weighted by geographic utilization for active and non-Medicare primary employees.
The achieved discount percentage is calculated Negotiated Savings/Eligible Billed Charges, after removing large claimants over a $250,000 threshold and Non-facility claims where the eligible billed charges are within three percent of the contractual allowed amount.
Negotiated Savings and Eligible Billed Charges follow the definition in the Industry Uniform Discount Data Specification; which also outlines various standard exclusions (e.g. claims where Aetna is a secondary payer on the claim, etc.)
These calculations are made using data from the Aetna Informatics® data warehouse and include three months of run-off experience.

** The final fee adjustment in case of a discount shortage is calculated as below:
Minimum of % of discount shortage x 20% x The billed eligible charge as defined above and 25% of total annual fee

The total fee adjustment based on all guarantees will not exceed 45% of total annual fee.

For the % of Medicare Guarantee:
For Inpatient, Outpatient, Ambulatory Surgical Centers and Professional/Ancillary claims where Medicare allowable charge are available, Aetna shares claims data with a third-party vendor for repricing through its Medicare Grouper to return Medicare allowable rates where available. The aggregate percentage is calculated as the Aetna allowed spend where Medicare allowed is available/Medicare allowable returned. The percentage of Medicare will be determined using Aetna's contracted providers located in North Carolina, South Carolina, and Virginia inclusive of arrangements available to the State of North Carolina (e.g. custom rates, etc.).

The final fee adjustment in case of a % of Medicare overage is calculated as below:
Minimum of % of overage / 216% x 10% x State of NC Allowed Amount (where Medicare allowable rates are available) and 20% of total annual fee

The total fee adjustment based on all guarantees will not exceed 45% of total annual fee.

For the Trend Guarantee:
We calculate target allowed claims per-member, per-month (PMPM) by multiplying base year claims times the net allowed trend adjustment. Processed claim amounts in excess of $250,000 for any individual claimant are excluded from the total allowed claims of both the base year and the guarantee period. Medical claims exclude pharmacy and specialty pharmacy claims, including those paid under the medical plan. Six months of runout data will be included in the calculation for the base and guarantee periods.

To ensure that we are comparing the base year and the projection year on the same basis, we adjust base year claims for factors impacting the relativity of the population such as changes in plan design, demographics, geography, included products, programs and services, third-party vendor solutions, or the impact of novel conditions.

We reserve the right to revise the guarantee if any of the following conditions are not met:
•The products, programs and services match those assumed in our proposed offer.
•Pharmacy Data: We receive pharmacy data file feeds at a minimum bi-weekly basis to support the care management program.
•Enrolled subscribers: The enrolled active employee and non-Medicare retiree population does not vary in size by more than 10 percent from the assumed enrollment of 333,445, or from the average enrollment in the base year.
•The Medical Trend Guarantee is considered met if:
•You terminate your Aetna medical plan in whole or in part (defined as a 50 percent or greater membership reduction from the membership we assumed in this proposal) prior to the end of the multi-year guarantee period, December 31, 2029.
•We do not receive all standard data submissions by December 7, 2024 (samples can be provided upon request).

The total fee adjustment based on all guarantees will not exceed 45% of total annual fee.

Describe the management information that you will provide SHP to support the year-end performance results.

The reconciliation of our guarantees will be included as part of the annual accounting package.

Provide samples of existing agreements, if any, that your network has used with other large plan sponsors to meet network discount targets or other network pricing guarantees.

Please refer to Attachment A-8.b Sample Existing Agreement for the sample documents.

Would you consider a gain-sharing arrangement off a negotiated PMPM claims cost? Perhaps, similar to the PMPM developed in the **Self-Funded Claims Projection - Attachment A-9?** If so, please elaborate

We have not provided a guarantee at this time.

ATTACHMENT A-8: NETWORK PRICING GUARANTEES (Out of State) - BAFO #1

Proposer:	Aetna Life Insurance Company
Network:	Broad CPII Network

The State Health Plan seeks the most favorable pricing from providers in the selected network and seeks a contractor that is confident enough in its ability to secure discounts to assume the full risk for any shortfall in the contracted pricing guarantees. From each bidder, the Plan is seeking (1) discount guarantees, (2) guarantees not to exceed a percentage of the fees charged by Medicare, and (3) guarantees to stay below an overall PMPM trend level. Bidders must provide the guarantee levels requested below and indicate whether they are willing to be at-risk for the full impact of any missed guarantees or a percentage of the full impact (with a minimum of 10% of the amount by which the guarantee was missed). Bidders will be scored on the guarantee levels and the amount placed at-risk. Guarantees can improve from one year to the next but should not become less favorable over time.

At the completion of each plan year, the Contractor shall provide an analysis of its performance against the guarantees. Guarantees will be calculated using claims from active employees and non-Medicare retirees; claims from Medicare retirees are excluded from the calculations.

	Initial Contract Term			1st Renewal Period	2nd Renewal Period
	01/01/25 -12/31/25	01/01/26 - 12/31/26	01/01/27 - 12/31/27	01/01/28 -12/31/28	01/01/29 - 12/31/29
Discount Guarantees					
Inpatient Facility Discount (%) (e.g., 50% discount)					
Fees At-Risk (select from dropdown list)	% of shortfall	% of shortfall	% of shortfall	% of shortfall	% of shortfall
Percentage of Shortfall (if selected from dropdown) **MINIMUM 10%**	20%	20%	20%	20%	20%
Additional Info/Explanation of Calculation of Fees At-Risk	Refer to the explanation provided under the Composite Target Discount section below.				
Outpatient Facility Discount (%) (e.g., 50% discount)					
Fees At-Risk (select from dropdown list)	Full shortfall	% of shortfall	% of shortfall	% of shortfall	% of shortfall
Percentage of Shortfall (if selected from dropdown) **MINIMUM 10%**	20%	20%	20%	20%	20%
Additional Info/Explanation of Calculation of Fees At-Risk	Refer to the explanation provided under the Composite Target Discount section below.				
Professional Fees Discount (%) (e.g., 50% discount)					
Fees At-Risk (select from dropdown list)	% of shortfall	% of shortfall	% of shortfall	% of shortfall	% of shortfall
Percentage of Shortfall (if selected from dropdown) **MINIMUM 10%**	20%	20%	20%	20%	20%
Additional Info/Explanation of Calculation of Fees At-Risk	Refer to the explanation provided under the Composite Target Discount section below.				
Composite Target Discount (%) Combined In and Out of State					
Fees At-Risk (select from dropdown list)	% of shortfall	% of shortfall	% of shortfall	% of shortfall	% of shortfall
Percentage of Shortfall (if selected from dropdown) **MINIMUM 10%**	20%	20%	20%	20%	20%
Additional Info/Explanation of Calculation of Fees At-Risk	Aetna is guaranteeing out of state employees network discounts as a component of the active employee and non-Medicare retiree population which will be reconciled on an aggregate basis. The percentages guaranteed and the amount at risk is detailed within the "Guarantees (In State" document in the Discount Guarantee section under Composite Target Discount %.				
Percent of Medicare Guarantees					
Inpatient Facility Costs (%) (e.g., 135% of Medicare)					
Fees At-Risk	% of overage	% of overage	% of overage	% of overage	% of overage
Percentage of Overage (if selected from dropdown) **MINIMUM 10%**	10%	10%	10%	10%	10%
Additional Info/Explanation of Calculation of Fees At-Risk	Refer to the explanation provided under the Composite Percent of Medicare Guarantee section below.				
Outpatient Facility Costs (%) (e.g., 135% of Medicare)					
Fees At-Risk	% of overage	% of overage	% of overage	% of overage	% of overage
Percentage of Overage (if selected from dropdown) **MINIMUM 10%**	10%	10%	10%	10%	10%
Additional Info/Explanation of Calculation of Fees At-Risk	Refer to the explanation provided under the Composite Percent of Medicare Guarantee section below.				
Professional Costs (%) (e.g., 135% of Medicare)					
Fees At-Risk	% of overage	% of overage	% of overage	% of overage	% of overage
Percentage of Overage (if selected from dropdown) **MINIMUM 10%**	10%	10%	10%	10%	10%
Additional Info/Explanation of Calculation of Fees At-Risk	Refer to the explanation provided under the Composite Percent of Medicare Guarantee section below.				
Composite Percent of Medicare Guarantees					
Fees At-Risk	% of overage	% of overage	% of overage	% of overage	% of overage
Percentage of Overage (if selected from dropdown) MINIMUM 10%	10%	10%	10%	10%	10%
Additional Info/Explanation of Calculation of Fees At-Risk	Aetna is guaranteeing out of state employees percent of Medicare results as a component of the entire active employee and non-Medicare retiree population which will be reconciled on an aggregate basis. The percentages guaranteed and the amount at risk is detailed within the "Guarantees (In State" document in Percent of Medicare Guarantees section under Composite % of Medicare Combined.				
Trend Guarantee					
Annual PMPM Incurred Medical Cost Trend (%) (e.g., 6%)					
Fees At-Risk		% of overage	% of overage	% of overage	% of overage
Percentage of Overage (if selected from dropdown)		20% total	20% total	20% total	20% total

Additional Info/Explanation of Calculation of Fees At-Risk	Trend guarantee begins in Year 2. Guarantee is percent increase over prior year.	Starting year 2, Aetna is guaranteeing year over year trend experienced by out of state employees as a component of the active employee and non-Medicare retiree population which will be reconciled on an aggregate basis. The percentages guaranteed and the amount at risk is detailed within the “Guarantees (In State” document in the Trend Guarantee section under Annual PMPM Incurred Medical Cost Trend %.	Starting year 2, Aetna is guaranteeing year over year trend experienced by out of state employees as a component of the active employee and non-Medicare retiree population which will be reconciled on an aggregate basis. The percentages guaranteed and the amount at risk is detailed within the “Guarantees (In State” document in the Trend Guarantee section under Annual PMPM Incurred Medical Cost Trend %.	Starting year 2, Aetna is guaranteeing year over year trend experienced by out of state employees as a component of the active employee and non-Medicare retiree population which will be reconciled on an aggregate basis. The percentages guaranteed and the amount at risk is detailed within the “Guarantees (In State” document in the Trend Guarantee section under Annual PMPM Incurred Medical Cost Trend %.	Starting year 2, Aetna is guaranteeing year over year trend experienced by out of state employees as a component of the active employee and non-Medicare retiree population which will be reconciled on an aggregate basis. The percentages guaranteed and the amount at risk is detailed within the “Guarantees (In State” document in the Trend Guarantee section under Annual PMPM Incurred Medical Cost Trend %.
Other Guarantees (Encouraged but not Required)					
Explain:	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Fees At-Risk	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Additional Info/Explanation of Calculation of Fees At-Risk	Not Applicable				

Describe your proposed formula for determining the actual performance against expected or quoted pricing guarantees?

Discount Guarantee:
The aggregate guaranteed percentage is calculated using the billed eligible charges by Inpatient Hospital, Outpatient Hospital and Physician/Other weighted by geographic utilization for active and non-Medicare primary employees.
The achieved discount percentage is calculated Negotiated Savings/Eligible Billed Charges, after removing large claimants over a $250,000 threshold and Non-facility claims where the eligible billed charges are within three percent of the contractual allowed amount.
Negotiated Savings and Eligible Billed Charges follow the definition in the Industry Uniform Discount Data Specification; which also outlines various standard exclusions (e.g. claims where Aetna is a secondary payer on the claim, etc.)
These calculations are made using data from the Aetna Informatics® data warehouse and include three months of run-off experience.

** The final fee adjustment in case of a discount shortage is calculated as below:
Minimum of % of discount shortage x 20% x The billed eligible charge as defined above and 25% of total annual fee

The total fee adjustment based on all guarantees will not exceed 45% of total annual fee.

For the % of Medicare Guarantee:
For Inpatient, Outpatient, Ambulatory Surgical Centers and Professional/Ancillary claims where Medicare allowable charge are available, Aetna shares claims data with a third-party vendor for repricing through its Medicare Grouper to return Medicare allowable rates where available. The aggregate percentage is calculated as the Aetna allowed spend where Medicare allowed is available/Medicare allowable returned. The percentage of Medicare will be determined using Aetna's contracted providers located in North Carolina, South Carolina, and Virginia inclusive of arrangements available to the State of North Carolina (e.g. custom rates, etc.).

The final fee adjustment in case of a % of Medicare overage is calculated as below:
Minimum of % of overage / 216% x 10% x State of NC Allowed Amount (where Medicare allowable rates are available) and 20% of total annual fee

The total fee adjustment based on all guarantees will not exceed 45% of total annual fee.

For the Trend Guarantee:
We calculate target allowed claims per-member, per-month (PMPM) by multiplying base year claims times the net allowed trend adjustment. Processed claim amounts in excess of $250,000 for any individual claimant are excluded from the total allowed claims of both the base year and the guarantee period. Medical claims exclude pharmacy and specialty pharmacy claims, including those paid under the medical plan. Six months of runout data will be included in the calculation for the base and guarantee periods.

To ensure that we are comparing the base year and the projection year on the same basis, we adjust base year claims for factors impacting the relativity of the population such as changes in plan design, demographics, geography, included products, programs and services, third-party vendor solutions, or the impact of novel conditions.

We reserve the right to revise the guarantee if any of the following conditions are not met:
•The products, programs and services match those assumed in our proposed offer.
•Pharmacy Data: We receive pharmacy data file feeds at a minimum bi-weekly basis to support the care management program.
•Enrolled subscribers: The enrolled active employee and non-Medicare retiree population does not vary in size by more than 10 percent from the assumed enrollment of 333,445, or from the average enrollment in the base year.
•The Medical Trend Guarantee is considered met if:
•You terminate your Aetna medical plan in whole or in part (defined as a 50 percent or greater membership reduction from the membership we assumed in this proposal) prior to the end of the multi-year guarantee period, December 31, 2029.
•We do not receive all standard data submissions by December 7, 2024 (samples can be provided upon request).

The total fee adjustment based on all guarantees will not exceed 45% of total annual fee.

Describe the management information that you will provide SHP to support the year-end performance results.

The reconciliation of our guarantees will be included as part of the annual accounting package.

Provide samples of existing agreements, if any, that your network has used with other large plan sponsors to meet network discount targets or other network pricing guarantees.

Please refer to Attachment A-8.b Sample Existing Agreement for the sample documents.

Would you consider a gain-sharing arrangement off a negotiated PMPM claims cost? Perhaps, similar to the PMPM developed in the **Self-Funded Claims Projection - Attachment A-9?** If so,

We have not provided a guarantee at this time.