Summary of Proposed Aetna Medicare Advantage Agreement

Medicare Advantage Agreement

Covered Benefits
Aetna shall provide fully-insured Medicare Plans to the City under this Contract. The Plans offered to Members include a Medicare Advantage PPO plan ("MA plan") and a standalone Medicare Prescription Drug plan ("PDP"). Aetna shall provide coverage to Members for all of the health care and pharmacy services and supplies that are covered by the Plan in accordance with the Evidence of Coverages which are incorporated into the Contract.

Term
Initial term: five (5) years and four (4) months beginning on September 1, 2023 and expiring on December 31, 2028.
Coverage under the PDP will commence on September 1, 2023 for Members who are enrolled in a group health plan other than Senior Care. Coverage under the Aetna PDP will commence on January 1, 2024 for Members who are enrolled in Senior Care prior to September 1, 2023.
Subsequent Terms: three (3) subsequent two-year renewal terms after the Initial Term
Additional Subsequent Terms: Following renewal of the Contract for three (3) Subsequent Terms, the Contract will thereafter renew for two-year renewal terms.

Enrollment
All of the City's current Medicare-eligible retirees and Medicare-eligible covered dependents , except for those Medicare-eligible retirees and their eligible dependents age 65 and older currently enrolled in HIP VIP retiree health plan or who have waived City Health Benefits, ("Eligible Enrollees") will automatically be enrolled in the MA plan. Eligible Enrollees who do not wish to be enrolled in the MA plan on the Effective Date will have the ability to opt-out into the HIP VIP retiree health plan or waive coverage.

2023 Plan Deductible
Aetna MA deductible is waived for 2023.

Termination
Aetna may terminate this Contract without cause after the Initial Term by providing the City with written notice no later than September 1, 2028.
Aetna may terminate this Contract by providing the City with at least 16 months written notice prior to the beginning of a Subsequent Term or an Additional Subsequent Term.

The City may terminate this Contract upon 60 days' notice. Any change to agreed-upon benefits, including the termination of this Contract, is subject to collective bargaining.

Privacy and Security
Aetna and the City shall each abide by all applicable laws, regulations and government requirements regarding the confidentiality and the safeguarding of individually identifiable health and other personal information, including the privacy and security requirements of HIPAA.

Administration of Benefits and Transition Responsibilities
Aetna is a fiduciary for the purpose of Section 503 of Title 1 of ERISA.

In the case of a transition to a successor vendor, Aetna agrees to provide claims data needed by the City's successor carrier to facilitate transition of care for Members, consistent with all applicable laws, regulations and government requirements.

Audit Rights

Not more than once each calendar year during the term of this Contract and for the prior contract year, the City or the City's independent outside auditor whom the City engages to conduct annual audits of the City's Services, may inspect and audit, or cause to be inspected and audited, the books and records of Aetna concerning all the Aetna's Services provided under this Contract

The City shall have the right to select its own auditor provided, however, that such auditor shall be independent and objective

Reporting Requirements

The establishment of a committee to review reports provided by Aetna and to meet with Aetna to discuss any issues related to the administration of the Plans. The MA Review Committee shall be composed of representatives and designated consultants from the City and representatives from the MLC and its designated consultants.

Aetna agrees to meet with the MA Review Committee no less than once a quarter to discuss any issues related to the administration of the Plans and to present and discuss with the MA Review Committee the reports listed below:

Aetna shall provide the following reports to the City and the MLC on a monthly basis:

- Eligibility reconciliation file to contain, at a minimum, the 'Member's contract number, demographics, enrollment date, and cancel date.
- Monthly standard utilization and cost reports for both medical (MA plans) and pharmacy (PDP).
- MA plan network utilization by market set forth as a percent of claims paid in network vs. out of network.
- MA plan provider recruitment status report for providers nominated by Member, City and/or Union.
- MA plan prior authorization approvals / denials reporting.
- MA plan program reporting – meals, non-emergency transportation, OTC benefit, Healthy Rewards and SilverSneakers.
- Appeals and grievances reports. **These reports will be submitted on a monthly, quarterly, and annual basis.**
- Monthly performance standard outcomes.
- Member Services utilization reports (i.e., web traffic, number of –calls - Call Center Operations Reporting and the nature of the members' inquiries).
- Part C and Part D Medicare Monthly Membership Reports (MMR), including all fields as received from CMS. The monthly MMR should be submitted by the end of the corresponding month.

Aetna shall provide the following reports to the City and the MLC on a quarterly basis:

- Performance standard report, indicating Aetna's performance for all performance standard measurements and whether standards were met. Reports must provide monthly performance data as well as quarterly aggregates.

- Quarterly reporting on the MA plan cost, utilization, and clinical performance. Reporting shall also include legislative updates. This report should be produced 60 days after the end of the reporting quarter with a one-month lag. Aetna shall present this report to City staff and its designees.
- Union retiree education by Labor Liaison – measured by staff meeting education, retiree chapter meetings and Medicare eligibility meeting education.

Aetna shall provide the following reports to the City and the MLC on an annual basis:

- MA plan Member satisfaction survey, which will include; overall Member satisfaction on MA plan benefits and services, network access, member services, claims and care management.
- MA plan customer service satisfaction survey – on mutually agreed service metrics.
- MA plan network utilization and network growth.
- Annual MA plan utilization reporting - provided 90 days with a 2-month lag.
- Annual standard PDP/pharmacy utilization.
- MA plan provider collaboration performance and Member attribution by market.
- Annual MA plan risk score reporting.
- Part C and Part D Model Output Reports (MOR) provided no more often than annually, including all fields as received from CMS. The MOR should be provided within 30 days of Aetna's receipt of this report from CMS.

Prior Authorization

Aetna has agreed to established a City-specific program for the MA plan that significantly limits the types of procedures that require prior authorization. Under this program, common procedures like high-tech radiology, diagnostic cardiology, and physical and occupational therapy will **not** require prior authorization. Based on Aetna's recent experience, nearly 80% of the procedures that typically require prior authorization will be accessible to City retirees/dependents without the need to obtain prior authorization.

Non-contracted providers are not required to seek prior authorization for services from Aetna; however, Aetna reserves the right to retrospectively review claims submitted by non-contracted providers and may deny coverage if the services are not medically necessary and/or not covered under the MA plan.

Prior Authorization Waiver: Aetna will agree that for the Initial Term of this Contract, prior authorization will not be required, except with regard to the limited services/items listed below. Every two years, Aetna will review the prior authorization program and the Parties will mutually evaluate the impact of the waiver of prior authorization and discuss in good faith whether changes are appropriate, including modification of the list in the Contact and use of the PA Vendor.

Services/items requiring prior authorization:

- Acute hospital inpatient, long-term acute care, acute physical rehabilitation, skilled nursing facility, and home care services.
- Services/items that are not covered by Medicare.
- Services that could be considered experimental and investigational in nature.
- Services that are cosmetic in nature (e.g., breast augmentation, removal of excessive skin/tummy tuck or eyelid surgery).
- Select Part D medications.

- Specialty medications, some of which are Part B medications, as set forth in ATTACHMENT J, which may be amended from time to time.
- Select drugs, therapies, procedures, services, and technologies covered by Medicare after the Effective Date of the MA plan, subject to mutual agreement of the Parties.

120 Day Prior Authorization Safe Harbor Provision. To smoothly transition in-network providers to the prior authorization program, for the first 120 days following the Effective Date of the MA plan, Aetna will: (1) implement a claim edit that will prevent an automatic denial of medical services rendered by in-network providers that are not submitted for Prior Authorization and pay such claims, and (2) send a letter to the in-network provider and the Member receiving such medical services to educate them regarding the MA plan's Prior Authorization requirements.

Emergency & Urgently Needed Services. Aetna will comply with 42 C.F.R. § 422.113, as may be amended from time to time, with respect to Prior Authorization and "emergency or urgently needed services", as those terms are defined by CMS in this regulation ("Emergency or Urgently Needed Services"). Specifically, consistent with this CMS regulation: (1) no Plan materials provided by Aetna to Members will contain instructions to obtain Prior Authorization with respect to Emergency or Urgently Needed Services, and (2) no Plan materials furnished by Aetna to providers, including contracts, will contain instructions to seek Prior Authorization before a Member has been stabilized.

Dispute Resolution

Except for proposed premium changes due to legislative changes, the Parties shall first attempt in good faith to resolve any dispute arising out of or relating to this Contract promptly by negotiation between executives and or officials who have authority to settle the controversy and who are at a higher level of management than the persons with direct responsibility for administration of this Contract.

If the dispute is not resolved by negotiation as detailed above, the Parties agree to then try in good faith to settle the dispute by non-binding mediation before resorting to the City's Dispute Resolution Process. Unless either Party disagrees, the mediator that will conduct the mediation will be Martin F. Scheinman of Scheinman Arbitration & Mediation Services. If either Party does not agree to appoint Mr. Scheinman as the mediator, another mediator to conduct such mediation will be selected by mutual agreement of the Parties.

Pursuant to the City's Dispute Resolution Process, Aetna agrees that during the pendency of the dispute resolution process, Aetna must continue to perform services in accordance with this Contract and as directed by the City.

Rate Summary

MA Plan

5 Year MA Member Rate Guarantee - 9/01/2023– 8/31/2028: $0 PMPM (Aetna and HIP VIP only)

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Prescription Drug Plan (PDP)

2023 PDP Member Rate: $103.50

2024 PDP Member Rate: $135.50

2025-2028 - Due to the passage of the Inflation Reduction Act of 2022, once CMS announces the direct subsidy amount for the upcoming plan year, Aetna will subtract the expected CMS Revenue from the Total Required Revenue and provide the City with a guaranteed premium rate.

Plan Benefit Summary

Implementation/Communication allowance **- $6M**
The allowance can be applied to reimburse you for identifiable charges for the reasonable value of services performed. Some examples of transition-related expenses it could be applied against are:

- Customized Member I.D. cards (creating, printing & mailing)
- Maintaining Member records due to the transition of business
- Handling Member enrollment, including the hiring of temporary customer service staff to work in the City's office to educate/ promote and communicate about the new Medicare Advantage Plan
- City and MLC Consulting Services related to implementation and education
- Special programming in order to transmit data to Aetna
- Open Enrollment kits and flyers
- Plan Highlights Brochure Mailings
- Healthy Home Visit Mailers
- Medicare Calendars
- Care Advocacy Mailing

Audit Allowance – A pre-implementation audit allowance of up to $60,000 and a post-implementation audit of up to $75,000 that may be used towards certain audit-related expenses associated with your Plan incurred during the 2023 Plan year.

Provider Pass Program
Aetna contracted providers are required to accept the MA PPO ESA Plan. Providers who are not contracted with Aetna are not required to accept the Aetna MA PPO ESA Plan, except when a member requires emergency or urgently needed care. However, providers are not required to become contracted to bill Aetna directly for covered patients. Aetna provides the same reimbursement to non-contracted providers that accept Medicare as traditional Medicare. Accordingly, most non-contracted providers are known to accept Aetna MA plans and bill Aetna directly.

However, if a member is currently receiving treatment from a non-contracted Medicare-eligible physician that does not already bill Aetna directly, Aetna will implement the steps of the Provider Pass program. If a member calls Aetna to advise that a Non-Contracted Physician refuses to accept the MA PPO ESA Plan and is attempting to require that the member pay for Covered Services up front at his/her office visit, the call will be referred to an Aetna Member Services Supervisor who will authorize a one-time payment for this office visit, up to a $1,000 maximum. Aetna will also work with the non-contracted provider to either bring the provider in-network or facilitate the provider remaining non-contracted, but billing Aetna directly for covered members. If the provider continues to decline to bill Aetna directly and the member wishes to continue to receive treatment from the provider and the task is covered by Medicare, the member may submit claims for reimbursement to Aetna directly.

Aetna Part D Information

Aetna's plan includes an **Open** formulary; this means that **all Part D FDA-approved prescription drugs** will be **covered.** Aetna has also included a supplemental benefit rider to include FDA-approved prescription drugs not covered by Part D.
The premium for the standalone Aetna Part D Plan includes coverage mandated under New York State law for enteral formulas.

Retrospective Experience Refund Agreement

Medicare Advantage Retrospective Experience Refund Agreement is for the initial 5-year contract period starting 08/01/2023 plus any contract extensions. The initial settlement period would be for the period beginning during August 1, 2023, through December 31, 2024. Subsequent settlements would be on a calendar year basis starting with calendar year 2024.

A refund, if any, will be determined utilizing the varying Medical Loss Ratio (MLR) thresholds based on the average Enrolled Members during the settlement period.

Performance Guarantees

The performance guarantees apply to the MA PPO ESA plan and PDP:

Implementation Performance Guarantees - $7M

- Member Satisfaction– Network and provider plan acceptance - $680k
- ID Card Production & Distribution - $380k
- Member Outreach-Retiree meetings - $380k
- Member Outreach- educational Outbound calls - $380k
- Call Center performance and availability - $380k
- Healthy Home Visits - $380k
- COVID and Flu Vaccinations - $380k
- Complaints to Medicare - $380k
- Ability to handle City Enrollment formats - $380k
- Eligibility Loaded within 3 business days of receipt - $380k
- Effective Strategy to handle enrollment - $380k
- Complete enrollment support - $380k
- Availability of "right" resources to address issues - $230k
- Timely acknowledgement - $230k
- Satisfaction with communication and interaction - $380k
- Account Management Team effectiveness - $540k
- Pharmacy Retail TAT – Paper Claims - $380k
- Pharmacy Mail Order Dispensing Accuracy - $380k

Ongoing Performance Guarantees - $9M

- Member Satisfaction– Network and provider plan acceptance - $770,830
- Expanded Concierge Account Management Support (OLR/Union - $470,830
- Member Satisfaction - $570,830
- Call Center Performance- First Call Resolution - $570,830
- Call Center Performance- Telephone Service Factor - $437,500

- Complaints to Medicare - $570,830
- Healthy Home Visits - $570,830
- Leverage the Healthy Reward incentive program to close gaps in care - $370,830
- Member engagement in care management programs - $370,830
- Member engagement in in home care - $370,830
- Excessive IRE Appeals Overturned - $500,000
- Risk Score Accuracy/Adequate Reimbursement - $570,830
- Account Management Team effectiveness - $570,880
- Communication of industry, trends, & CMS updates - $570,830
- Timely and accurate submission of required data - $570,830
- Pharmacy Retail TAT – Paper Claims - $570,830
- Pharmacy Mail Order Dispensing Accuracy - $570,830