Part IA – Technical Proposal
RFP Title: Utilization Management and Large Case Management

RFP 3084
Vendor Name: American Health Holding, Inc.
Address: 7400 West Campus Road, F-510
New Albany, OH 43054
Proposal Opening Date: December 3, 2013
Proposal Opening Time: 2:00 p.m.

AmericanHealth
American Health Holding Inc

Creating Healthy Outcomes

American Health Holding, Inc. ■ 7400 West Campus Road, F-510 ■ New Albany, Ohio 43054
Web www.AmericanHealthHolding.com ■ Toll-free 866-614-4244 ■ Email marketing@ahhinc.com

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American Health Attachments

November 25, 2013

State of Nevada, Purchasing Division
Marcy Troescher, Purchasing Officer
515 E. Musser Street, Suite 300
Carson City, NV 89701

Dear Ms. Troescher:

On behalf of American Health Holding, Inc. (American Health), I thank you for the opportunity to participate in your Request for Proposal (RFP) process. American Health understands your plan design components and requirements as outlined in RFP 3084 for Utilization Management and Large Case Management. Our qualifications make us an excellent vendor candidate. Please accept this letter and accompanying material as our official proposal for the products and services requested by the State of Nevada in RFP 3084.

We are a uniquely experienced Utilization Management and Large Case Management partner for PEBP. We believe our capabilities are best summarized by the qualities below:

- **Our commitment to Nevada –** American Health is committed to providing "best in class" service to the 169,540 lives we currently cover in the State of Nevada. Additionally, our proposed Account Manager for the state resides in Las Vegas and has experience servicing the State of Nevada.
- **Our experience with state government plans –** American Health has the background and hands-on know-how to service a wide variety of clients, including state, health/welfare funds, self-insured companies, third party administrators and other types of organizations. Founded in 1993, American Health provides medical management services to approximately 2.3 million lives, including state enrollees of approximately 171,000.
- **Our success at controlling costs –** American Health has developed a comprehensive approach to ensuring the quality and appropriateness of care while maximizing cost savings and avoiding preventable high-cost procedures and hospitalizations.
- **Satisfaction:** 96% of our clients are satisfied with our products and services. In addition, 98% believe that our staff are well-trained, knowledgeable professionals. Our people work hard every day to go above and beyond our clients' expectations. More than 60 of our clients have provided testimonials about our services, which we encourage you to view on our website: www.americanhealthholding.com.
- **Our approach –** We will leverage our success and experience to form a true partnership with PEBP while working toward your objectives. We will consult with you and share ideas for plan design based upon best practices within the industry and our block of business.

- **Our Case Ownership Model –** American Health assigns a specific nurse to each member with an open case. This model enables us to focus on individuals (rather than just "callers") and to improve discharge planning. It also allows us to be fully cognizant of both the personal and financial implications of a case in a "real time" environment.

We pride ourselves on delivering timely solutions that impact the daily lives of our members as well as our customer's bottom line. We are confident that our extensive experience and broad array of medical management solutions will allow American Health to meet and exceed PEBP's expectations, and we look forward to moving to the next stage of the selection process. Please feel free to contact me with questions any time. Again, thank you for the response opportunity.

Best regards,

Paul Lavin
President and CEO

About American Health Holding, Inc.

URAC ACCREDITED

Founded in 1993, American Health Holding, Inc. (American Health) believes that the combination of building partnerships with clients and delivering innovative and cutting-edge methods of containing health care costs is vital to our continued growth and development. We provide comprehensive services through a professional staff of physicians and registered nurses who are highly qualified in cost management issues including quality assurance standards.

Who We Are

- National medical management firm serving approximately 2.3 million lives in all 50 states, the Caribbean and Bermuda
- More than 20 years of experience with cost management solutions and member advocacy
- Services that span the health care continuum
- URAC-accredited, integrated Utilization Management, Case Management and Disease Management programs
- Client-focused flexibility to maximize cost savings and ensure quality of care
- Licensed in all required states

What Makes Us Unique

- Onsite capabilities
- One-stop shop for medical management
- The preferred vendor among multiple stop-loss carriers
- Proprietary software and guidelines from MCG Health
- Leading-edge criteria and reporting capabilities
- Client-focused flexibility, customizable programs
- Technology-oriented, web-based access
- Emphasis and commitment to quality

Who We Serve

- Third-party administrators
- State and local governments
- Health/welfare funds
- Self-insured companies
- Reinsurance carriers and MGUs
- Health care/business coalitions
- Health insurance carriers
- PPOs, HMOs and MCOs
- Independent Practice Associations

Services You Can Depend On

We hold the belief that "when you've seen one customer, you've seen one customer." Because no two customers are alike, we strive to understand the unique needs and directions of our clients. We deliver a medical management process that uniquely meshes our services with what our clients need and want. Our full spectrum of medical management services includes:

- Utilization Management
- Advanced Radiology Scheduling Services
- Case Management
- Specialty Case Management
- Pre-Admission and Post-Discharge Counseling
- Wellness
- Disease Management
- Performance-Based Wellness
- Maternity Management
- Medical Evacuation
- Onsite Medical Management
- Medical Review
- Independent External Review
- Medical Disclosure
- Integrated Behavioral Health
- 24/7 Physician Consultations
- 24/7 Nurse Line and Information Library
- Bill Audit Services
- Out-of-Network Repricing and Negotiations

AmericanHealth

Web www.AmericanHealthHolding.com

Toll-free 866.614.4244

Email marketing@ahhinc.com

VENDOR INFORMATION SHEET FOR RFP 3084

Vendor Must:

A) Provide all requested information in the space provided next to each numbered question. The information provided in Sections V1 through V6 will be used for development of the contract;

B) Type or print responses; and

C) Include this Vendor Information Sheet in Tab III of the Technical Proposal.

V1	Company Name	American Health Holding, Inc.

V2	Street Address	7400 West Campus Road, F-510

V3	City, State, ZIP	New Albany, OH 43054

V4	Telephone Number		
	Area Code: 866	Number: 614-4244	Extension:

V5	Facsimile Number		
	Area Code: 866	Number: 248-9777	Extension:

V6	Toll Free Number		
	Area Code: 866	Number: 614-4244	Extension:

V7	***Contact Person for Questions / Contract Negotiations, including address if different than above***
	Name: Anne Klie
	Title: Director, Business Development
	Address:
	Email Address: aklie@ahhinc.com

V8	Telephone Number for Contact Person		
	Area Code: 614	Number: 933-7990	Extension:

V9	Facsimile Number for Contact Person		
	Area Code: 866	Number: 248-9777	Extension:

V10	***Name of Individual Authorized to Bind the Organization***	
	Name: Paul Lavin	Title: President and CEO

V11	Signature ***(Individual must be legally authorized to bind the vendor per NRS 333.337)***	
	Signature: Paul E. Lavin	Date: 11-25-13

State of Nevada
Department of Administration
Purchasing Division
515 E. Musser Street, Suite 300
Carson City, NV 89701

Brian Sandoval
Governor

Greg Smith
Administrator

SUBJECT:	Amendment 1 to Request for Proposal 3084
RFP TITLE:	Utilization Management and Large Case Management Services
DATE OF AMENDMENT:	September 30, 2013
DATE OF RFP RELEASE:	September 25, 2013
OPENING DATE:	December 3, 2013
OPENING TIME:	2:00 PM
CONTACT:	Marcy Troescher, Procurement Staff Member

The following shall be a part of RFP ***3084.*** If a vendor has already returned a proposal and any of the information provided below changes that proposal, please submit the changes along with this amendment. You need not re-submit an entire proposal prior to the opening date and time.

The following change has been made to the timeline for RFP 3084 *Utilization Management and Large Case Management Services*.

3084 RFP TIMELINE

Task	Date/Time
Deadline for submitting questions	10/15/2013 @ 2:00 PM
Answers posted to website	On or about ~~October 19, 2013~~ 10/22/2013
Deadline for submittal of Reference Questionnaires	No later than 4:30 PM on 12/02/2013
Deadline for submission and opening of proposals	No later than 2:00 PM on 12/03/2013
Evaluation period (approximate time frame)	12/04/2013-01/06/2014
Selection of vendor	On or about 1/09/2014
Anticipated BOE approval	4/08/2013
Contract start date (contingent upon BOE approval)	7/01/2014

ALL ELSE REMAINS THE SAME FOR RFP 3084.

Vendor must sign and return this amendment with proposal submitted.

Vendor Name: American Health Holding, Inc.

Authorized Signature: Paul E [illegible]

Title: President and CEO Date: 11-25-13

This document must be submitted in the "State Documents" section/tab of vendors' technical proposal.

State of Nevada
Department of Administration
Purchasing Division
515 E. Musser Street, Suite 300
Carson City, NV 89701

Brian Sandoval
Governor

Greg Smith
Administrator

SUBJECT:	Amendment 2 to Request for Proposal 3084
RFP TITLE:	Utilization Management and Large Case Management Services
DATE OF AMENDMENT:	October 23, 2013
DATE OF RFP RELEASE:	September 25, 2013
OPENING DATE:	December 3, 2013
OPENING TIME:	2:00 PM
CONTACT:	Marcy Troescher, Purchasing Officer

The following shall be a part of RFP ***3084.*** If a vendor has already returned a proposal and any of the information provided below changes that proposal, please submit the changes along with this amendment. You need not re-submit an entire proposal prior to the opening date and time.

---

1. Can you please tell us how many Registered Nurses and how many Technicians will be required for this?

   PEBP relies on the vendor to provide the appropriate staff to meet the requirements of the contract.

2. If our company provides utilization management services listed, but not all, would the bid still be considered?

   PEBP is seeking a vendor that can provide all of the services listed in the Overview of Project and Scope of Work.

3. If our company does not provide Large Case Management Services, would the bid still be considered?

   See the response to question #2.

4. If our company provides utilization management/pre-certification services for specialty high dollar medical services not listed, will these services be considered within this bid?

   See the response to question #2.

5. Section 3.17.3 requires that we review Attachment M – Privacy Security Policies and Procedures, and indicate our agreement and/or exceptions. Page ii of Attachment M references

Vendor Name: _____

Authorized Signature: _____

Title: _____ Date: _____

This document must be submitted in the "State Documents" section/tab of vendors' technical proposal.

ATTACHMENT A – CONFIDENTIALITY AND CERTIFICATION OF INDEMNIFICATION

Submitted proposals, which are marked "confidential" in their entirety, or those in which a significant portion of the submitted proposal is marked "confidential" **will not** be accepted by the State of Nevada. Pursuant to NRS 333.333, only specific parts of the proposal may be labeled a "trade secret" as defined in NRS 600A.030(5). All proposals are confidential until the contract is awarded; at which time, both successful and unsuccessful vendors' technical and cost proposals become public information.

In accordance with the Submittal Instructions of this RFP, vendors are requested to submit confidential information in separate binders marked "**Part I B Confidential Technical**" and "**Part III Confidential Financial**".

The State will not be responsible for any information contained within the proposal. Should vendors not comply with the labeling and packing requirements, proposals will be released as submitted. In the event a governing board acts as the final authority, there may be public discussion regarding the submitted proposals that will be in an open meeting format, the proposals will remain confidential.

By signing below, I understand it is my responsibility as the vendor to act in protection of the labeled information and agree to defend and indemnify the State of Nevada for honoring such designation. I duly realize failure to so act will constitute a complete waiver and all submitted information will become public information; additionally, failure to label any information that is released by the State shall constitute a complete waiver of any and all claims for damages caused by the release of the information.

This proposal contains Confidential Information, Trade Secrets and/or Proprietary information as defined in ***Section 2 "ACRONYMS/DEFINITIONS."***

Please initial the appropriate response in the boxes below and provide the justification for confidential status.

Part I B – Confidential Technical Information			
YES	*X*	NO	
Justification for Confidential Status			
Portions of our responses to 3.11.1.11, 3.13.4, and 3.16 are considered confidential. Each of these original responses can be found in Tab VI of Part IA – Technical Proposal. The information is not known or available to the public and is considered to include trade secrets. It provides American Health with an advantage over its competitors. We take reasonable efforts to protect it from disclosure.			

A Public Records CD has been included for the Technical and Cost Proposal			
YES	*X*	NO	

Part III – Confidential Financial Information			
YES	*X*	NO	
Justification for Confidential Status			
Per the specifications of 4.1.11 of the RFP, financial information and documentation can be found in Part III – Confidential Financial Information.			

American Health Holding, Inc.

Company Name

Signature

Paul Lavin

Print Name

11-25-13

Date

This document must be submitted in Tab IV of vendor's technical proposal

ATTACHMENT C – VENDOR CERTIFICATIONS

Vendor agrees and will comply with the following:

(1) Any and all prices that may be charged under the terms of the contract do not and will not violate any existing federal, State or municipal laws or regulations concerning discrimination and/or price fixing. The vendor agrees to indemnify, exonerate and hold the State harmless from liability for any such violation now and throughout the term of the contract.

(2) All proposed capabilities can be demonstrated by the vendor.

(3) The price(s) and amount of this proposal have been arrived at independently and without consultation, communication, agreement or disclosure with or to any other contractor, vendor or potential vendor.

(4) All proposal terms, including prices, will remain in effect for a minimum of 180 days after the proposal due date. In the case of the awarded vendor, all proposal terms, including prices, will remain in effect throughout the contract negotiation process.

(5) No attempt has been made at any time to induce any firm or person to refrain from proposing or to submit a proposal higher than this proposal, or to submit any intentionally high or noncompetitive proposal. All proposals must be made in good faith and without collusion.

(6) All conditions and provisions of this RFP are deemed to be accepted by the vendor and incorporated by reference in the proposal, except such conditions and provisions that the vendor expressly excludes in the proposal. Any exclusion must be in writing and included in the proposal at the time of submission.

(7) Each vendor must disclose any existing or potential conflict of interest relative to the performance of the contractual services resulting from this RFP. Any such relationship that might be perceived or represented as a conflict should be disclosed. By submitting a proposal in response to this RFP, vendors affirm that they have not given, nor intend to give at any time hereafter, any economic opportunity, future employment, gift, loan, gratuity, special discount, trip, favor, or service to a public servant or any employee or representative of same, in connection with this procurement. Any attempt to intentionally or unintentionally conceal or obfuscate a conflict of interest will automatically result in the disqualification of a vendor's proposal. An award will not be made where a conflict of interest exists. The State will determine whether a conflict of interest exists and whether it may reflect negatively on the State's selection of a vendor. The State reserves the right to disqualify any vendor on the grounds of actual or apparent conflict of interest.

(8) All employees assigned to the project are authorized to work in this country.

(9) The company has a written equal opportunity policy that does not discriminate in employment practices with regard to race, color, national origin, physical condition, creed, religion, age, sex, marital status, sexual orientation, developmental disability or handicap.

(10) The company has a written policy regarding compliance for maintaining a drug-free workplace.

(11) Vendor understands and acknowledges that the representations within their proposal are material and important, and will be relied on by the State in evaluation of the proposal. Any vendor misrepresentations shall be treated as fraudulent concealment from the State of the true facts relating to the proposal.

(12) Vendor must certify that any and all subcontractors comply with Sections 7, 8, 9, and 10, above.

(13) The proposal must be signed by the individual(s) legally authorized to bind the vendor per NRS 333.337.

American Health Holding, Inc.

Vendor Company Name

Vendor Signature

Paul Lavin — 11-25-13

Print Name — Date

This document must be submitted in Tab IV of vendor's technical proposal

ATTACHMENT B – TECHNICAL PROPOSAL CERTIFICATION OF COMPLIANCE WITH TERMS AND CONDITIONS OF RFP

I have read, understand and agree to comply with ***all*** the terms and conditions specified in this Request for Proposal.

YES _____ I agree to comply with the terms and conditions specified in this RFP.

NO ***X*** I do not agree to comply with the terms and conditions specified in this RFP.

If the exception and/or assumption require a change in the terms in any section of the RFP, the contract, or any incorporated documents, vendors ***must*** provide the specific language that is being proposed in the tables below. If vendors do not specify in detail any exceptions and/or assumptions at time of proposal submission, the State will not consider any additional exceptions and/or assumptions during negotiations.

American Health Holding, Inc.
Company Name

Signature

Paul Lavin
Print Name

11-25-13
Date

Vendors MUST use the following format. Attach additional sheets if necessary.

****Regarding exception language preceded by or concluded with ellipses, American Health intends the language preceding and following the proposed exception language to remain unchanged.***

*****Information identified as a Note, which is presented in bold and italics, is not considered part of the proposed exception language and is for informational purposes only.***

EXCEPTION SUMMARY FORM

EXCEPTION #	RFP SECTION NUMBER	RFP PAGE NUMBER	EXCEPTION* ** (Complete detail regarding exceptions must be identified)
1	3.8.1.2	10	Regarding the requirement to disclose a subcontractor within 60 days, American Health has one named subcontractor, Family Practice Outreach, LLC, which is owned by Roland Griggs, MD, our Medical Director of 20 years. While we do not foresee any changes to this long-standing relationship, we recognize that if for some reason (for an example, a health issue) Dr. Griggs is no longer able to serve as Medical Director, American Health would respond promptly to identify and contract with an appropriate replacement. Because such an event could occur without notice, we are not able to accept the notification and penalty requirement defined above. With that said, we commit to timely, open communication with PEBP on any subcontractor change and would provide updates on the transition.
2	3.19.1	40	Regarding the required independent financial audit, this applies to our parent company, Aetna, Inc. Aetna, Inc. is a publically held company, whose audit results will be made available to the State.
3	Attachment D-Contract Form	2 of the Contract	American Health requests the language in 9B Inspection & Audit be deleted and replaced with the following: Contractor agrees to allow the State access to Contractor's premises for inspection

EXCEPTION #	RFP SECTION NUMBER	RFP PAGE NUMBER	EXCEPTION* ** (Complete detail regarding exceptions must be identified)
			and audit during normal business hours. Subject to the Confidentiality covenants set forth in this Agreement, Contractor agrees to at its office, make available during normal business hours any and all books, records or other documents in its possession directly related to the performance of its duties under this Agreement. Audits provided by this Section of the Agreement shall be limited to no more than one during any initial or renewal term. The State will provide a copy of any final audit results to Contractor, and the State agrees to reimburse Contractor for its costs associated with such Audit at Contractor's then customary and reasonable audit fees.
4	Attachment D-Contract Form	2 of the Contract	American Health requests the addition of the following definitions to the Contract: • "Admission" shall mean any entry of a Member into (or the extension of a Member's stay in) an acute care hospital for acute inpatient health care services. • "Certification" shall mean notification given by American Health, on behalf of the State, to a Member and/or Provider that the Member's proposed Admission, extension of an Admission, or Admission that has previously occurred as a result of an emergency, for a specified number of days, or other health care services subject to review, appears to be medically necessary and reasonable and customary under established medical practice and standards for the submitted diagnosis and clinical situation, based upon the information provided to American Health. • "Employee" shall mean a person whose employment, or other affiliation or status, results in such person's entitlement to benefits under a Plan. • "Member" shall mean any person or Employee who may be entitled to have Admissions or other health care services paid for under a Plan. • "Participant" shall mean an eligible Employee. • "PPPM" shall mean Per Participant Per Month. • "Plan" shall mean any arrangement administered by The State that may provide for payment for Admissions or other health care services or case management services and that benefits from, and may provide as part of its health care operations, disease management services. • "Provider" shall mean any person or entity who proposes to provide, or does provide, health care services to a Member.
5	Attachment D-Contract Form	3 of the Contract	American Health requests the following revision to 10 C Cause Termination for Default or Breach....This Contract may be terminated by either party upon written notice of any uncured default or breach to the other party as follows:....
6	Attachment D-Contract Form	4 of the Contract	American Health requests the language in 12 LIMITED LIABILITY be deleted and replaced with the following: LIMITED LIABILITY. ALL GOODS AND SERVICES UNDER THIS AGREEMENT ARE PROVIDED "AS IS" AND, EXCEPT FOR WARRANTIES THAT MAY NOT BE DISCLAIMED AS A MATTER OF LAW, AMERICAN HEALTH DISCLAIMS ALL REPRESENTATIONS AND WARRANTIES, WHETHER EXPRESSED OR IMPLIED, INCLUDING WARRANTIES OF MERCHANTABILITY AND FITNESS FOR A PARTICULAR PURPOSE. IN NO EVENT SHALL EITHER PARTY BE LIABLE TO THE OTHER FOR

EXCEPTION #	RFP SECTION NUMBER	RFP PAGE NUMBER	EXCEPTION* ** (Complete detail regarding exceptions must be identified)
			ANY INDIRECT, GENERAL, CONSEQUENTIAL PUNITIVE, EXEMPLARY, DISCRETIONARY, ACCUMULATIVE, ENHANCED, EXCESS, LIQUIDATED, MULTIPLE, SPECIAL OR ADDITIONAL STATUTORY DAMAGES (INCLUDING, BUT NOT LIMITED TO, LOST PROFITS) LOSS OF USE, LOSS OF DATA, COST OF PROCUREMENT OR SUBSTITUTE SERVICES OR ANY SIMILAR CLAIM OR DEMAND EXCEPT ACTUAL OR COMPENSATORY DAMAGES OF ANY KIND OR NATURE WHATSOEVER ARISING OUT OF OR IN CONNECTION WITH THIS AGREEMENT, EVEN IF THE PARTY HAD BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES OR EVEN IF SUCH DAMAGES WERE REASONABLY FORESEEABLE.
7	Attachment D-Contract Form	4 of the Contract	American Health requests the language in 14 INDEMNIFICATION be deleted and replaced with the following: 14 MUTUAL INDEMINFICATION. Each party shall indemnify, defend, and hold harmless the other and the others' officers, directors, employees and agents, against losses, claims, damages, judgments, liabilities or expense (including reasonable counsel fees and costs) (i.e. $125.00, per hour for state employed attorneys), incurred as a result of negligent performance (or non-performance), or any willful malfeasance, by such party or any of its officers, directors, employees, or agents, in connection with the performance of any of such party's duties and obligations under this Agreement. The provisions of this section shall survive expiration or termination of this Agreement.
8	Attachment D-Contract Form	4 of the Contract	American Health requests 11 REMEDIES be deleted. Please see Exception 6 above, which details remedies.
9	Attachment D-Contract Form	5-7 of the Contract	Regarding 16 INSURANCE SCHEDULE, American Health requests the following: **Opening paragraph to be revised to the following:** ....Policies shall meet the terms and conditions as specified herein. The State shall have no liability for providing Contractor with insurance except as specifically provided in the Contract.... **Deletion of the following paragraph:** Prior to approval of the insurance policies by the State shall be a condition precedent to any payment of consideration under this Contract and the State's approval of any changes to insurance coverage during the course of performance shall constitute an ongoing condition subsequent to this Contract. Any failure of the State to timely approve shall not constitute a waiver of the condition. ***Note: Aetna is a $50 Billion corporation, and its insurance policies will meet or exceed required limits.*** **16A:** Deletion of the following language only: ....as specified in Attachment BB, incorporated hereto by attachment.....***Note: There is no Attachment BB.*** **16A:** Deletion of the following language only: ....Until such time as the insurance is no longer required by the State, Contractor shall provide the State with renewal or replacement evidence of insurance no less than thirty (30) days before the expiration or replacement of the required insurance.... **16B:** Deletion of B1 Additional Insured. Additionally, we request the following revisions to 16B: 2. Deletion of the following language only: ....Each.... and replacement with The Workers' Compensation.... ***Note: We would like to maintain our ability to review and/or pursue any***

EXCEPTION #	RFP SECTION NUMBER	RFP PAGE NUMBER	EXCEPTION* ** (Complete detail regarding exceptions must be identified)
			claims that may arise from the State's negligence. 4. Deletion of Deductibles and Self-Insured Retentions and replacement with the following: Deductibles and Self-Insured Retentions. Insurance maintained by Contractor shall not relieve Contractor from the obligation to pay any deductible or self-insured retention. ***Note: As typical with larger companies, higher deductibles and self-insured retentions are used to manage the cost of insurance. Aetna is a $50 Billion corporation and chooses to maintain deductibles and retentions that it is easily able to absorb.*** 5. Deletion of Policy Cancellation and replacement with the following: Policy Cancellation. Except for ten (10) days' notice for non-payment of premiums, the Contractor shall provide thirty (30) days prior written notice to the State of Nevada, c/o Contracting Agency, if the policy is to be canceled, non-renewed or coverage and/or limits reduced, and shall provide that notices required by this Section shall be sent by certified mail to the address shown on page one (1) of this contract. ***Note: Insurers are no longer willing to provide notices of cancellation. Our policies provide for at least 60 days advance notification of any adverse change in policy conditions.*** **16C:** We request the following revision to 2. Additional Insured Endorsement: An Additional Insured Endorsement (CG 20 10 11 85 or CG 20 26 11 85 or applicable substitute), signed by an authorized insurance company representative....***Note: Our General Liability policy contains a provision to add additional insureds by our written acknowledgement on a contract or certificate of insurance, without the need for a formal endorsement.*** 4. We request the following revision to 4. Review and Approval: Certificates of Insurance must be submitted for review and approval by the State prior to the commencement of work by Contractor.... ***Note: Our insurance policies are considered proprietary information. However, we will be glad to provide evidence of required coverage through a certificate of insurance or pertinent sections of the policy.***
10	Attachment D-Contract Form	7 of the Contract	American Health requests the language in 23 CONFIDENTIALITY be deleted and replaced with the following: Each party acknowledges and understands the competitive value and confidential nature of internal, non-public business, financial and marketing information of each other, including without limitation the terms and conditions of this Agreement, as well as sensitive information related to the States, clients, Providers, patients and Members (all collectively "Confidential Information"). Each party agrees to use its best efforts (and not less than that employed to protect each party's own confidential information) to safeguard the Confidential Information and to prevent the unauthorized, negligent or inadvertent use or disclosure thereof. Neither party shall use such Confidential Information, or improperly disclose it to any third party, at any time during or after termination of this Agreement, except as specifically contemplated by this Agreement or upon the other party's prior written consent. Each party shall use appropriate safeguards to protect the confidentiality of such Confidential Information. The provisions of

EXCEPTION #	RFP SECTION NUMBER	RFP PAGE NUMBER	EXCEPTION* ** (Complete detail regarding exceptions must be identified)
			this section shall survive expiration or termination of this Agreement.
11	Attachment D-Contract Form	7 of the Contract	American Health requests 21 STATE OWNERSHIP OF PROPRIETARY INFORMATION be revised to the following: ....All such materials shall be delivered into State possession or where delivery is impracticable Contractor agrees to destroy or hold such material in confidence pursuant to the Confidentiality provisions of this Agreement, Contractor's record retention policies or state law, whichever is more restrictive and upon completion, termination, or cancellation of this Contract. Contractor shall not use, willingly allow, or cause to have such materials used for any purpose other than performance of Contractor's obligations under this Contract without the prior written consent of the State. Notwithstanding the foregoing, the State shall have no proprietary interest in any materials licensed for use by the State that are subject to patent, trademark, or copyright protection or any other proprietary business of the Contractor.
12	Attachment D-Contract Form	8 of the Contract	American Health requests the deletion of 29. ASSIGNMENT OF ANTITRUST CLAIMS. ***Note: This provision is typically not applicable to the services provided by American Health.***
13	Attachment D-Contract Form	To be determined	American Health requests the addition of the following section to the Contract: LIMITATION OF CONTRACTOR'S AUTHORITY AND LIABILITY. The State or its Plans, not Contractor, makes the ultimate decision to pay or not to pay a claim for an Admission, health care services or benefits of a Member or a Provider. Contractor's authority under this Agreement is solely to determine whether Admissions, procedures or health care services requested by Members or Providers (or previously provided, in the case of an emergency) appear to be medically necessary, reasonable and customary under established medical practice and standards for the submitted diagnosis and clinical situation based upon the information provided to Contractor and not to determine whether the State or its Plans should pay or deny a Member's or Provider's claim for payment for such Admissions, procedures or health care services. Further, Contractor shall not have the duty to advise The State, or a Member or a Provider, of a Member's eligibility for coverage under a Plan (or otherwise), availability of benefits under a Plan (or otherwise) or entitlement to receive payment or reimbursement (or any other benefit) for any Admission, procedure or health care services requested or previously provided to a Member. Contractor shall use reasonable efforts to refer any such questions to the State, as requested by the State. The State is solely responsible for Plan design, including compliance with all applicable law. The provisions of this Section shall survive expiration or termination of this Agreement.
14	Attachment D-Contract Form	8 of the Contract	American Health requests the deletion of 26 WARRANTIES, to be replaced with Exception 6.
15	Attachment N – Business Associate Agreement (BAA)	5 of the BAA	Regarding 2.05 Breach of Unsecured Protected Health Information, American Health requests the deletion of ....five (5) days..... and replacement with ....fifteen (15) days..... ***Note: We ask this request be granted, as this is a reasonable timeframe to review and respond appropriately to the potential breach.***

EXCEPTION #	RFP SECTION NUMBER	RFP PAGE NUMBER	EXCEPTION* ** (Complete detail regarding exceptions must be identified)
16	Attachment N – BAA	5-6 of the BAA	American Health requests 2.06 Notice of a Breach of Unsecured Protected Health Information be replaced with the following language: 2.06 Notice of a Breach of Unsecured Protected Health Information. In the event of a Breach involving Unsecured Protected Health Information, the Business Associate will notify the Covered Entity without reasonable delay, but no later than fifteen (15) days after discovery of the Breach. The Covered Entity will notify individuals, the media or the Secretary of HHS, as necessary. ***Note: American Health will notify the Covered Entity of a breach and the Covered Entity would make required notifications.***
17	Attachment N – BAA	8 of the BAA	American Health requests 2.17 Responses to Subpoenas be revised to the following: ....any use or disclosure of Protected Health Information or any failure in Business Associate's health data security measures, Business Associate shall reasonably assist the Covered Entity's compliance with the notice and protective action obligations set forth in 45 C.F.R. § 164.512(e) in accordance with the Covered Entity's standard policy and procedures.
18	Attachment N – BAA	14 of the BAA	American Health requests 6.11 Applicable Laws be revised to the following: Business Associate agrees that it will materially comply with all applicable laws and regulatory requirements in the performance of this Agreement....
19	Attachment E – Insurance Schedule for RFP 3084 (Schedule)	1 of Schedule	American Health requests the INDEMNIFICATION CLAUSE be revised to the following: ....It is the specific intention of the parties that the Indemnitee shall, in all instances, with respect to claims arising from the negligent or willful acts or omissions of the Indemnitee, be indemnified by Contractor from and against any and all claims, in proportion to the Contractor's degree of negligence.....
20	Attachment E - Schedule	3 of Schedule	American Health requests F. SUBCONTRACTORS be revised to the following: All coverages for subcontractors, if used, shall be subject to the minimum requirements identified above for Contractor. ***Note: Our General Liability policy contains a provision to add additional insureds by our written acknowledgement on a contract or certificate of insurance, without the need for a formal endorsement.***

ASSUMPTION SUMMARY FORM

ASSUMPTION #	RFP SECTION NUMBER	RFP PAGE NUMBER	ASSUMPTION (Complete detail regarding assumptions must be identified)
1	3.15	34-35	Assuming the State requires a separate instance of iSuite, American Health recommends a minimum of four months to ensure a clean transition into PEBP's programs. Should the State not require a separate instance of iSuite, the implementation timeframe would be reduced to three months.

This document must be submitted in Tab V of vendor's technical proposal

PROPOSED STAFF RESUME

A resume must be completed for all proposed contractor staff and proposed subcontractor staff.

COMPANY NAME:	American Health Holding, Inc.		
X Contractor		☐ **Subcontractor**	
Name:	Dennis Bryant	**X Key Personnel**	
Classification:	Vice President, Business Support	**# of Years in Classification:**	6
Brief Summary: of Experience:	Dennis has more than 20 years of experience in customer service, technology, consulting and management. He previously applied his expertise to the insurance, manufacturing, global consulting and eCommerce industries, working with internationally recognized companies such as Abbott Laboratories, Philips Electronics and Atos-Origin. He joined American Health as a consultant in 2002 and was instrumental in the development and implementation of the company's industry-leading proprietary iSuite software system.		
# of Years with Firm:	11		

RELEVANT PROFESSIONAL EXPERIENCE

Required Information: ***MMYYYY to Present:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	07/01/2007 to Present American Health American Health Paul Lavin, President and CEO 7400 West Campus Rd., New Albany, OH 43054 614-933-7654 plavin@ahhinc.com As Vice President, Business Support, Dennis oversees American Health's business support, facility management, project management and implementation teams.

Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	06/05/2005 to 06/30/2007 American Health American Health Paul Lavin, President and CEO 7400 West Campus Rd., New Albany, OH 43054 614-933-7654 plavin@ahhinc.com Director, Applications Development Established and defined a new corporate IT strategic infrastructure and process. Established best-in-breed business and technical processes, positioning the company to utilize technical infrastructure to gain market share. Provided leadership to a cross-functional team of up to 22 professionals representing 35,000 person-hours of effort to deliver a best-in-breed healthcare management system. Implemented a HIPAA compliant, rules-based, and secure Internet application. Implemented a HIPAA/EDI framework for the 278 and 834 HIPAA transaction sets. Delivered processes and software to deploy new clients and convert existing clients in a highly efficient environment.
Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	

EDUCATION

Institution Name: ***City:*** ***State:*** ***Degree/Achievement:*** ***Certifications:***	Northeast Missouri State University Kirksville Missouri Bachelor of Science in Computer Science and Business Administration. Additionally, Dennis has completed extensive vendor and internal corporate training programs.

REFERENCES

Minimum of three (3) required, including name, title, organization, phone number, fax number and email address	Kerry Kovaleski Arizona Foundation for Medical Care Director, Medical Management (p) 602-417-2318 KKovaleski@azfmc.com (Preferred contact method) Gregg Kamas Employee Benefit Management Services, Inc. Chief Health Officer (p) 800-777-3575 ext. 1249 gkamas@ebms.com Melissa Walton Employee Benefit Management Services, Inc. Case Management Business Analyst 800-777-3575 ext. 1297 mwalton@ebms.com

4. COMPANY BACKGROUND AND REFERENCES

4.1 VENDOR INFORMATION

4.1.1 Vendors must provide a company profile in the table format below.

Question	Response
Company name:	***American Health Holding, Inc.***
Ownership (sole proprietor, partnership, etc.):	***Corporation - American Health operates as an independent subsidiary of Aetna, Inc. (NYSE:AET)***
State of incorporation:	***Ohio***
Date of incorporation:	***January 15, 1993***
# of years in business:	***20***
List of top officers:	***Paul Lavin, MBA, CPA, president and CEO*** ***Ron Gibb, executive vice president and chief operating officer***
Location of company headquarters:	***7400 West Campus Road, F-150*** ***New Albany, OH 43054***
Location(s) of the company offices:	***In addition to our company headquarters at 7400 West Campus Road, F-150, New Albany, OH 43054, our nurses and case managers telecommute from locations around the US.***
Location(s) of the office that will provide the services described in this RFP:	***In addition to our company headquarters at 7400 West Campus Road, F-150, New Albany, OH 43054, our nurses telecommute from locations around the US.***
Number of employees locally with the expertise to support the requirements identified in this RFP:	***American Health currently has a staff of more than 471 employees located locally and nationally.***
Number of employees nationally with the expertise to support the requirements in this RFP:	***American Health currently has a staff of approximately 471 employees located locally and nationally.***
Location(s) from which employees will be assigned for this project:	***Primary services will be provided telephonically by American Health telecommuting nurses and case managers. Additional services will be provided telephonically by American Health telecommuting nurses and case managers in various US locations. Intake services will be provided telephonically by American Health staff located in our corporate offices in Ohio. In addition, many of our senior staff members, who will be actively involved with your account, are located in our corporate offices in Ohio. American Health anticipates providing an account manager based in Nevada and, subject to availability, a case manager in Northern Nevada.***

	Case Management	Specialty Case Management (Renal/Maternity/Oncology/Transplant)	Utilization Management	Intake
Dedicated Staff	Yes	Yes	Yes	Yes
Location	Case Management services will be provided telephonically by American Health telecommuting case managers in various US locations. Additionally, subject to availability our Case Management staffing will include a nurse located in Northern Nevada.	Case Management services will be provided telephonically by American Health telecommuting case managers in various US locations.	Case Management services will be provided telephonically by American Health telecommuting nurses in various US locations.	Intake services will be provided telephonically by American Health staff located in our corporate offices in Ohio.
Comments	To increase efficiency and effectiveness during high volume and vacation periods, back up will be provided telephonically by American Health corporate or telecommuting case managers. Our goal is always to provide dedicated staff; however, this is also dependent on volume.	American Health case managers are highly-skilled in their areas of specialty. Our goal is always to provide dedicated staff; however, this is also dependent on volume.	To increase efficiency and effectiveness during high volume and vacation periods, back up will be provided telephonically by American Health corporate or telecommuting nurses. Our goal is always to provide dedicated staff; however, this is also dependent on volume.	Our goal is always to provide dedicated staff; however, this is also dependent on volume.
Features of Staffing Model	Even though select Case Management services may not require dedicated staff, our Case Ownership Model assigns a specific nurse to each member with an open case. Our model enables us to focus on individuals (rather than just "callers") once a case has been identified via our Utilization Review process or through alternative methods for identification and referral. Our model also allows us to be more fully cognizant of both the personal and financial implications of a case in a "real time" environment. Communication between Case Management and Utilization Management is enhanced through iSuite, American Health's proprietary, integrated medical management software system. Our nurses can see each other's cases through iSuite and collaborate to ensure the member is getting the best possible care. As an added benefit to PEBP, we can load the State's network information in iSuite on a weekly or monthly basis so all nurses, regardless of their location, will have access to the State's listing of in-network physicians and providers.			

4.1.2 **Please be advised**, pursuant to NRS 80.010, a corporation organized pursuant to the laws of another state must register with the State of Nevada, Secretary of State's Office as a foreign corporation before a contract can be executed between the State of Nevada and the awarded vendor, unless specifically exempted by NRS 80.015.

American Health is registered with the Nevada Secretary of State Office as a foreign corporation.

4.1.3 The selected vendor, prior to doing business in the State of Nevada, must be appropriately licensed by the State of Nevada, Secretary of State's Office pursuant to NRS 76. Information regarding the Nevada Business License can be located at http://sos.state.nv.us.

Question	Response
Nevada Business License Number:	***NV20001233804***
Legal Entity Name:	***American Health Holding, Inc.***

Is “Legal Entity Name” the same name as vendor is doing business as?

Yes	***X***	No	

If “No”, provide explanation.

4.1.4 Vendors are cautioned that some services may contain licensing requirement(s). Vendors shall be proactive in verification of these requirements prior to proposal submittal. Proposals that do not contain the requisite licensure may be deemed non-responsive.

American Health acknowledges the above PEBP requirements.

4.1.5 Has the vendor ever been engaged under contract by any State of Nevada agency?

Yes		No	***X***

If “Yes”, complete the following table for each State agency for whom the work was performed. Table can be duplicated for each contract being identified.

Question	Response
Name of State agency:	
State agency contact name:	
Dates when services were performed:	
Type of duties performed:	
Total dollar value of the contract:	

4.1.6 Are you now or have you been within the last two (2) years an employee of the State of Nevada, or any of its agencies, departments, or divisions?

Yes		No	***X***

If “Yes”, please explain when the employee is planning to render services, while on annual leave, compensatory time, or on their own time?

If you employ (a) any person who is a current employee of an agency of the State of Nevada, or (b) any person who has been an employee of an agency of the State of Nevada within the past two (2) years, and if such person will be performing or producing the services which you will be contracted to provide under this contract, you must disclose the identity of each such person in your response to this RFP, and specify the services that each person will be expected to perform.

4.1.7 Disclosure of any significant prior or ongoing contract failures, contract breaches, civil or criminal litigation in which the vendor has been alleged to be liable or held liable in a matter involving a contract with the State of Nevada or any other governmental entity. Any pending claim or litigation occurring within the past six

(6) years which may adversely affect the vendor's ability to perform or fulfill its obligations if a contract is awarded as a result of this RFP must also be disclosed.

Does any of the above apply to your company?

Yes		No	***X***

If "Yes", please provide the following information. Table can be duplicated for each issue being identified.

Question	**Response**	
Date of alleged contract failure or breach:		
Parties involved:		
Description of the contract failure, contract breach, or litigation, including the products or services involved:		
Amount in controversy:		
Resolution or current status of the dispute:		
If the matter has resulted in a court case:	Court	Case Number
Status of the litigation:		

4.1.8 Vendors must review the insurance requirements specified in ***Attachment E, Insurance Schedule for RFP 3084.*** Does your organization currently have or will your organization be able to provide the insurance requirements as specified in ***Attachment E.***

Yes	***X*** ***As modified***	No	

Any exceptions and/or assumptions to the insurance requirements ***must*** be identified on ***Attachment B, Technical Proposal Certification of Compliance with Terms and Conditions of RFP.*** Exceptions and/or assumptions will be taken into consideration as part of the evaluation process; however, vendors must be specific. If vendors do not specify any exceptions and/or assumptions at time of proposal submission, the State will not consider any additional exceptions and/or assumptions during negotiations.

Upon contract award, the successful vendor ***must*** provide the Certificate of Insurance identifying the coverages as specified in ***Attachment E, Insurance Schedule for RFP 3084.***

American Health acknowledges the above PEBP requirements.

4.1.9 Company background/history and why vendor is qualified to provide the services described in this RFP. Limit response to no more than five (5) pages.

Founded in 1993, American Health provides medical management services to approximately 2.3 million lives across the United States, the Caribbean and Bermuda. We believe our capabilities can be best summarized by the qualities below, which position us as a uniquely qualified partner of PEBP for the delivery of medical management programs and services to the State of Nevada.

Our presence in Nevada

While we are a national medical management company, we are proud to provide a personal customer service experience. For PEBP, this includes extensive experience in your state. We service 169,540 lives in Nevada, including partnerships with multiple Health and Welfare funds.

In addition, our proposed account manager is based in Las Vegas and is experienced serving the State of Nevada. She is a registered nurse who holds a master's degree in Health Care Informatics from the University of Colorado. She will leverage her strong clinical and informatics background to build a consultative relationship with the PEBP.

Our customer service philosophy

We work hard every day to exceed our clients' expectations; as a result, they feel good about doing business with us. Our customer service philosophy can be described in the four points below, which offers clients a service experience that inspires loyalty and keeps them coming back for more.

- ***Flexibility: At American Health, one size does not fit all. We have designed our services to be flexible, which allows our customers to customize their programs to fit their unique needs. We have experience working with clients of all sizes and in many industries, so you can have confidence in our ability to help design the medical management program that works best for you.***
- ***Competitive price: Thanks to our efficiency and strong productivity management, we offer very competitive pricing. We strive to make our services valuable to our customers. Quality programs and services are still our focus.***
- ***Satisfaction: 96% of our clients are satisfied with our products and services. In addition, 98% believe that our staff are well-trained, knowledgeable professionals. Our people work hard every day to go above and beyond our clients' expectations. More than 60 of our clients have provided testimonials about our services, which we encourage you to view on our website: www.americanhealthholding.com. Additionally, please visit Tab IX to see the results of our most recent client satisfaction survey.***
- ***Relationships: A big part why so many of our clients are satisfied with our services is that we take the time to build consultative relationships. We listen to our clients' specific needs and work to find a solution, even if one is not apparent. We are trustworthy, attentive and proactive. We do not just have clients — we have partners.***

We tell our clients every day that if they ask us do something, we will try to figure out a way to do it; often at no extra charge.

Our differentiators

There are a few other attributes that set us apart:

***Quality**: We offer unparalleled quality in our products. Our Utilization Management and Case Management programs are URAC-accredited. Our team is credentialed and experienced, our clinical programs use national guidelines and we have checks and balances along the way to ensure we are making appropriate decisions.*

Our comprehensive Total Quality Management (TQM) program is designed as an objective and systematic approach to monitoring and evaluating the quality of services we provide to our clients, their groups and members. The TQM Program includes regular auditing, monitoring and evaluation of performance against key indicators, thus enabling American Health to deliver continuous improvements and improved results.

***Best system platform, reporting and analytics**: We believe our medical management system, iSuite, is the best in the industry. iSuite integrates our programs and provides the efficiency we need to get things done quickly and correctly. With iSuite, we manage work and offer system access to both HealthSCOPE and the State, allowing for full visibility into medical management activities.*

iSuite is web-based, meaning users can access its powerful features without the costly installation, set up, maintenance, hardware and software support costs typically associated with technology investments. iSuite's rules and workflow engine automate all managed care processes and, because it places the patient at the center of all activities, integrates Utilization Management and Case Management.

iSuite's EZ Reports tool allows users to access a wide variety of reports on demand. Over the past several years, we have made a multi-million dollar investment in our Business Intelligence department, resulting in reporting capabilities that are best in class. We are positioned to make additional strides in our ability to quickly and proactively spot trends in outcomes, evaluate outliers and better assist plans in managing the health and wellness of their populations.

***Integration with HealthSCOPE Benefits**: American Health has a strong relationship with HealthSCOPE. We work together to deliver custom and cost-effective solutions to approximately 35 HealthSCOPE groups, ranging in size from five to 74,000 employees. We have a high level of daily interaction already in place to ensure seamless service to clients.*

***Specialty Case Management**: Our URAC-accredited Case Management services are designed to improve the quality of patient care while maximizing cost savings. We provide individuals a better understanding of specialized care needs, access to Centers of Excellence and specialty care facilities, education on alternatives to costly inpatient care and direction toward in-network discounts. We work with members to educate and help them make choices that contribute to a healthier lifestyle, thus reducing the incidence of complications and future medical costs. Our Specialty Case Management programs meet the complex needs of members in need of services for Maternity, Neonatal and Pediatrics, Oncology and Transplant cases.*

***Data analytics**: American Health has made substantial investments in reporting and analytics since 2011, including the following:*

- ***Built a data warehouse, which allows us to provide answers in a matter of hours***
- ***Formed a new Business Intelligence department***
- ***Assembled a team of eight informatics professionals and data analysts***
- ***Added substantial features to our quarterly reports***
- ***Enhanced our Executive Summary reporting capabilities for large groups***

However, our journey is not complete. Future plans include the introduction of a Client Information Portal for web-based, interactive analytics. We also have plans to leverage ICD-10 for deeper analysis into intervention opportunities and to improve our claims data management capabilities and prepare for the advanced needs of population health monitoring.

4.1.10 Length of time vendor has been providing services described in this RFP to the public and/or private sector. Please provide a brief description.

American Health has provided clinical management services, including Utilization Management and Case Management, since 1993 to a wide variety of entities such as TPAs, HMOs, PPOs, IPAs, Taft-Hartley multi-employer/union funds, single employer (corporate), City/State/Federal government, schools, and associations. We currently provide medical management services to nearly 2.3 million members.

4.1.11 Financial information and documentation to be included in Part III, Confidential Financial Information of vendor's response in accordance with Section 9.5, Part III – Confidential Financial Information.

4.1.11.1 Dun and Bradstreet Number

4.1.11.2 Federal Tax Identification Number

4.1.11.3 The last two (2) years and current year interim:

Profit and Loss Statement
Balance Statement

Per 4.1.11, responses to the above information can be found in Part III – Confidential Financial Information, which is included with our submission.

See Part III - Confidential Financial Information
- 4.1.11.3 Aetna Financial Information and Documentation

4.2 SUBCONTRACTOR INFORMATION

4.2.1 Does this proposal include the use of subcontractors?

Yes	***X***	No	

If "Yes", vendor must:

4.2.1.1 Identify specific subcontractors and the specific requirements of this RFP for which each proposed subcontractor will perform services.

American Health utilizes the services of Family Practice Outreach, LLC, which is owned by Roland Griggs, M.D., our medical director who oversees our

Utilization Management process. In certain circumstances, our nurses and case managers will refer cases for review to Dr. Griggs. Cases may also be referred to our Consulting Physician Review Panel or to an Independent Review Organization (IRO). For purposes of this RFP, and unless instructed otherwise by PEBP, American Health considers Dr. Griggs as our only subcontractor and has included the appropriate subcontractor information in our proposal. American Health considers the IROs to be vendors versus subcontractors.

4.2.1.2 If any tasks are to be completed by subcontractor(s), vendors must:

A. Describe the relevant contractual arrangements;

American Health's board-certified medical director plays a number of key roles in the delivery of our medical management programs. For example, if a case has unique circumstances that raise questions for the Utilization Management nurse handling the case, the medical director will review the case to determine the best course of action and reach out to the member's physician for a peer-to-peer discussion, if necessary. Our medical director also reviews all cases for which a provider or member has received an adverse review/decision to determine appropriate next steps. Our medical director also serves on the Total Quality Management Committee (TQM), reviews and approves the TQM Program Plan and Description and provides physician consultation for new procedures or new technology/pharmacology.

B. Describe how the work of any subcontractor(s) will be supervised, channels of communication will be maintained and compliance with contract terms assured; and

Certain delegated activities are regularly audited through the American Health TQM Program. Results of TQM Program audits are presented monthly to Senior Directors and Clinical Operations and quarterly to the TQM committee. American Health also reserves the right to investigate/audit a subcontractor's performance at any time. American Health monitors performance using the specifications described in the contract/subcontract, quality indicators, and monthly financial and project management reports.

C. Describe your previous experience with subcontractor(s).

Dr. Griggs has been American Health's consulting medical director since 1993, bringing more than 22 years of medical management experience. Dr. Griggs is a licensed physician in 20 states. He received his B.A. from Dartmouth College and a Medical Degree and Masters Degree in Hospital and Health Services Administration from The Ohio State University. Dr. Griggs is certified in Quality Assurance and Utilization Review by the American Board of Quality Assurance and Utilization Review Physicians (ABQAURP) and by the American Board of Medical Specialties certified for Family Medicine.

4.2.1.3 Vendors must describe the methodology, processes and tools utilized for:

A. Selecting and qualifying appropriate subcontractors for the project/contract;

Dr. Griggs has served as American Health's consulting medical director since 1993, our year of inception. For detailed information on his qualifications, please reference our response to 4.2.1.2 C. Our selection of vendors is based on a process including documenting our requirements, identifying multiple vendors who meet the requirements, evaluating them on consistent criteria, checking references, narrowing the vendor field, and selection.

B. Ensuring subcontractor compliance with the overall performance objectives for the project;

American Health monitors performance using the specifications described in the contract/subcontract, quality indicators, and monthly financial and project management reports. Additionally, our TQM Program includes audits that ensure subcontractor compliance with performance objectives.

C. Ensuring that subcontractor deliverables meet the quality objectives of the project/contract; and

Please see our response to 4.2.1.3 B above.

D. Providing proof of payment to any subcontractor(s) used for this project/contract, if requested by the State. Proposal should include a plan by which, at the State's request, the State will be notified of such payments.

American Health acknowledges this PEBP requirement. If proof of subcontractor payment is requested, we will notify the State in a manner agreed to by both parties.

4.2.1.4 Provide the same information for any proposed subcontractors as requested in ***Section 4.1, Vendor Information***.

Question	Response
Company name:	***Family Practice Outreach, LLC***
Ownership (sole proprietor, partnership, etc.):	***LLC***
State of incorporation:	***Ohio***
Date of incorporation:	***09/10/1987***
# of years in business:	***27***
List of top officers:	***Roland Griggs, MD***
Location of company headquarters:	***7739 East Broadway, #360, Tucson, AZ 85710***
Location(s) of the company offices:	***Tucson, AZ***

Question	Response
Location(s) of the office that will provide the services described in this RFP:	***Tucson, AZ***
Number of employees locally with the expertise to support the requirements identified in this RFP:	***n/a***
Number of employees nationally with the expertise to support the requirements in this RFP:	***1***
Location(s) from which employees will be assigned for this project:	***Tucson, AZ***

4.2.1.5 Business references as specified in ***Section 4.3, Business References*** must be provided for any proposed subcontractors.

American Health acknowledges this requirement and has provided three references. The references for medical management services also include comments representing client feedback for the services that are performed by Dr. Griggs as medical director.

4.2.1.6 Vendor shall not allow any subcontractor to commence work until all insurance required of the subcontractor is provided to the vendor.

American Health acknowledges the above requirement.

4.2.1.7 Vendor must notify the using agency of the intended use of any subcontractors not identified within their original proposal and provide the information originally requested in the RFP in ***Section 4.2, Subcontractor Information***. The vendor must receive agency approval prior to subcontractor commencing work.

American Health acknowledges the above requirement.

4.3 BUSINESS REFERENCES

4.3.1 Vendors should provide a minimum of three (3) business references from similar projects performed for private, state and/or large local government clients within the last ten (10) years.

American Health acknowledges this requirement and has provided three references.

4.3.2 Vendors must provide the following information for ***every*** business reference provided by the vendor and/or subcontractor:

The "Company Name" must be the name of the proposing vendor or the vendor's proposed subcontractor.

Reference #:	***1 – HealthSCOPE Benefits, Inc.***		
	American Health Holding, Inc.		
Identify role company will have for this RFP project (Check appropriate role below):			
X	***VENDOR***		***SUBCONTRACTOR***
Project Name:	Utilization Management and Case Management Vendor		

Primary Contact Information	
Name:	***Mary Catherine Person***
Street Address:	***27 Corporate Hill Drive***
City, State, Zip	***Little Rock, AR 72205***
Phone, including area code:	***501-225-1551***
Facsimile, including area code:	***501-225-9354***
Email address:	Mary.person@healthscopebenefits.com
Alternate Contact Information	
Name:	***Pat Kauffman***
Street Address:	***27 Corporate Hill Drive***
City, State, Zip	***Little Rock, AR 72205***
Phone, including area code:	***501-218-7753***
Facsimile, including area code:	***501-225-9354***
Email address:	Pat.kauffman@healthscopebenefits.com
Project Information	
Brief description of the project/contract and description of services performed, including technical environment (i.e., software applications, data communications, etc.) if applicable:	***American Health serves as a medical management vendor partner for HealthSCOPE Benefits. We regularly exchange electronic enrollment and plan data in the manner described within our response. In addition, our leadership and account services teams are in continual contact in an effort to ensure client satisfaction.***
Original Project/Contract Start Date:	***June 1, 2009***
Original Project/Contract End Date:	***June 1, 2015***
Original Project/Contract Value:	***The annual revenue for each reference provided by American Health is between one million and 410 million dollars.***
Final Project/Contract Date:	***n/a***
Was project/contract completed in time originally allotted, and if not, why not?	***This is not applicable to the relationship between HealthSCOPE Benefits and American Health, as our contract and partnership are ongoing.***
Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	***This is not applicable to the relationship between HealthSCOPE Benefits and American Health, as our contract and partnership are ongoing.***

Reference #:	***2 – State of Arkansas***		
	American Health Holding, Inc.		
Identify role company will have for this RFP project (Check appropriate role below):			
X	***VENDOR***		***SUBCONTRACTOR***
Project Name:	Utilization Management and Case Management Vendor		

Primary Contact Information	
Name:	***Michele Hazelett***
Street Address:	***501 Woodlane Avenue, Ste. 500***
City, State, Zip	***Little Rock, AR 72201***
Phone, including area code:	***501-682-5500***
Facsimile, including area code:	***501-682-1168***
Email address:	Michele.hazelett@dfa.arkansas.gov
Alternate Contact Information	
Name:	***Doug Shackleford***
Street Address:	***501 Woodlane Avenue, Ste. 500***
City, State, Zip	***Little Rock, AR 72201***
Phone, including area code:	***501-682-5500***
Facsimile, including area code:	***501-682-1168***
Email address:	Doug.shackleford@dfa.arkansas.gov
Project Information	
Brief description of the project/contract and description of services performed, including technical environment (i.e., software applications, data communications, etc.) if applicable:	***American Health provides Utilization Management, Case Management, Disease Management, bariatric program services, Maternity Management, and 24/7 Nurse Line for the State of Arkansas. The group utilizes our iSuite system. In addition, we coordinate imports/exports, plan rules, case transition, telecommunications, letters, reports and system access.***
Original Project/Contract Start Date:	***July 1, 2007***
Original Project/Contract End Date:	***July 1, 2010***
Original Project/Contract Value:	***The annual revenue for each reference provided by American Health is between one million and 410 million dollars.***
Final Project/Contract Date:	***July 1, 2013 to June 30, 2014***
Was project/contract completed in time originally allotted, and if not, why not?	***The original contract was completed in the time originally allotted and was extended through June 30, 2014. The State of Arkansas is currently under contract for services with American Health. As such, this is not applicable to the current contract.***
Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	***The State of Arkansas is currently under contract for services with American Health. As such, this is not applicable to the current contract.***

Reference #:	***3 – State of Arizona***		
	American Health Holding, Inc.		
Identify role company will have for this RFP project (Check appropriate role below):			
X	***VENDOR***		***SUBCONTRACTOR***
Project Name:	Utilization Management and Case Management Vendor		
Primary Contact Information			
Name:	***Chanelle Bergren***		
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Project Information			
Brief description of the project/contract and description of services performed, including technical environment (i.e., software applications, data communications, etc.) if applicable:	***American Health provides the following services to the State of Arizona: Utilization Management, Case Management (including Transplant and Out-of-Network Negotiations), Disease Management, Maternity Management, and 24/7 Nurse Line. The group utilizes our iSuite system. In addition, we coordinate imports/exports, plan rules, case transition, telecommunications, letters, reports and system access.***		
Original Project/Contract Start Date:	***January 1, 2008***		
Original Project/Contract End Date:	***December 31, 2014, by amendment***		
Original Project/Contract Value:	***The annual revenue for each reference provided by American Health is between $1 million and 410 million dollars.***		
Final Project/Contract Date:	***January 1, 2014-December 31, 2014 (amended)***		
Was project/contract completed in time originally allotted, and if not, why not?	***The original contract was completed in the time originally allotted and was extended through December 31, 2014. The State of Arizona is currently under contract for services with American Health. As such, this is not applicable to the current contract.***		
Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	***The State of Arizona is currently under contract for services with American Health. As such, this is not applicable to the current contract.***		

4.3.3 Vendors must also submit ***Attachment F, Reference Questionnaire*** to the business references that are identified in ***Section 4.3.2***.

American Health acknowledges the above PEBP requirements.

4.3.4 The company identified as the business references must submit the Reference Questionnaire directly to the Purchasing Division.

American Health acknowledges that our three references must submit Attachment F, Reference Questionnaire to the State of Nevada Purchasing Division.

4.3.5 It is the vendor's responsibility to ensure that completed forms are received by the Purchasing Division on or before the deadline as specified in ***Section 8, RFP Timeline,*** for inclusion in the evaluation process. Reference Questionnaires not received, or not complete, may adversely affect the vendor's score in the evaluation process.

American Health acknowledges the above PEBP requirements.

4.3.6 The State reserves the right to contact and verify any and all references listed regarding the quality and degree of satisfaction for such performance.

American Health acknowledges the above PEBP requirements.

4.4 VENDOR STAFF RESUMES

A resume must be completed for each proposed key personnel responsible for performance under any contract resulting from this RFP per ***Attachment G, Proposed Staff Resume.***

Please see our completed Attachment G, Proposed Staff Resumes in Tab VIII.

5 COST

5.1 Vendors must provide detailed fixed prices for all costs associated with the responsibilities and related services. Clearly specify the nature of all expenses anticipated (refer to Attachment I, Cost Schedule).

American Health acknowledges the above PEBP requirements.

5.2 PEBP currently pays its Utilization Management/Large Case Management vendor $1.65 per participant per month (PPPM) for Large Case Management and $1.09 PPPM for Utilization Management.

American Health acknowledges the above information.

6. FINANCIAL

6.1 PAYMENT

6.1.1 Upon review and acceptance by the State, payments for invoices are normally made within 45 – 60 days of receipt, providing all required information, documents and/or attachments have been received.

American Health acknowledges the above PEBP requirements.

6.1.2 Pursuant to NRS 227.185 and NRS 333.450, the State shall pay claims for supplies, materials, equipment and services purchased under the provisions of this RFP electronically, unless determined by the State Controller that the electronic payment would cause the payee to suffer undue hardship or extreme inconvenience.

American Health acknowledges the above PEBP requirements.

6.2 BILLING

6.2.1 The State does not issue payment prior to receipt of goods or services.

American Health acknowledges the above PEPB requirement.

6.2.2 The vendor must bill the State as outlined in the approved contract and/or payment schedule.

American Health acknowledges the above PEPB requirement.

6.2.3 Vendors may propose an alternative payment option. Alternative payment options must be listed on ***Attachment J, Cost Proposal Certification of Compliance with Terms and Conditions of the RFP.*** Alternative payment options will be considered if deemed in the best interest of the State, project or service solicited herein.

American Health acknowledges the above PEBP requirements.

7. WRITTEN QUESTIONS AND ANSWERS

In lieu of a pre-proposal conference, the Purchasing Division will accept questions and/or comments in writing, received by email regarding this RFP.

American Health acknowledges the above PEBP requirements.

7.1 QUESTIONS AND ANSWERS

7.1.1 The RFP Question Submittal Form is located on the Services RFP/RFQ Opportunities webpage at http://purchasing.state.nv.us/services/sdocs.htm. Select this RFP number and the "Question" link.

American Health acknowledges the above PEBP requirements.

7.1.2 The deadline for submitting questions is as specified in ***Section 8, RFP Timeline***.

American Health acknowledges the above PEBP requirements.

7.1.3 All questions and/or comments will be addressed in writing and responses emailed or faxed to prospective vendors on or about the date specified in ***Section 8, RFP Timeline***.

American Health acknowledges the above PEBP requirements.

3. SCOPE OF WORK

The Public Employees' Benefits Program (PEBP) is seeking a vendor that will work in partnership with PEBP and other PEBP vendors to assure the continued success of the PEBP CDHP. Vendors are required to duplicate the level of service presently offered to the participants of the PEBP CDHP. This does not, however, preclude proposing vendors from presenting alternative solutions that relate to Utilization Management and Large Case Management services.

UM services shall include, but will not be limited to, the following:

- Utilization management and large case management;
- Pre-certification of specified medical services to determine medical necessity;
- Concurrent and retrospective review; and
- Management reporting.

PEBP oversees the administration of the CDHP medical and dental plans. The medical plan requires the services of a Utilization Management (UM) vendor to provide pre-certification services, utilization management, large case management, and other medical management services for the participants of the PEBP CDHP as described in this RFP.

American Health acknowledges the above information.

3.1 CURRENT PLAN CENSUS

The CDHP plan covers all eligible State employees, certain non-state local government agencies, full-time employees of the Nevada System of Higher Education, and members of the Nevada Senate and Assembly. Dependents of the above-mentioned groups may also be covered. Benefits are also extended to retirees who are receiving benefits from specified public retirement systems, their surviving spouses, and/or eligible dependent children.

As of August 1, 2013, PEBP has approximately 42,183 plan participants who include active and retired individuals from the state and from several local government employers. Of those, 19,332 have elected the self-funded medical Consumer Driven Health Plan (CDHP) and dental PPO Plan; 11,146 participants have elected coverage from a Health Maintenance Organization (HMO) for medical benefits; and 9,761 participants are on the Medicare Exchange for medical benefits. Only those participants and their covered dependents enrolled in the CDHP are eligible for utilization management/large case management as defined under this contract.

	Primary	Dependents	Total
State Active			
CDHP	14,754	13,095	27,849
Non-state Active			
CDHP	7	6	13
State Retiree			
CDHP	2,866	1,168	4,034
Non-state Retiree			

CDHP	1,705	244	1,949
Totals	19,332	14,513	33,845

American Health acknowledges the above information.

3.2 CURRENT PEBP VENDORS

- HealthSCOPE Benefits - Third Party Claims Administrator, HSA and HRA Administrator (CDHP), FSA Administrator, National Medical PPO Network;
- Catamaran Rx - Pharmacy Benefits Manager (CDHP);
- Walgreens Pharmacy and Walgreens Specialty Pharmacy – Subcontractor of Catamaran Rx for mail order and specialty drug services;
- Extend Health - Medicare Exchange and HRA Administration for participants on the Exchange;
- Sierra Healthcare Options and Hometown Health Providers – Nevada Statewide Medical PPO Network (PPO Plan);
- Diversified Dental Services - Dental PPO Network (HMO and CDHP);
- Health Claim Auditors - Health Plan Auditor services (Excludes HMO vendors);
- Aon Hewitt - Actuary/ Consultants;
- Hometown Health Plans – Northern Nevada HMO;
- Health Plan of Nevada - Southern Nevada HMO; and
- Hometown Health Providers - Utilization Management, Large Case Management.

American Health acknowledges the above information.

3.3 UTILIZATION MANAGEMENT, CASE MANAGEMENT, AND PRE-CERTIFICATION

Please refer to PEBP's Master Plan Document (MPD) for a complete list of services that require pre-certification at www.pebp.state.nv.us. Please note that the MPD posted on the PEBP website is indicative of the current plan year only.

3.3.1 The plan's current utilization management program includes the following services:

3.3.1.1 Case management and large case management;

3.3.1.2 All elective inpatient hospital admissions, including planned use of a hospital for a dental purpose;

Exception: a pregnant mother does not need to notify the UM company about the admission for delivery unless the stay will exceed 48 hours for a vaginal delivery or 96 hours for a C-section.

3.3.1.3 All admissions to a skilled nursing facility or sub-acute facility;

3.3.1.4 All admissions to any hospital or rehab facility for rehabilitation therapy;

3.3.1.5 All organ/tissue pre-transplantation related expenses, including the admission for transplantation services;

3.3.1.6 Foot surgeries such as bunionectomy, correction of hammer toes, or corrective procedures on metatarsals, phalanges (toes), metatarsophalangeal joint, and interphalanageal joint;

3.3.1.7 Carpal tunnel surgery;

3.3.1.8 Genetic testing and/ or counseling for, but not limited to amniocentesis, chorionic villus sampling (CVS), alphafetoprotein (AFP), BRCA1 and BRCA2, and apo E;

3.3.1.9 Weight-loss surgery;

3.3.1.10 All spinal surgeries, inpatient or outpatient, to include but not limited to laminotomy, discectomy, stereotaxis and neurostimulators;

3.3.1.11 Dialysis- Inpatient and Outpatient;

3.3.1.12 Cardiac Pace Makers;

3.3.1.13 Illnesses requiring chemotherapy;

3.3.1.14 Any procedure that might be deemed to be experimental and/or investigational; and

3.3.1.15 Durable medical equipment when the cost is expected to exceed $1,000.00.

American Health acknowledges the above PEPB requirements.

3.4 MANAGEMENT REPORTING

3.4.1 The UM vendor must provide management reports in a form and content approved by PEBP. These reports will be provided at PEBP's request in a hard copy and/or electronic media format to PEBP and PEBP's actuary/consultant when requested. PEBP is looking to its vendors to propose reporting that could best meet the needs of the State and the program.

3.4.2 UM vendor must provide access to the UM vendor's web-based reporting tools to assigned PEBP staff.

3.4.3 The UM vendor must also have the capability to provide ad hoc reports at PEBP's request at no additional cost. Proposing vendors should include sample copies of reports as an attachment to their proposals.

American Health acknowledges the above PEBP requirements.

3.5 VENDOR STAFFING

The UM vendor must maintain sufficient staff to meet the needs of PEBP and PEBP participants, including but not limited to the following:

3.5.1 An account manager, whose primary responsibility is PEBP;

3.5.2 Registered nurses, whose primary responsibility is PEBP; and

3.5.3 Technicians whose primary responsibility is to assist PEBP staff, PEBP participants, and PEBP providers with answers to questions.

3.5.4 Nursing licensure requirements may be required in all 50 states. Vendors are encouraged to review current licensing capabilities and compare them with the requirements in the State of Nevada www.nursingboard.state.nv.us.

American Health acknowledges the above PEBP requirements. Regarding 3.5.3, American Health considers "technicians whose primary responsibility is to assist PEBP staff…." to refer to our Intake Coordinators. While our Utilization Management staff is nurse-driven, it is supplemented by our Intake Coordinators, who work with providers and/or members to complete documentation during an initial call.

3.6 QUALITY ASSURANCE

The UM vendor is responsible for internal quality control processes to regularly evaluate the performance and accuracy of the services provided. Findings of internal quality control evaluations will be provided to PEBP and will be included in quarterly reports provided to the PEBP Board.

American Health acknowledges the above PEBP requirements.

3.7 UTILIZATION REVIEW AND PRE-CERTIFICATION APPEAL RESOLUTION

The UM vendor is responsible for adhering to an appeal process certified by an accredited organization such as URAC. The current appeal process is outlined in PEBP's Master Plan Document (MPD) found at www.pebp.state.nv.us.

American Health acknowledges the above PEBP requirements. We are accredited by URAC for Health Utilization Review. As such, our appeals process complies with URAC and DOL requirements as applicable.

3.8 NOTIFICATION OF SUB-CONTRACTORS

3.8.1 Disclosure of the names of all vendor subcontractors, as well as the physical locations where PEBP data is maintained and/or stored, must be communicated to PEBP at least 60 days prior to contract implementation.

3.8.1.1 Implementation will not be permitted until PEBP has provided written authorization to the vendor.

3.8.1.2 Failure of the vendor to notify PEBP of a change to (or addition of) an authorized subcontractor may result in a financial penalty.

A. The financial penalty is identified in the Performance Standards, Guarantees, and Penalties section of the RFP (Section 3.19.1).

B. Failure to disclose a subcontractor or other entity at least 60 days prior to the subcontractor or other entity having access to PEBP data will result in a penalty of 5% of the vendor's previous year's billed administrative charges per occurrence. Should subsequent billed charges not be sufficient to cover the penalty in full, the balance will be billed by PEBP and considered due upon receipt. Vendors must indicate their organization's acknowledgement of this requirement.

American Health has one named subcontractor, Family Practice Outreach, LLC, which is owned by Roland Griggs, MD, our medical director of 20 years. While we do not foresee any changes to this long-standing relationship, we recognize that if for some reason (for an example, a health issue) Dr. Griggs is no longer able to serve as medical director, American Health would respond promptly to identify and contract with an appropriate replacement. Because such an event could occur without notice, we are not able to accept the notification and penalty requirement defined above. With that said, we commit to timely, open communication with PEBP on any subcontractor change and would provide updates on the transition.

3.9 COLLABORATION WITH PEBP AND PEBP VENDORS

3.9.1 The UM/CM vendor will be required to allow PEBP's Third Party Administrator, HealthSCOPE Benefits, view-only access to its Utilization Management/Case Management IT system on a real-time basis.

3.9.2 The UM/CM vendor will be required to set up an electronic interface with PEBP's Third Party Administrator, HealthSCOPE Benefits, for daily feeds of pre-certifications and authorizations.

3.9.3 The UM/CM vendor will be required to host bimonthly calls with PEBP and other vendors as identified by PEBP for status reports on participants enrolled in large case management.

3.9.3.1 As the host, the UM/CM vendor agrees to provide a toll-free number

and passcodes for PEBP approved vendors to access the bimonthly calls. These calls will allow for PEBP and its vendors to collaborate on the direction of care and provide solutions to any issues that may be identified.

3.9.3.2 Before each call, the UM/CM vendor will send via secure email, a large case management report to PEBP and its participating vendors in a format approved by PEBP. The report will include, but not be limited to, the names of the individual patients who are under large case management, ID number of primary PEBP participant, the diagnosis(es), current treatment, and place of treatment. The discussion will include:

A. The case manager's recommendations (if any) for treatment based on the unique needs of each PEBP participant enrolled in large case management;

B. Any claim payment issues the participant may have experienced to allow PEBP's Third Party Administrator, HealthSCOPE Benefits, the opportunity to resolve; and

C. Any prescription drug issues the participant may have experienced to allow PEBP's pharmacy benefit manager, Catamaran, the opportunity to resolve.

3.9.4 There may be instances where a Letter of Agreement is warranted for services provided, for example, at an out-of-network provider. The UM/CM vendor understands that PEBP and its third party administrator, HealthSCOPE Benefits, will have full discretionary authority to determine the level of benefits that will be provided. Please indicate your organization's ability to provide these services with these requirements.

3.9.5 PEBP contracts with a health plan auditor to perform routine audits on behalf of PEBP. PEBP and its health plan auditor will comply with all applicable confidentiality laws and will not reveal any confidential information acquired as a result of the audit. PEBP has the right to review/audit records for the entire term of the contract without limitation. Any information, documents, etc., which the UM/CM vendor may deem as containing "trade secrets" or "proprietary information" will not preclude an examination of such items through the audit process. Please indicate that your organization would agree to this condition.

American Health acknowledges each of the above PEBP requirements in 3.9.

3.10 REVIEWED CASES

For the time period of July 1, 2012, through June 30, 2013, the current UM vendor provided the review services for PEBP as detailed in ***Attachment L – UM-CM Vendor Report Format***.

American Health acknowledges the above.

3.11 CARE COORDINATION

3.11.1 Case Management and Large Case Management

Case management is a collaborative process which assesses plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality and cost-effective outcomes.

3.11.1.1 How long has your organization provided case management services?

American Health has provided Case Management services since 1993.

3.11.1.2 What location will house the staff (including nurses) that will be responsible for PEBP's case management?

Please see American Health's recommended Case Management staffing solution for PEBP, which is detailed below.

	Case Management	Specialty Case Management (Renal/Maternity/Oncology /Transplant)	Intake
Dedicated Staff	Yes	Yes	Yes
Location	Case Management services will be provided telephonically by American Health telecommuting case managers in various US locations. In addition, subject to availability our Case Management staffing will include a nurse located in Northern Nevada.	Case Management services will be provided telephonically by American Health telecommuting case managers in various US locations.	Intake services will be provided telephonically by American Health staff located in our corporate offices in Ohio.
Comments	To increase efficiency and effectiveness during high volume and vacation periods, back up will be provided telephonically by American Health corporate or telecommuting case managers. Our goal is always to provide dedicated staff; however, this is also dependent on volume.	American Health case managers are highly skilled in their areas of specialty. Our goal is always to provide dedicated staff; however, this is also dependent on volume.	Our goal is always to provide dedicated staff; however, this is also dependent on volume.
Features of Staffing Model	Even though select Case Management services may not require dedicated staff, our Case Ownership Model assigns a specific nurse to each member with an open case. Our model enables us to focus on individuals (rather than just "callers") once a case has been identified via our Utilization Review process or through alternative methods for identification and referral. Our model also allows us to be more fully cognizant of both the personal and financial implications of a case in a "real time" environment. Communication between Case Management and Utilization Management is enhanced through iSuite, American Health's proprietary, integrated medical management software system. Our nurses can see each other's cases through iSuite and collaborate to ensure the member is getting the best possible care. As an added benefit to PEBP, we can load the State's network information in iSuite on a weekly or monthly basis so all nurses, regardless of their location, will have access to the State's listing of in-network physicians and providers.		

American Health is committed to providing "best in class" service to the nearly 169,540 lives we currently cover in the state of Nevada. For the July 1, 2014 implementation, our philosophy is to recruit additional nurses in Nevada and its

surrounding states in order to further strengthen Case Management services we provide to Nevada-residing members. In addition, subject to availability our Case Management staffing will include a nurse located in Northern Nevada.

3.11.1.3 Does your organization provide telephonic case management services, onsite case management, or a combination of both?

American Health is proposing a telephonic Case Management model.

3.11.1.4 Please describe in detail your organization's criteria for general case management services. Examples of general case management instances are provided below. The following information should be included as an attachment to your proposal:

A. Opportunities to transfer patients to facilities offering an appropriate level of care more cost effectively;

B. Meeting durable medical equipment needs;

C. Planning for hospital discharges;

D. Coordinating home health care needs;

E. Coordinating hospice care; and

F. Coordinating community based services.

Placement into Case Management is based on the ability to impact the quality, cost and/or appropriateness of services via a case manager's interventions. Patients who have had frequent admissions (two or more in less than six months) are considered for Case Management services in order to avert ongoing readmissions. Cases are assigned by case type according to the level of nursing assessment, coordination, planning and evaluation requirements, the severity of illness and/or the number of co-morbidities, the complexity of treatment plan, the anticipated length of case duration, and the client's need for medical information, cost projection or prognosis. Following are examples of case types for which American Health provides Case Management services:

- ***Large Case Management***
- ***Continuing Care Coordination***
- ***Research and Review***
- ***Medical Disclosure***
- ***Behavioral Health/Substance Abuse***
- ***Maternal Newborn***
- ***Short-term Case Management (STCM)***

Opportunities to transfer patients to facilities offering an appropriate level of care more cost effectively is a standard part of our process and contributes to cost savings.

See Additional Attachments included with our Proposal

- 3.11.1.4 – 3.11.1.5 Case Management Criteria and Case Types

3.11.1.5 Please describe in detail your organization's criteria for large case management. This information should be included as an attachment to your proposal. Examples of potential large case management instances are provided below:

A. Repeated in-patient admissions, excessive length of stay, or frequent treatment;

B. Potentially large-dollar claims;

C. Chronic or progressive disease;

D. Lack of qualified care-givers in the home setting;

E. Multiple diagnoses;

F. Acute or subacute rehabilitation of physical, speech, or occupational therapies which exceed three (3) months of treatment;

G. IV therapy or parenteral nutrition;

H. Severe injuries; and

I. Non-compliance with medical treatment plan as prescribed by physician or other health care provider.

As indicated in our response above, American Health assigns cases to Case Management based on criteria and case type. For complete details, please refer to the document 3.11.1.4 – 3.11.1.5 Case Management Criteria and Case Types included in the Attachments section of our proposal.

See Additional Attachments included with our Proposal

- 3.11.1.4 – 3.11.1.5 Case Management Criteria and Case Types

3.11.1.6 Does your organization allow self-referrals for large case management? Will your organization allow PEBP to refer covered individuals for large case management? These services shall be provided at no additional cost.

Yes. American Health will allow self-referrals and referrals by PEBP for Large Case Management at no additional charge.

3.11.1.7 Please describe your organization's philosophy regarding large case management. For example, is the goal of your organization to assist with restoration of the patient health and function, management of outcomes, and prevention of primary and secondary complications? Please describe your organization's philosophy in detail, explaining how your organization maintains its philosophy and achieves maximum outcomes for complicated large cases.

Case Management opportunities are identified during the Utilization Review process, using nationally recognized criteria and systems to flag a member's current medical situation. The system incorporates an automated trigger list that can be customized by PEBP. This list is based on ICD-9, CPT and dollar threshold criteria. A case is also flagged when a member's length-of-stay reaches five days. When a case is identified for potential Case Management, it is then referred for further evaluation to ensure we work the right cases at the right times to achieve the best outcomes for both the member and PEBP. Once high-risk cases are identified, our Case Management program matches the level and method of services to the intensity of the case in the most cost-efficient manner possible.

While all health care delivery requires some level of management, some cases need more focused intervention than others. The goal of our Case Management program is to target those cases that require more attention in order to achieve better medical outcomes for members and greater cost savings for our customers. Our criteria and systems are specifically designed to identify complicated large cases such as catastrophic and complex illnesses, transplants and trauma cases. They also prompt our review specialists to ask questions about seemingly routine, uncomplicated cases that may reveal increased risk.

PEBP will benefit from our ability to provide a high level of integration between our Utilization Management and Case Management products. Our ability and expertise with providing you with tightly integrated solutions both sets our medical management apart in the marketplace and results in early intervention, providing substantial cost savings.

3.11.1.8 Please describe in detail how your organization coordinates transplant cases. This information should be provided as an attachment to your proposal.

American Health's Case Management criteria and systems are specifically designed to identify catastrophic and complex illnesses, transplants and trauma cases. Once high-risk cases are identified, American Health Case Management matches the level and method of case management services to the intensity of the case in the most cost-efficient manner possible.

See Additional Attachments included with our Proposal

- 3.11.1.8 – 3.11.1.9 Transplants and Centers of Excellence

3.11.1.9 PEBP's third party administrator coordinates transplant services with recognized Centers of Excellence. Does your organization

work with a Centers of Excellence referral program? Will your organization agree to work in cooperation with PEBP's third party administrator assisting the participants who require care at a Center of Excellence?

American Health coordinates with the third-party administrator or other vendor partner to coordinate services and negotiate pricing. If PEBP requires a referral to a specific network, our nurses work with the member and recommend an in-network facility with the best services and location. American Health will agree to work in cooperation with PEBP's third-party administrator to assist participants who require care at a Center of Excellence.

See Additional Attachments included with our Proposal

- 3.11.1.8 – 3.11.1.9 Transplants and Centers of Excellence

3.11.1.10 For an account the size of PEBP, how many covered individuals would your organization expect to meet large case management criteria?

For an account the size of PEBP, we would expect to have approximately 500-600 cases open per year. This estimate is based on the anticipated case volume that would result from American Health's Utilization Management triggers, as well as referrals from other sources.

PEPB's Case Management volume as reported in Amendment 2 is lower than what we would expect. This is reflected in the pricing we provided in our Cost Proposal. Our pricing assumes no more than 20% greater than the utilization provided in Amendment 2 to Request for Proposal 3084.

3.11.1.11 Please describe in detail how your organization's case managers would interact with patients, patients' families, and PEBP.

Case managers speak with the member, family members (with member's permission), treating physicians and facilities to ensure the best treatment plan for the individual. Case managers step in to help members efficiently navigate the health care system. They work with members to:

- ***Help them understand what to expect during the course of their treatment***
- ***Establish collaborative long- and short-term goals***
- ***Complete telephonic assessments that assist in determining Case Management needs and requirements***
- ***Provide education on how to effectively interface with their providers***
- ***Address questions or concerns the member and/or family members may have throughout treatment and recovery***

Key to Case Management success is our case managers' ability to identify, coordinate and negotiate alternative treatment plans and related costs. American Health works to judiciously expedite a member's move from a costly inpatient setting to the most appropriate alternate setting. This requires the case manager to work with the member, family, treatment providers and facilities, as well as with additional ancillary vendors such as home health care

and local support groups, to coordinate a caring treatment plan that uses the member's plan benefit dollars as efficiently as possible.

Case managers negotiate at all levels of care for members and clients in an effort to reduce claims cost. Program results are reflected in the claims cost savings achieved through our case managers' efforts. Case managers follow cases from start to completion and continually communicate with all parties involved. Every case is unique and is organized according to the specific needs of a member, but, on average, cases remain open for four months. At the onset of Case Management, a case manager may make multiple calls per day regarding a case, working with the member, provider, facility, client contact, and stop-loss carrier. As the member's condition improves, the number of calls will decrease; but the case manager will continue to manage the case until the member is stable and all cost savings have been realized.

See Part IB – Confidential Technical Proposal Attachments

- 3.11.1.11 – Case Management Process Flow

See Additional Attachments included with our Proposal

- Letter Sample: CM Welcome and Consent, Physician Outreach

3.11.1.12 Please describe in detail how your organization's case managers will interact with PEBP staff. Under what circumstances does your organization expect to interact with PEPB staff?

American Health case managers would interact with PEBP staff in a variety of ways to ensure ongoing success of the Case Management program. For example, our nurses would be available to meet weekly by telephone to review cases to ensure patients' needs are being met and to discuss treatment options that are aligned with plan coverage. They would also work with PEBP to review reports, including:

- ***Case Management Summary – Summarizes all Case Management activity such as patient participation and financial impact of case management.***
- ***Open Case Listing – Identifies the number of patients enrolled in Case Management and includes detail on diagnoses, intensity of services, the date a case was opened, and the case manager assigned to each case.***
- ***Clinical Case Management Report – Patient-specific, detailed clinical report that includes history, care plan, interventions, savings and prognosis of the participant. This report will include detail for Large Case Management cases in addition to Case Management cases and will be sent to the appropriate individual responsible for administration of the health plan.***

Simply stated, going forward our customer-focused flexibility and experience will allow us to work with PEBP in an ever-expanding role to ensure a successful program that achieves optimal results for the State of Nevada.

3.11.1.13 Please describe in detail the qualifications that your organization requires of your case managers.

American Health case managers have on average between 10 and 15 years of medical management experience providing case management services. In

addition to the qualifications listed below, their caring spirit and administrative professionalism makes them "best in class."

- ***Active registered nursing license in state of employment OR Bachelor's degree in health related field and licensure as a health professional***
- ***At least three years of experience in an acute hospital setting or a minimum of five years of experience in a specialty field***
- ***Active CCM certification as a case manager preferred. Approximately 70% of our case managers are CCM certified.***
- ***Diverse medical background with exposure to multiple environments***
- ***Excellent verbal/written communication skills***

Case managers are also hired by specialty background with the following specialties represented by our current staff of nurses:

- ***Oncology: In order to be on this team, nurses must be experienced in this area and knowledgeable about the latest cancer treatment options and alternatives. Our oncology nurses place a premium on cultivating relationships with Cancer Centers of Excellence and staying abreast of breakthroughs in oncology treatment strategies.***
- ***Maternity/Neonates: Maternity/Neonate Case Management provides a continuum of care during pregnancy and offers additional education, management and negotiation with home health vendors during complicated pregnancies. Case managers are extremely knowledgeable regarding the management of high-risk pregnancies, premature babies, childhood diseases, treatments, growth and developmental stages. They provide education and support to expectant mothers in order to reduce instances of complications and subsequent high-cost claims.***
- ***Medical/Surgical: Case managers have experience with an array of disease processes and services. Attuned to the nuances and progression of individual disease states, they are familiar with the criteria for treatment options and alternatives and work to ensure that the most appropriate treatment is chosen for patients.***
- ***Psychiatric/Substance Abuse: Master-level LISW or LSW, social workers and psychiatric nurses work with treatment centers to develop psycho/social assessments and identify community resources to assure that behavioral treatment plans minimize unnecessary inpatient days.***
- ***Rehabilitation: Case managers work with facilities to arrange services and equipment for transition from acute settings to appropriate levels of care. Case managers provide guidance and education to patients and monitor patient progress and outcomes to ensure levels of function are successfully maintained.***
- ***Transplant: Case managers work with Transplant Centers of Excellence, financial coordinators, and claims offices to coordinate services and negotiate pricing. Case managers follow patients receiving transplants to monitor outcomes.***

As previously indicated, American Health is committed to providing "best in class" service to the 169,540 lives we currently cover in the State of Nevada. For the July 1, 2014 implementation, our philosophy is to recruit additional nurses in Nevada and its surrounding states in order to further strengthen Case Management services we provide to Nevada-residing members.

3.11.1.14 What is your ratio of licensed staff to total covered lives?

The table below indicates American Health's current medical management staffing ratios. As you can see, our staffing levels reflect the efficiency provided by iSuite, our proprietary integrated medical management system.

Position	Staffing Ratio
Utilization Management Nurses	1 FTE per 20,000 employees
Case Management Nurses	1 FTE per 7,000 members
Medical Directors	1 full-time, 3 part-time assistants
Physician Review Panel	53 Physicians

3.11.1.15 At what point during a hospital admission is discharge planning initiated? Please describe your organization's involvement with hospital discharge planning.

Discharge planning begins during the pre-certification process in Utilization Management and is often initiated early during the member's hospital stay or even before the member checks into the hospital. American Health's Utilization Management nurses and case managers perform discharge-planning duties and will work with members, physicians, hospital staff and home care agencies as necessary. When possible, we coordinate appropriate planning for early discharge of the member to a less intense treatment setting or to their home, without sacrificing the quality of care.

3.11.1.16 How does your organization calculate return on investment for case management expenses? Please provide a sample copy of your organization's return on investment report as an attachment to your proposal.

American Health calculates ROI by totaling all managed and negotiated savings as generated by our case managers and dividing that total by the amount of fees paid for Case Management services in any given time period. To illustrate the overall value of Case Management, our market leading Case Management outcomes summary report provides a comprehensive and transparent view into these cost containment savings.

See Additional Attachments included with our Proposal

- 3.12.1 – Executive Summary in Sample UM and CM Reports

3.11.1.17 Is your organization's case management service for behavioral health and substance abuse managed by a separate subcontracted vendor and/or provided at a different location from the location

indicated in ***section 3.10.1.2***? If yes, is the case management protocol different from other general case management services? Please describe the differences, if any.

No. Case Management services for behavioral health and substance abuse are provided for by American Health's staff of case managers and follow the same protocols as our general Case Management. Master-level LISW or LSW, social workers and psychiatric nurses work with treatment centers to develop psycho/social assessments and identify community resources to assure that behavioral treatment plans minimize unnecessary inpatient days.

3.11.1.18 If your organization does not contract with a separate behavioral health and substance abuse case management vendor, please describe your organization's protocol for managing these cases, or indicate if behavioral health/substance abuse protocol is the same as for other care management services. This information may be provided as an attachment to your proposal.

American Health's protocols for behavioral health/substance abuse cases are the same as those for our other Case Management case types.

See Additional Attachments included with our Proposal

- 3.11.1.4 – 3.11.1.5 Case Management Criteria and Case Types

3.11.1.19 Many PEBP participants reside outside of the state of Nevada, requiring licensed case management nurses in all states where PEBP participants reside. Please indicate any state(s) in which your organization does **not** currently have a licensed case management nurse.

American Health has nurses located and licensed in 44 of the 50 states. We do not currently have licensed nurses in Connecticut, Maine, North Dakota, Rhode Island, Vermont and Wyoming; however, this is not a limitation on our ability to provide Case Management in all 50 states.

3.11.2 Pre-certification

Pre-certification is the review of "need" for an inpatient hospital admission or other specified medical services before the services are rendered by a healthcare provider. For a list of services that currently require a pre-certification, please refer to PEBP's Master Plan Document located on the PEBP website at www.pebp.state.nv.us.

3.11.2.1 Describe your organization's process for managing inpatient hospital pre-certification requests.

The following summary details American Health's pre-certification process:

- ***The patient, provider, claimant or their authorized representative may initiate a precertification request for a review by telephone, letter or fax.***
- ***Participants should follow their health plan's rules and guidelines for making a Utilization Management request, including contacting the***

Utilization Management vendor regarding an inpatient admission or outpatient service, (including elective, urgent, emergent, or other services defined by the client's health plan).

- ***If the initial caller is a patient or their authorized representative, the intake coordinator or Utilization Management nurse will:***
  - ***Search the UR system for an existing patient or member, record and verify the demographic information or, if no record is found, obtain and enter the initial demographics in the UR system within 24 hours of receipt of request.***
  - ***Contact the attending physician's office or the admitting/UR Department at the hospital/facility to verify the information provided by the patient or their authorized representative.***
  - ***Request any additional clinical information needed to complete the review.***
- ***If the initial caller is a physician's office, the admitting/UR department at a hospital or a medical provider, and the caller has clinical information, the intake coordinator will transfer the caller to a nurse who will:***
  - ***Confirm the type of review request. The nurse may override late notification as needed or upon request of Client.***
  - ***Obtain and document all relevant clinical information, including the type of admission, diagnosis code, and procedure code(s) requested or performed.***
  - ***After receipt of the clinical information necessary for completion of the review, the review determination will be made.***
- ***Apply appropriate clinical criteria when making medical necessity determinations for requested services. Review determinations are based solely on the clinical information obtained at the time of the review determination.***
- ***If necessary clinical information is provided and clinical criteria appear to be met, results of the review will be verbally communicated to the caller at the time of the determination. The caller/requestor will be advised of the following:***
  - ***Number of certified days/services;***
  - ***Reference number;***
  - ***Last day covered by certification; and***
  - ***Date that an update is needed for continued inpatient stay settings.***
  - ***The intake coordinator will read the appropriate disclaimer, document that it has been given, and certify the case in the UR system.***
- ***If necessary clinical information is provided and clinical criteria are not met, the nurse will***
  - ***Advise the patient's physician/provider, that we are unable to certify services, and must refer the case the same day to a physician reviewer.***
  - ***Document in the UR System that criteria has not been met and indicate that case has been referred to a physician reviewer.***
- ***Assess the patient's discharge planning needs/services to determine if appropriate for Case Management referral.***
- ***Record detailed information about each contact in the UR system, including the date and name of person(s) contacted.***

3.11.2.2 What is the average length of time for your organization to pre-certify inpatient hospital admissions?

The average length of time for American Health to pre-certify an inpatient hospital admission is 24 – 48 hours, depending on whether we receive the request during normal business hours or during the weekend or holiday.

Elective and emergency admission requests are reviewed the same day as received. If the necessary medical information is provided and medical criteria are met, the caller is advised of the approved days/services and a date for follow-up review at the time of the initial review request. If the caller is unable to provide the medical information, necessary for completion of review, the review is completed within one working day of receipt of the pertinent medical information. Certification letters are sent to the patient.

3.11.2.3 Describe your organization's process for managing outpatient surgery pre-certification requests.

American Health follows the same process to pre-certify outpatient surgeries that we use to pre-certify inpatient requests, which are outlined in our response to question 3.11.2.1 above.

3.11.2.4 What is the average length of time for your organization to pre-certify outpatient surgical services?

The average length of time for American Health to pre-certify an outpatient hospital admission is 24 – 48 hours, depending on whether we receive the request during normal business hours or during the weekend or holiday.

3.11.2.5 Does your organization refer to established medical necessity guidelines for pre-certification, such as those published by Milliman?

American Health's Utilization Management and Case Management programs use criteria from MCG Health, LLC (formerly Milliman Care Guidelines) to help establish appropriate, patient-specific goals, and implement intensive management techniques to ensure that the member's needs are met as effectively and cost-efficiently as possible.

American Health uses the 17th Edition of MCG Health's Care Guidelines. Among the most important features of the Care Guidelines are the benchmarks they provide to help establish appropriate, patient-specific goals. The following MCG Health modules are used during the course of providing Utilization Management services:

- ***Ambulatory Care***
- ***Inpatient and Surgical Care***
- ***General Recovery Guidelines***
- ***Recovery Facility Care***
- ***Behavioral Health***

Infrequently, MCG Health care guidelines are not available. In these instances, we use Aetna guidelines and/or other sources from the public domain when certifying requests.

3.11.2.6 How are pre-certifications accepted? Please complete the following table by double-clicking the appropriate responses below.

Method	**Accepted**
Telephone	☒Yes ☐ No
E-mail/Internet	☒Yes ☐ No
Facsimile	☒Yes ☐ No
Regular mail	☒Yes ☐ No
Other (please describe)	

3.11.2.7 Does your organization provide written confirmation when a pre-certification request is approved or denied? Please provide a sample of your pre-certification approval and denial notifications as an attachment to your proposal.

When a pre-certification request is approved, American Health sends a letter to the member within one working day of service approval (providers are notified verbally of all certified decisions when the determination is made). If the pre-certification is denied, an appropriate letter is mailed within 24 hours after the date of the request and all medical information necessary to substantiate the need for the treatment or service recommended is received. Letters are sent to the patient, provider, facility and claims payer. Claims payers are notified of all determinations via mail, fax, or electronic transmission.

The sample letters included with our proposal are representative of the letters we send. American Health is happy to work with PEBP to develop custom, co-branded letters that meet PEBP's specific needs.

See Additional Attachments included with our Proposal

- 3.11.2.7 - Letter Samples: UM Certification and UM Denial

3.11.2.8 Concerning PPO plans for which your organization provides pre-certification services: During the time periods of July 1, 2011 – June 30, 2012, and July 1, 2012 – June 30, 2013, what percentage of inpatient hospital pre-certification requests were denied by your organization? Please list each time period separately.

American Health's denial rates for inpatient hospital pre-certification requests for the applicable time periods are provided below. Our block of business is

comprised of predominantly self-funded groups. The groups have summary plan descriptions that require a benefit differential for PPO networks. However, we do not specifically report on PPOs.

Pre-certification Denial Rate
July 1, 2011 – June 30, 2012 .....1.6%
July 1, 2012 – June 30, 2013 .....1.8%

3.11.2.9 What are the credentials, qualifications, and experience of staff determining pre-certifications for inpatient and outpatient services?

The vast majority of pre-certification is performed by American Health's staff of Utilization Management nurses who on average have 10 years of experience and the following qualifications:

- ***Registered nurse***
- ***Active licensure in state of practice***
- ***Diverse medical background***
- ***At least three years acute hospital care and/or Utilization Management experience***
- ***Excellent verbal/written communication skills***

While most pre-certifications are completed by a nurse, there are instances (5-10%) when a non-clinical intake coordinator may perform "auto-certifications," e.g. if PEBP wants a procedure or test certified so it will trigger to Case Management. Intake coordinators have the following qualifications:

- ***Four-year degree is strongly preferred***
- ***Medical coding/terminology knowledge, preferred***
- ***Prior call center experience***
- ***Excellent verbal and written communication skills***
- ***Knowledge of computer/word processing/typing skills***

3.11.2.10 Please describe in detail your organization's denial process. Describe inpatient and outpatient services separately.

In compliance with the requirements of the regulations under the Patient Protection and Affordable Care Act (PPACA), American Health makes the initial determination for urgent care requests within 24 hours of receipt of request and in accordance with the Full and Fair Review requirements, provides claimant notice before a determination is made.

When a denial is made, an appropriate letter is mailed within 24 hours after the date of the request and all medical information necessary to substantiate the need for the treatment or service recommended is received. Letters are sent to the patient, person acting on behalf of the patient, or health care provider.

- ***For end-of-stay determinations, a Utilization Review system-generated letter is mailed.***
- ***For pre-op days, delay in service days, etc., a special letter is prepared and mailed (Utilization Review nurse shall document in notes).***

For adverse determinations, the written notice will include:

- ***The specific reason or reasons and clinical rationale for the adverse determination.***

- ***If applicable, reference to the specific plan provisions on which the benefit determination is based.***
- ***If applicable, the source of the clinical criteria that was used as guidelines in making the determination.***
- ***Details on how to request and receive, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the patient's request and also any internal rule, guideline, protocol or similar clinical criteria that was relied upon in making the adverse determination.***
- ***Instructions on how to further appeal the adverse determination.***

Non-certification determinations may only be made by Physician Reviewers. Nurses will record non-certification of the appropriate day(s) and/or procedure(s) in each case, facilitate a Reconsideration request and/or Expedited Appeal request as needed, ensure appropriate non-cert letters are dispensed, and educate members/family/providers regarding our Standard Appeal processes.

Each non-cert requires an adverse determination (non-certification) letter that is mailed to the member, attending physician and facility. The Utilization Management nurse is responsible for ensuring the appropriate non-cert letter is posted the same day the determination is received. If the non-cert determination is at the end of the patient's stay, the system will generate the non-cert letter. The Utilization Management nurse shall view the letter in the system to ensure all information in the letter is correct including the non-cert reason. If the non-cert determination involves a pre-op day, delay of service day(s), a partial cert/non-cert, etc., a special non-cert letter which cannot be generated by the system will be required. The Utilization Management nurse must oversee completion of correct letter including review of all information after letter is typed. The attending physician may request Reconsideration if he/she wishes to speak with the Physician Reviewer who made the non-cert determination or an alternate Physician Reviewer if initial reviewer is not able to return call.

Attending physicians or facilities may submit additional information which is first reviewed by the Utilization Management nurse to see if criteria can now be met. If criteria are still not met, the nurse will forward additional clinical information to the Physician Reviewer. The nurse will then provide the Physician Reviewer's telephone number and explain to the attending physician that he/she will need to call the Physician Reviewer to discuss the case. The Physician Reviewer has 24 hours to return the call and inform the attending physician of the determination including a statement of the medical reasons for non-certification of services.

The Utilization Management nurse must follow up to ensure the physician to physician conversation was completed. If there is a reversal of the non-cert determination, the Nurse will notify all providers, document each call and revise the non-certifications. If the case involves Urgent Care, the attending physician may request an Expedited Appeal within 24 hours after a non-certification determination is rendered.

3.11.2.11 Please describe your criteria for determining medical necessity for weight loss surgeries such as gastric bypass or lap band surgery.

American Health's Utilization Management and Case Management programs use criteria from MCG Health, LLC (formerly Milliman Care Guidelines) to determine medical necessity for weight loss surgeries; however, we will defer to more stringent criteria established by the plan and are happy to work with PEBP to evaluate your plan design.

3.11.2.12 Please confirm that your organization has reviewed PEBP's current pre-certification requirements as described in the PEBP Master Plan Document and your ability to provide this service.

American Health confirms that we have reviewed PEBP's current pre-certification requirements included in the Master Plan Document.

3.11.2.13 If PEBP expands the number of services that require pre-certification, please confirm that your organization will not increase its fees as quoted in your original cost proposal.

American Health's price for Utilization Management is based on the utilization provided in Amendment 2, #21. While our goal is to keep pricing stable, we reserve the right to review the projected volume that would result from the expanded services to determine the need for additional pricing. As an alternative option, we would be available to work with the State to identify possible options to eliminate certification of services that may not be providing savings or referrals in order to offset the cost of the new services.

3.11.3 Concurrent Review

3.11.3.1 Please describe your organization's process for inpatient hospital concurrent reviews. This information may be provided as an attachment to your proposal in the form of a narrative and/or flow chart.

Concurrent review is conducted based on severity of illness, intensity of service, and length of stay when the patient remains hospitalized, or when the course of treatment extends beyond the initial certified length of stay. The review frequency for extension of the initial determination varies and is not routinely conducted on a daily basis.

- ***On the assigned review date, the Utilization Management staff will contact the physician's office, or hospital/facility, and request information regarding continued stay, continued outpatient services or discharge status of the patient.***
- ***If clinical criteria are met for continued stay, the nurse will:***
  - ***Advise the requestor of the certification of additional days/services and the reference number.***
  - ***Advise the caller of the number of extended days certified, the new total number of certified days, the last covered day and the next review date for medical necessity determination for continued***

services. For services, the number of extended visits certified, the new total number of certified visits, total certification period and the next review date for medical necessity determination for continued services. All information is documented in the case notes.

- ***If clinical criteria are not met for continued stay, the nurse will:***
  - ***Advise the patient's physician/provider, that we are unable to certify services, and refer the case the same day to a physician reviewer.***
  - ***Document in the UR System that criteria has not been met and indicate that case has been referred to a physician reviewer.***

3.11.3.2 How frequently does your organization re-assess a patient's need for continued hospitalization under the concurrent review process?

The frequency with which we conduct concurrent review varies from client to client and is based on a number of variables, such as the severity of illness, intensity of service, the length of stay when the patient remains hospitalized, or when the course of treatment extends beyond the certified length of stay.

3.11.3.3 Please describe your organization's criteria for determining continued medical necessity.

American Health's Utilization Management and Case Management programs use criteria from MCG Health, LLC (formerly Milliman Care Guidelines) to determine continued medical necessity.

3.11.3.4 If your organization refers to its own medical necessity guidelines, please describe your guidelines in detail. This information should be included as an attachment to your proposal.

American Health's Utilization Management and Case Management programs use criteria from MCG Health, LLC (formerly Milliman Care Guidelines). Infrequently, Milliman Guidelines are not available. In these instances, we use Aetna guidelines and/or other sources from the public domain when certifying requests.

3.11.3.5 Please provide examples of all provider and participant communications related to this function and how your organization delivers these communications.

See Additional Attachments included with our Proposal
3.11.3.5 / 3.11.4.5 Letter Samples: Concurrent and Retrospective Review

3.11.4 Retrospective Review

3.11.4.1 Please describe the process and criteria used for retrospective review. This information may be provided as an attachment to your proposal in the form of a narrative and/or flow chart.

Retrospective reviews for medical necessity are completed when American Health is provided with clinical information after an admission/service has taken place and if requested by the customer to review the case.

- ***The charge for our Medical Review services is included in the pre-certification PPPM price provided in Attachment I, Cost Proposal.***
- ***There may be client-specific timeframes for determination of a retrospective review.***
- ***The UR nurse will attempt to obtain the necessary clinical information via phone.***
  - ***If the information is not available by phone, the Utilization Review nurse will request the relevant clinical information.***
  - ***Upon receipt of such information, the UR nurse will review to determine if appropriate criteria appear to be met.***
- ***If clinical criteria appear to be met, results of the review will be verbally communicated to the caller and will also be sent in writing to the patient/member, physician, and provider, as appropriate, within one (1) calendar day of the medical necessity determination. The caller is advised that the days/services have been certified and that the case has been entered in the Utilization Review system.***
- ***If clinical criteria do not appear to be met, the Nurse will:***
  - ***Advise the patient's physician/provider that we are unable to certify services and refer the case the same day to a Physician Reviewer.***
  - ***Document in the Utilization Review system that criteria do not appear to be met and indicate that the case has been referred to a Physician Reviewer.***

3.11.4.2 Does your organization perform retrospective reviews on-site, telephonically, or a combination of both?

American Health performs retrospective reviews telephonically.

3.11.4.3 What are the credentials, qualifications, and experience of staff handling retrospective review?

Retrospective reviews are conducted by American Health's staff of registered nurses who have on average 10 years of experience and the following qualifications:

- ***Registered nurse***
- ***Active licensure in state of practice***
- ***Diverse medical background***
- ***At least three years acute hospital care and/or Utilization Management experience***
- ***Excellent verbal/written communication skills***

3.11.4.4 How is the need for retrospective review determined?

As detailed in our response to question 3.11.4.1 above, American Health completes retrospective reviews for medical necessity when we are provided with clinical information after an admission/service has taken place or when requested by the customer to review the case.

3.11.4.5 Please provide examples of all participant communications related to this function and how your organization delivers these communications.

See Additional Attachments included with our Proposal

- 3.11.3.5 / 3.11.4.5 Letter Samples: Concurrent and Retrospective Review

3.12 MANAGEMENT REPORTING

3.12.1 Please describe and list your organization's standard reports and provide examples of each. Your standard reports should include but not be limited to case management reports; outcomes; bed days approved, denied, and saved; average length of stay; and large case management status reports.

Over the past several years, we have made a multi-million dollar investment in our Business Intelligence department, resulting in reporting capabilities that are best in class. We are positioned to make additional strides in our ability to quickly and proactively spot trends in outcomes, evaluate outliers and better assist plans in managing the health and wellness of their population. Following is a summary of our Case Management and Utilization Management reports that are available through iSuite, American Health's proprietary medical management system. In addition to the scheduled reports listed below, PEBP will be able to use iSuite to generate ad hoc reports when reports are needed more frequently. Ad hoc reports are included in our care management programs at no additional charge.

For reports that include patient information, PEBP can be assured that we follow strict HIPAA guidelines to protect the privacy and security of PHI, ePHI and other sensitive documents and information. Furthermore, American Health implements industry "Best-Practice" security standards to safeguard the integrity, confidentiality, and availability of its electronic data.

CASE MANAGEMENT REPORTS

- ***Case Management Summary: An aggregate report summarizing all Case Management activity. Includes patient-specific information, such as diagnosis and referral source, and financial impact of Case Management, such as savings detail and negotiated and managed savings. Quarterly.***
- ***Open Case Listing: Group-level report identifying the number of patients enrolled in Case Management, and includes detail on diagnoses, intensity of services, the date the case was opened, and the case manager assigned to each case. Available upon client request.***
- ***Clinical Case Management: Patient-specific, detailed clinical report that includes history, care plan, interventions, savings and prognosis of the participant. Monthly or bimonthly.***

UTILIZATION MANAGEMENT REPORTS

- ***Utilization Management Summary: An aggregate report that summarizes all Utilization Management activity, including statistical impact, comparison with benchmarks, and savings associated with the program. Quarterly.***
- ***Daily Patient Activity: Detailed listing of cases reviewed by the Utilization Management department, including patient-specific information such as admission activity, discharge***

activity, diagnoses, providers, Case Management triggers and length of services certified. Report can be run by notification date, admission/start date or discharge/end date. Available upon client request.

- ***Certification Activity: Detailed listing of all cases reviewed by the Utilization Management department, including a patient activity update detailing length of stay, diagnoses, services provided, providers and physicians, as well as authorization information and whether the case triggered for Case Management. The report captures all certification activity, including TPA notes, for cases in which a decision has been rendered. Available upon client request.***
- ***Extended Length of Stay: Detailed listing of cases reviewed by the Utilization Management department that shows cases in which the length of acute stay exceeded a number of days agreed upon with our client (typically 5-7 days). The report includes patient-specific information such as length of stay, diagnoses, services provided, providers and physicians, as well as authorization information and whether the case triggered for Case Management, and nurse notes. Available upon client request.***
- ***Case Management Referral Activity: Detailed listing of Utilization Management cases in which a patient's diagnosis triggered referral to Case Management or required monitoring during concurrent review. The report includes information on length of stay, diagnoses, services provided, providers and physicians, as well as authorization information. Available upon client request.***
- ***Inpatient Facility Distribution: Summarizes inpatient activity by facility. Includes total admissions, total days utilized and average length of stay. Available upon client request.***

For the State of Nevada, American Health will be pleased to produce a quarterly and annual Executive Summary to augment our standard reporting package. The Executive Summary is intended to provide unique insights into aggregate medical management outcomes across the entire of spectrum of programs and services. The report is tailored to the specific experience of large groups, and, as such, follows a general guideline for content. The State of Nevada will benefit from the services of a dedicated Business Intelligence analyst who will be responsible for analyzing your cost containment outcomes and benchmarking those outcomes against key statistics. There is no additional fee for this Executive Summary report and analytics service. An sample Executive Summary report is included in our attachments for your review.

See Additional Attachments included with our Proposal

- 3.12.1 Sample Reports: Case Management and Utilization Management

3.12.2 Are your reports available via the web?

Yes. Assuming the State's third-party administrator provides a State of Nevada-specific eligibility file to American Health, PEBP will have access to a wide variety of reports through iSuite's EZ Reports application.

Options include:

Scheduled

- ***Set up by American Health's Business Support Team***
- ***System-generated during off hours***
- ***Clients can access EZ Reports through the iSuite portal***
- ***Ideal for running standard reports at predetermined, set intervals (daily, weekly, monthly, quarterly)***

On Demand

- ***Generated by the client on an as-needed basis using preset templates***
- ***Ideal for running reports at renewal time or for custom date ranges***
- ***Reports can be generated at the client or group level and simultaneously run for multiple groups***

Program Highlights

- ***User-friendly portal***
- ***Online option eliminates fax or mail time***
- ***Accessible via the EZ Reports page on iSuite***
- ***Secure portal and role-based access ensure confidentiality of information***
- ***Search capability allows clients to quickly find important information within a report***
- ***Copy and paste functionality allows for reproduction of specific report elements***
- ***Reports can be saved to the client's network and e-mailed or printed as needed***

See Additional Attachments included with our Proposal

- 3.12.2 Overview of iSuite Reporting

3.12.3 Please describe the process for requesting ad hoc reports and list the average turnaround time for each. Please confirm that ad hoc reports will be provided to PEBP at no additional cost.

If PEBP requires a report with a specific date range that falls outside your scheduled reports, you can utilize the On-demand Reports feature in EZ Reports to generate an ad hoc report. On-demand ad hoc reporting allows trained users to generate reports from preset templates, using whatever date range is needed. On-demand reporting will allow you to generate reports as needed, using preset templates, and to generate reports at renewal time or for variable date ranges. As previously indicated, ad hoc reports are included in our care management programs at no additional charge.

3.12.4 Does your organization provide the following standard reports? Double-click each appropriate response.

Report	**Provided**
Outcome Management	☒Yes ☐ No
Patterns of Care	☒Yes ☐ No
Inpatient utilization	☒Yes ☐ No
Utilization by diagnosis	☒Yes ☐ No
Case specific detail	☒Yes ☐ No

Activity and days reduced	☒Yes ☐ No
Savings summary	☒Yes ☐ No

3.13 FACILITY CHANNELING

3.13.1 Please describe the process and criteria used by your organization that will direct PEBP participants to in-network facilities.

If we are provided with the PEBP's electronic download of networks or given access to online listings, our case managers and Utilization Management nurses can direct enrollees to in-network providers. To that end, and as part of our medical management services, we can help plan participants in identifying in-network providers and explain the impact of using in-network providers on their out-of-pocket costs. This typically involves steerage to in-network providers or referral of the member back to their benefit plan.

3.13.2 If a bed is not available at an in-network facility, will your organization negotiate a discount with an out-of-network facility? Is there a separate fee for providing this service?

Negotiation for services is included in our Case Management program—we do not charge a separate fee. If a bed is not available at an in-network facility, a case manager will contact the physician/provider to describe Case Management's role and to obtain clinical information and treatment plan. The nurse will determine the medical necessity of services prior to any rate negotiations, define services and timeframes for which the case manager is requesting a discount, request and obtain the physician/provider's list/retail cost for the service, and discuss/negotiate a discounted rate for the defined service. The case manager will review the stated list/retail cost, negotiated rate, services and time frames with the physician/provider to verify that all information is accurate.

In instances in which negotiation cannot take place at the point of the admission, American Health can provide out-of-network claim repricing and negotiation services. Our Out-of-Network Discounts program offers PEBP access to a network of more than 300,000 providers, ensuring the best opportunity for savings is achieved on bills that are not covered by a primary network discount. A network discount is found for approximately 85% of claims within minutes of entering them into the system. In either option, high-dollar claims and those for which no discount is found are reviewed by an American Health out-of-network claim specialist to ensure that maximum savings are achieved. In situations where there is no match to a network provider, our claim specialists can typically negotiate a discount of 15% to 20% of billed charges.

3.13.3 How are out-of-network negotiated discounts communicated to PEBP and PEBP's third-party administrator?

When negotiating out-of-network discounts, the case manager will discuss the negotiation proposal with the claims payer or PEBP contact prior to making a final agreement with the physician/provider and develop and forward the service notification form with the pricing, service and time frame information to the physician/provider and claims payer unless otherwise directed by PEBP.

3.13.4 Attach a detailed description of the entire discount negotiation process, including communications between all parties involved in the process.

See Part IB – Confidential Technical Proposal Attachments

- 3.13.4 Policy and Procedure - CM Pricing Negotiations

3.14 ACCOUNT SERVICE

3.14.1 During what hours (and time zones) will your organization's telephone lines be staffed?

3.14.1.1 For PEBP staff?
3.14.1.2 For PEBP participants?
3.14.1.3 For providers?

Our phone lines will be open Monday through Friday from 5 a.m. to 5 p.m. PT; however, we are happy to work with PEBP to adjust the hours in order to meet your needs. American Health will provide PEBP with a dedicated, toll-free customer service telephone line(s) using new telephone numbers or the toll-free numbers PEBP currently uses, which will allow us to streamline the transition of services for your members. In addition, confidential voice mail, which includes instructions for leaving messages, is available after business hours and during holidays. Voice mail is monitored 24/7 with responses made to urgent requests in a timely manner. We can also provide PEBP with a customized pre-certification website that we would monitor during normal business hours. The website allows PEBP providers to make requests for pre-certification and clinical updates any time, any day.

See Additional Attachments included with our Proposal

- 3.14.1 PEBP AHH Pre-certification Website

3.14.2 PEBP requires vendors to assign a dedicated account manager to meet with PEBP on a regular basis to discuss performance, address administration issues, and review reports. Please confirm that your organization agrees to this requirement.

American Health confirms its agreement to assign a dedicated account manager. The account manager will be assigned based on his or her proven ability as an advocate and will be given the authority within our organization to drive change. Our account manager will lead escalation and resolution of any issues and will be readily available to meet with PEBP on a regular basis to discuss performance, address administration issues, and review reports. A key responsibility of the account manager is to understand your needs so our partnership with you results in satisfaction levels that exceed PEBP's expectations.

3.14.3 From what location will the account manager be servicing PEBP?

American Health's objective is to have the account manager service PEBP from a location in Nevada. Depending on staffing, we plan to assign Julie Wilson as your account manager. She is

based in Las Vegas and is experienced serving the State of Nevada. She is a registered nurse who holds a master's degree in Health Care Informatics from the University of Colorado. She will leverage her strong clinical and informatics background to build a consultative relationship with the PEBP.

3.14.4 Can you receive electronic enrollment and eligibility data? Please confirm that your organization will accept electronic enrollment information in a format determined by PEBP.

American Health can receive electronic enrollment and eligibility data. We can transfer a daily export file that includes all medical decisions to the outsourcing company (claims payer) via a data feed, so you can adjudicate claims accordingly. American Health can accept a client's data in any desired frequency, including daily, and in many formats, including the version 5010 HIPAA 834 format. The data is sent to us securely using PGP encryption on our FTP/SFTP server. As part of the implementation process, we will work with you to ensure successful loading of the eligibility into iSuite, which uses Secure Socket Layer (SSL) with 128-bit encryption over the Internet to ensure privacy of protected health information (PHI). Our software is compliant with HIPAA security, privacy and transaction standards, and we support the X12N EDI 5010 transaction set 834 (Enrollment and Disenrollment in a Health Plan).

3.14.5 Do you employ the services of a Medical Director? If so, please list the Director's qualifications, credentials, and experience.

Roland Griggs, M.D., M.P.H., a subcontractor, has been American Health's Medical Director since 1993, bringing more than 20 years of both clinical and medical management experiences to our team. He is an active Family Practice Physician and has more than 10 years of service in a medical managed care environment. He received his B.A. from Dartmouth College and a Medical Degree and Masters Degree in Hospital and Health Services Administration from The Ohio State University. Dr. Griggs holds a managed care accreditation from the American Board of Quality Assurance and Utilization Review Physicians, Inc. and is a licensed physician in numerous states, including Nevada.

3.15 IMPLEMENTATION SERVICES

3.15.1 Describe your implementation plan to meet a start date of July 1, 2014. Include steps required to implement the program such as notification to PEBP participants, providers, and other vendors.

American Health will work in tandem with PEBP and its business partners to develop a quality implementation plan that meets the needs of each organization. The sample plan included with our proposal details the processes and steps we address during the implementation process. We provide a team of professionals, led by an implementation manager, from each area of our company to ensure a successful implementation. One of our goals is to build an implementation team comprised of staff from PEBP and American Health to bring collaborative knowledge of both operations together. During the implementation, we focus on areas such as client discovery, iSuite system setup, imports/exports, pre-certification rules, case transition, medical management models, telecommunications, letters, reports, and system access. Within these areas we determine if the programs will be private-labeled and if customized phone flows, networks, program carve-outs, etc. will be utilized. Our approach allows us to jointly deliver a seamless transition. American Health provides electronic versions of member materials that can

be private-labeled for the State to distribute to members. We are available to assist with the creation of a provider communication for distribution by the State or network. As part of the implementation plan, we would determine any required vendor communications.

See Additional Attachments included with our Proposal

- 3.15.1 PEBP Implementation Plan

3.15.2 Is your organization prepared to assign an exclusive team to assist with the implementation process? How many exclusive service representatives would be assigned for the initial implementation?

Yes. American Health will assign an exclusive team to assist PEBP before, during, and after implementation. We recognize the importance of implementing your choice of our medical management services efficiently and seamlessly. To do that, we manage each implementation in a "Project Management" mode. This entails the following:

- ***An implementation project manager (IPM) from our Business Support Team (BST) will be assigned to your implementation.***
- ***The IPM will establish a kickoff meeting with you to begin this process.***
- ***Between the kickoff meeting and the "go-live" date, status meetings will be conducted as requested by the IPM and our team (usually weekly).***
- ***A detailed project plan will be designed for your implementation, including clearly defined activities, responsibilities and timelines, to ensure the desired "go-live" date is met.***
- ***A dedicated account manager located in Nevada will be assigned to your account prior to implementation and will remain with you to serve your needs consistently.***
- ***General workforce training typically consists of a two- to three-week period before the "go live" date to cover American Health's systems and procedures.***

As stated above, we manage each implementation as a project. While we can guarantee the State's implementation will be a high-priority project for our organization, we cannot guarantee that our IPM will exclusively work on this account. Additionally, it is occasionally necessary to bring in additional specialists to ensure delivery of a high-quality implementation. American Health will draw on the depth of our organization as/if needed to ensure the State's implementation runs smoothly.

3.15.3 Describe the most frequent problems your organization has encountered during previous transitions for plans of this size. How were these resolved?

Implementations typically run efficiently. Our largest implementation to start at one time was a large, national retailer with 170,000 employee and 425,000 member lives. The entire implementation process went very smoothly without any telephone, computer or other problems. Occasionally, we encounter difficulties with IT department scheduling and workflows between the parties, which can result in delays or other issues. As a result, we will ensure our early discussions focus on describing processes and expectations to support a smooth implementation in all areas.

3.15.4 Please confirm that your cost proposal includes all costs associated with implementation services. You must provide a detailed description of any implementation service and/or fee charge not specifically included in your cost proposal.

American Health confirms that our cost proposal includes all costs associated with implementation services.

3.15.5 What is the minimum amount of time recommended to ensure a clean transition into the proposed program?

American Health recommends a minimum of four months to ensure a clean transition into PEBP's programs, assuming the State requires a separate instance of iSuite. Should the State not require a separate instance of iSuite, the implementation timeframe would be reduced to three months.

3.16 DISASTER RECOVERY PLAN

3.16.1 Your organization is required to submit with the proposal a disaster recovery plan in the event of a major disaster that disables most or all of your processing capabilities for the PEBP. A major disaster includes, but is not limited to:

Disaster Backup and Recovery (DBAR) is based on a primary and fail-over data center. Both data centers are hardened, state-of-the-art facilities that use redundant commercial power sources, diesel powered emergency generators and redundant data/telephonic circuits from multiple carriers. The application is installed and operational in the primary data center. There is redundant hardware in the fail-over data center and the data is replicated between the two sites. In the event of a disaster in the primary site, the backup copy is promoted to full production.

3.16.1.1 A hardware system failure/collapse;

The system employs multiple and redundant servers on the presentation and business logic tiers. The system would continue to operate in the event of a hardware failure on a single server.

3.16.1.2 A software system failure/collapse;

American Health maintains three independent environments: development, testing and production. All software changes are promoted from development to the testing area. Our quality team performs rigorous tests to ensure defects are not published to production. The system undergoes one major and two minor releases each month using a controlled change methodology. This process has allowed AHH to maintain a 99.8% system up metric for five years.

3.16.1.3 Any natural disaster or Act of God; and

The data centers are hardened facilities that can withstand most disaster scenarios. As mentioned above, the two data centers act as a backup to each other.

3.16.1.4 Total loss of electrical/backup power.

Both data centers have diesel powered emergency back generators that can run indefinitely to maintain power to the systems.

See Part IB – Confidential Technical Proposal Attachments

- 3.16.1 Emergency Management Response Plan

3.16.2 Please explain the anticipated time frames to restore normal operations once the disaster situation has been resolved.

Each scenario is unique and the recovery times vary with the scenario. The planned time to restore normal operations following a disaster is four days.

3.16.3 How often is your disaster recovery plan reviewed and/or updated?

American Health formally reviews and updates our plans twice annually.

3.16.4 Describe in detail how the plan will be customized to meet the needs of PEBP.

The DBAR plan will not be customized for PEBP, as it meets and/or exceeds the requirements. American Health can deploy a separate instance of iSuite for PEBP in order to meet the data retention requirements. This instance would follow the same robust DBAR plan as the rest of American Health's systems.

3.16.5 Please provide with your proposal your plan for regularly scheduled backups for PEBP data for the day-to-day computer-related processing operations and where the backups will be stored.

The system is fully backed up once per day, and transaction logs are backed up every hour. These backup files are moved to SAN storage and replicated to the failover data center.

3.17 PRIVACY AND SECURITY

3.17.1 Is all data contained in the proposed system (active and "at rest") stored in an encrypted format?

Yes, the system encrypts all information in transit using 32-bit Secured Socket Layer (SSL) encryption. The databases at rest are encrypted using Microsoft's Transparent Data Encryption (TDE) facility.

3.17.2 Do all of your organization's current systems, policies and procedures currently comply with the following (including any systems storing or processing PEBP data):

3.17.2.1 Title 45 of the Codified Federal Regulations (CFR) HITECH Breach Rule - 45 CFR §160 and §164;

3.17.2.2 HIPAA Privacy and Security Rules – 45 CFR §160, §162, and §164; and

3.17.2.3 Audited for compliance with the HITECH Breach Rule and HIPAA Privacy and Security Rules.

3.17.2.4 Are corrective actions implemented by your organization for issues identified in the audit?

Regarding 3.17.2, American Health's systems, policies and operating procedures meet or exceed all HIPAA and HITECH privacy and security rules. Our employees are trained annually in the proper use and protection of protected health information. Our care management programs, systems and policies are certified with URAC. American Health undergoes annual audits from our parent company and employs an external security company to conduct vulnerability testing. American Health maintains a robust risk and change management program, our policies are reviewed/updated annually and electronic logs are continually checked.

3.17.3 Vendor and all of the vendor's subcontractors must comply with all PEBP privacy and security policies and procedures. A copy of PEBP's privacy and security policies and procedures is provided under ***Attachment M – Privacy Security Policies and Procedures***. Please indicate that your organization would agree to these conditions.

American Health maintains policy and procedure that is similar to and supports PEBP policy and procedure contained in Attachment M.

3.17.4 Vendor must sign and agree to the terms of PEBP's Business Associates Agreement (BAA). A copy of PEBP's BAA is provided under ***Attachment N – Business Associate Agreement.*** Please indicate that your organization would agree to this condition.

Please refer to Attachment B in Tab V for American Health's exceptions to the State's Attachment N, Business Associate Agreement.

3.18 ELECTRONIC DATA INTERCHANGE (EDI)

3.18.1 All exchange of PEBP electronic formatted data, as well as data exchange between PEBP and vendors, shall be approved in advance by PEBP's Information Technology Officer or designated staff.

American Health will work with PEBP's Information Technology Officer or other designated staff for pre-approval of all electronic data interchange.

3.18.2 The file format for eligibility data exchange is fixed field, flat file. Exact file specifications will be determined by PEBP. All EDI will require file level encryption. All files exchanged between PEBP and its vendors are accomplished via FTP. Please confirm your ability to comply with this requirement.

American Health can accept fixed field, flat file format eligibility files. The mutually agreed upon specification must contain the minimum information necessary to populate the required fields in our software system. American Health is capable of sending/receiving files encrypted using PGP (Pretty Good Privacy) and SFTP (Secure File Transport Protocol).

3.18.3 All data is the property of PEBP. Data cannot be shared, distributed, or used outside contract specification without permission from PEBP. All data must be made available upon PEBP's request.

American Health agrees that all data is the property of PEBP. We agree that PEBP data cannot be shared, distributed or used outside contract specification without permission from PEBP.

As an option, American Health is able to build a separate, distinct instance of our software, iSuite, for the support of PEBP and its data. The data in the separate instance will be solely that of PEBP. The separate instance would allow American Health to purge data, and the entire instance, in accordance with PEBP requirements and applicable regulatory guidelines. Our cost proposal includes separate pricing for this option, and our implementation timeline has been adjusted accordingly. The separate system instance incorporates new hardware, software, storage and on-going workflow changes to support PEBP's requirements.

3.19 PERFORMANCE STANDARDS, GUARANTEES, PENALTIES

Please confirm that your organization will agree to the following performance standards, guarantees, and financial penalties. Compliance will be determined by PEBP and PEBP's health plan auditor. PEBP reserves the right to revise the performance standards, guarantees, and financial penalties as needed. PEBP's health plan auditor will audit the UM Vendor every odd numbered year of the existing vendor contract.

July 1, 2014- June 30, 2019

Service Performance Standard	Guarantee	Method of Measurement	Performance Guarantee Penalty Amount
I. Quarterly and annual management reports	100.0%	Delivery of Quarterly reports within 45 days of end of reporting period as established by PEBP	1% of annual administration fees per report per day greater than 10 days.
II. Notification of potential high expense cases. High expense case is defined as a single claim or treatment plan expected to exceed $100,000.00.	95.0%	Designated PEBP staff will be notified within 5 business days of the UM vendors initial notification of the requested service	For each percentage point, or a fraction thereof below the annual guarantee, 1% of annual administration fees.
III. Pre-certification information shall be provided to PEBP's third party administrator	98%	Pre-certification requests from healthcare providers shall be communicated to PEBP's Third Party Administrator using an approved method e.g. electronically, within 5 business days of UM completing Precertification determination	For each percentage point, or a fraction thereof below the annual guarantee, 1% of annual administration fees.
IV. Concurrent hospital review	98%	Concurrent hospital reviews shall be completed and communicated using an approved method e.g. electronically within 5 business days of determination decision	For each percentage point, or a fraction thereof below the annual guarantee, 1% of annual administration fees.

Compliance with service category I is determined by PEBP's Executive Officer. Compliance with service categories II, III & IV is determined by audits performed by PEBP's health plan auditor conducted in odd numbered years. Annual is typically defined as the time period starting July 1 and ending June 30 of each year of the contract.

- Public Employees' Benefits Program will collect performance guarantee amount by withholding the appropriate amount from vendor's annual administration fees. If no further administrative fees are due, PEBP will send an invoice for the penalty amount to the vendor. Payment is due within 30 days. Failure to pay within 30 days will result in a penalty of 1.5% of the penalty amount per month, compounded monthly.
- Upon contract termination, PEBP may withhold payment of a portion of the last invoice until after all audits have been accepted by the PEBP Board. The portion of payment withheld will be not more than the lesser of:
  1. The last invoice received by PEBP; or
  2. An amount equal to 100% of the largest quarterly penalty assessed during the last two years of the contract.

American Health confirms its agreement with the above performance standards, guarantees and financial penalties.

3.19.1 Selected vendor will be required to have an independent financial audit performed annually and a copy of the audit shall be provided to the State within 30 days of its completion. The date of the audit shall be mutually agreed upon.

American Health is a subsidiary of Aetna, Inc., a publicly held company. American Health will annually provide a copy of Aetna, Inc.'s. annual financial report at the time of its availability.

3.19.2 Exceptions to the requirements of this Scope of Work must be clearly stated in ***Attachment B – Technical Proposal Certification of Compliance with Terms and Conditions of RFP***, noting a) the RFP section to which vendor is taking exception, and b) future expectations for meeting the requirement, a projected timetable, and detailed plans for meet the requirement, along with the vendor staff and qualifications assigned.

American Health acknowledges the above PEBP requirement.

3.19.3 Vendors are encouraged to include any additional information in their proposals that would be considered useful to PEBP.

Following are three key characteristics of American Health that set us apart from the competition:

- ***American Health has extensive experience implementing and servicing key accounts, including state government clients for which we currently cover approximately 171,000 members. What sets us apart from the competition is our <u>flexibility</u> and <u>hands on commitment</u>. For example, in addition to assigning a dedicated account manager to PEBP, our Leadership Team and Paul Lavin, the president of our company, will be available as resources for strategic planning and to ensure service levels meet the State of Nevada's expectations.***
- ***Our proposed account manager is based in Las Vegas and gained experience serving the State of Nevada during her tenure with APS Healthcare. She is a registered nurse and holds a masters degree in Health Care Informatics. She will leverage her strong clinical and informatics background to build a consultative relationship with the PEBP.***
- ***Over the years, American Health has developed successful recruiting, training and retention programs that allow us to ramp up to provide "best in class" medical management services for PEBP. This will enable us to work with PEBP to define a customized solution that includes American Health employees who reside in Nevada.***
- ***In addition, our presence in the State of Nevada is a key differentiator. We currently manage nearly 169,540 lives in Nevada, providing us an excellent understanding of regional care norms, providers and health care trends in the state.***

PROPOSED STAFF RESUME

A resume must be completed for all proposed contractor staff and proposed subcontractor staff.

COMPANY NAME:	American Health Holding, Inc.		
X Contractor		☐ **Subcontractor**	
Name:	Donna Todd, MSN, RN-BC, CCM	**X Key Personnel**	
Classification:	Senior Director, Clinical Operations	**# of Years in Classification:**	3
Brief Summary: of Experience:	Donna has more than 25 years of health care experience in both acute and managed care. Prior to joining American Health, Donna worked at Mount Carmel St. Ann's Hospital in Columbus, Ohio, as Team Lead of Case Management/Social Work Services.		
# of Years with Firm:	14		

RELEVANT PROFESSIONAL EXPERIENCE	
Required Information: ***MMYYYY to Present:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	05/2010 to Present American Health American Health Paul Lavin, President and CEO 7400 West Campus Rd., New Albany, OH 43054 614-933-7654 plavin@ahhinc.com As Senior Director, Clinical Operations, Donna is responsible for the leadership of case management and serves as the clinical expert within the senior management team. Her expertise is called upon to determine the strategic direction of our products, as well as to provide information to clients and potential clients.
Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	05/2009 to 05/2010 American Health American Health Paul Lavin, President and CEO 7400 West Campus Rd., New Albany, OH 43054 614-933-7654 plavin@ahhinc.com Interim Director of Case Management Duties included performing oversight of the case management department.

Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	08/2008 to Present American Health American Health Paul Lavin, President and CEO 7400 West Campus Rd., New Albany, OH 43054 614-933-7654 plavin@ahhinc.com Director, Product Management Duties included training, legal/compliance liaison, Information Technology liaison and client implementations for the operations department. Other roles at American Health from 02/1999 to 08/2008 included Interim Director of Disease and Wellness Management, Case Management Staff Development Coordinator, Case Management Supervisor and Case Manager.

EDUCATION	
Institution Name: ***City:*** ***State:*** ***Degree/Achievement:*** ***Certifications:***	Otterbein College Westerville Ohio Masters of Science in Nursing. Graduated June 1998 Bachelors of Science in Nursing. Graduated December 1988 Associate of Science in Nursing. Graduated June 1983 Advanced Practice Nurse Educator Certificate, Concentration in Staff Development/Client Education. Completed June 2008

REFERENCES	
Minimum of three (3) required, including name, title, organization, phone number, fax number and email address	Gregg Kamas Chief Health Officer EBMS, Inc. (p) 800-777-3575 ext. 1249 gkamas@ebms.com Karen Glassman, CRRN, RN Manager, Case Management and Medical Appeals Assurant Health (p) 414-299-6338 Karen.glassman@assurant.com Tiya Kifle, MSN, MEd, RN Clinical Director Felbry College, School of Nursing (p) 614-781-1085 tkifle@felbrycollege.com

PROPOSED STAFF RESUME

A resume must be completed for all proposed contractor staff and proposed subcontractor staff.

COMPANY NAME:	American Health Holding, Inc.		
X Contractor		☐ **Subcontractor**	
Name:	Julie Wilson		**X Key Personnel**
Classification:	Account Executive	**# of Years in Classification:**	2
Brief Summary: of Experience:	Julie brings a strong background in clinical informatics and client relations to American Health. In her previous role as Operations Manager at APS Healthcare, Julie oversaw the daily operations of the company's Nevada service center and served as an Account Manager. She has 15 years of clinical experience as a registered nurse. As an account executive, Julie provides account management and support to clients ensuring that the voice of the customer is communicated throughout American Health operations.		
# of Years with Firm:	2		

RELEVANT PROFESSIONAL EXPERIENCE

Required Information: ***MMYYYY to Present:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	9/2011 to Present American Health American Health Paul Lavin, President and CEO 7400 West Campus Rd., New Albany, OH 43054 614-933-7654 plavin@ahhinc.com Account Executive Responsible for client satisfaction and oversight of contractual delivery for Western Region, including self-funded, fully-insured, state and municipality and Taft Hartley Fund clients.
Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	9/2007 to 9/2011 APS Healthcare APS Healthcare 44 South Broadway, Suite 1200 White Plains, NY 10601 800-305-3720 Clinical Operations Manager/Client Delivery Executive Responsible for daily oversight and management of the team responsible for delivery of UM/CM/DM services. Clients included State of Nevada PEBP, Nevada Medicaid, and Colorado Medicaid.
Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	

EDUCATION

Institution Name: ***City:*** ***State:*** ***Degree/Achievement:*** ***Certifications:***	University of Colorado Denver Colorado Master of Science, Health Care Informatics August 2013 Pennsylvania State University University Park Pennsylvania Bachelor of Science, Nursing December 1998 Current Nevada RN License

REFERENCES	
Minimum of three (3) required, including name, title, organization, phone number, fax number and email address	Chanelle Bergren Plan Administration Manager Human Resources Division, Benefit Services Arizona Department of Administration 100 N.15th Ave Suite 103, Phoenix, AZ 85007 Phone 602-542-0395 Fax 602-542-4048 Chanelle.Bergren@azdoa.gov Leslie Johnstone Vice President, Nevada Operations HealthInsight Phone 702-777-8370 Fax 702-968-4501 ljohnstone@healthinsight.org Shelli Lara Innovative Healthcare Delivery 3540 W Sahara Ave #444 Las Vegas, NV 89102 Phone702-218-4493 Fax 702-441-7106 slara@.ihdcare.com

PROPOSED STAFF RESUME

A resume must be completed for all proposed contractor staff and proposed subcontractor staff.

COMPANY NAME:	American Health Holding, Inc.		
X Contractor		☐ **Subcontractor**	
Name:	Lisa Hopkins, RN	**X Key Personnel**	
Classification:	Director, Utilization Management	**# of Years in Classification:**	2
Brief Summary: of Experience:	Lisa has been a nurse for over 30 years. She spent thirteen of those years in the acute care arena. Prior to joining American Health, she worked as Clinical Team Leader for Private Healthcare Systems, directly supervising Care Coordinators and Staff Assistants on a daily basis. She transitioned to the role of Utilization Management Nurse Reviewer when American Health acquired Private Healthcare Systems in 2007.		
# of Years with Firm:	6		

RELEVANT PROFESSIONAL EXPERIENCE	
Required Information: ***MMYYYY to Present:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	02/2011 to Present American Health American Health Paul Lavin, President and CEO 7400 West Campus Rd., New Albany, OH 43054 614-933-7654 plavin@ahhinc.com As Director, Utilization Management, Lisa oversees 10 direct reports and a department of 60 UM nurses. She is primarily responsible for UM including the appeal department, Medical Review and Independent External Review. She assists with client-related functions. Lisa ensures compliance with applicable laws and regulations on an ongoing basis.
Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	02/2009 to 02/2011 American Health American Health Paul Lavin, President and CEO 7400 West Campus Rd., New Albany, OH 43054 614-933-7654 plavin@ahhinc.com As Utilization Management Nurse Manager, Lisa organizes, manages, and provides clinical leadership in day-to-day operations of the UM department, including appeals and medical review. She acts as the liaison between UM and other operational areas, performs recruitment/evaluation/training for 24 direct reports, and assists in resolving client issues. Lisa ensures compliance with policies, procedures, DOL timeframes, URAC and HIPAA standards.

Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	03/2008 to 02/2009 American Health American Health Paul Lavin, President and CEO 7400 West Campus Rd., New Albany, OH 43054 614-933-7654 plavin@ahhinc.com As Utilization Management Nurse Supervisor, Lisa supervised Care Coordinators and Staff Assistants daily. She also provided training, collaborated with management, and dealt with claims payers to resolve issues as needed.

EDUCATION

Institution Name: ***City:*** ***State:*** ***Degree/Achievement:*** ***Certifications:***	York College of Pennsylvania York PA Bachelor of Science in Nursing, Minor in Psychology

REFERENCES

Minimum of three (3) required, including name, title, organization, phone number, fax number and email address	John Kachergius Vice President of Administration Allied Benefit Systems, Inc. (p) 312-261-9258 (f) 312-906-8443 jkachergius@alliedbenefit.com Arthur Orzano Managing Supervisor National Organization of Industrial Trade Unions (p) 718-291-3434 (f) 718-291-0531 aorzano@noitu.org Gregg Kamas Chief Health Officer EBMS, Inc. (p) 800-777-3575 ext. 1249 gkamas@ebms.com

PROPOSED STAFF RESUME

A resume must be completed for all proposed contractor staff and proposed subcontractor staff.

COMPANY NAME:	American Health Holding, Inc.		
X Contractor		☐ **Subcontractor**	
Name:	Rob Dubois	**X Key Personnel**	
Classification:	Senior Director, Client Services	**# of Years in Classification:**	1
Brief Summary: of Experience:	Rob has 19 years' experience in the health care industry, most recently as Director of Product Development for a leading consumer-directed health plan. His diverse background includes direct clinical practice as a behavioral health/substance abuse therapist, call center management and implementation, and account management. As Senior Director, Client Services, Rob leads the account executive team to ensure the voice of the customer is communicated throughout American Health's operations.		
# of Years with Firm:	6		

RELEVANT PROFESSIONAL EXPERIENCE

Required Information: ***MMYYYY to Present:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	3/2013 to Present American Health American Health Paul Lavin, President and CEO 7400 West Campus Rd., New Albany, OH 43054 614-933-7654 plavin@ahhinc.com Senior Director, Client Services Rob manages the Client Services Department, ensuring overall client satisfaction and oversight of contractual delivery for over 150 self-funded, fully-insured, state and municipality and Taft Hartley Fund clients.
Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	3/2008 to 3/2013 American Health American Health Paul Lavin, President and CEO 7400 West Campus Rd., New Albany, OH 43054 614-933-7654 plavin@ahhinc.com Account Executive Responsible for client satisfaction and oversight of contractual delivery for Midwest Region, including self-funded, fully-insured, state and municipality and Taft Hartley Fund clients.

Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	

EDUCATION	
Institution Name: ***City:*** ***State:*** ***Degree/Achievement:*** ***Certifications:***	The Ohio State University Columbus Ohio Masters of Social Work

REFERENCES	
Minimum of three (3) required, including name, title, organization, phone number, fax number and email address	Chanelle Bergren Insurance Contract Administrator Arizona Department of Administration (p) 602-542-0395 (f) 602-542-4744 Chanelle.Bergren@azdoa.gov John Kachergius Vice President of Administration Allied Benefit Systems, Inc. (p) 312-261-9258 (f) 312-906-8443 jkachergius@alliedbenefit.com Arthur Orzano Managing Supervisor National Organization of Industrial Trade Unions (p) 718-291-3434 (f) 718-291-0531 aorzano@noitu.org

PROPOSED STAFF RESUME

A resume must be completed for all proposed contractor staff and proposed subcontractor staff.

COMPANY NAME:	American Health Holding, Inc.		
☐ **Contractor**		**X Subcontractor**	
Name:	Roland Griggs, MD		**X Key Personnel**
Classification:	Medical Director	**# of Years in Classification:**	20
Brief Summary: of Experience:	Dr. Griggs has been American Health's consulting Medical Director since 1993, bringing more than 22 years of medical management experience. In addition, he has operational experience for multiple provider-based businesses including a telemedicine supported, house-call practice and a rural integrated hospital system. Dr. Griggs has worked extensively with underserved populations such as the Navajo tribe, physically challenged children and homebound poor. Dr. Griggs is a licensed physician in 20 states.		
# of Years with Firm:	20		

RELEVANT PROFESSIONAL EXPERIENCE

Required Information: ***MMYYYY to Present:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	01/1993 to Present American Health American Health Paul Lavin, President and CEO 7400 West Campus Rd., New Albany, OH 43054 614-933-7654 plavin@ahhinc.com As Medical Director, Dr. Griggs plays a number of key roles in the delivery of our medical management programs. For example, if a case has unique circumstances that raise questions for the Utilization Management nurse handling the case, the medical director will review the case to determine the best course of action and reach out to the member's physician for a peer-to-peer discussion, if necessary. Our medical director is also available to review cases for which a provider or member has received an adverse review/decision to determine appropriate next steps. Dr. Griggs also performs all initial reviews that involve medical necessity determinations and Physician Consultation for new procedures or new technology/pharmacology.
Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	

Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	

EDUCATION	
Institution Name: ***City:*** ***State:*** ***Degree/Achievement:*** ***Certifications:***	Dartmouth College Hanover New Hampshire Bachelors Degree Ohio State University Columbus Ohio Medical Degree and Master's Degree in Hospital and Health Services Administration. Dr. Griggs is certified in Quality Assurance and Utilization Review by the American Board of Quality Assurance and Utilization Review Physicians and is American Board of Medical Specialties certified for Family Medicine

REFERENCES	
Minimum of three (3) required, including name, title, organization, phone number, fax number and email address	Mary Catherine Person President HealthSCOPE Benefits, Inc. (p) 501-225-1551 Mary.Person@healthscopebenefits.com Chanelle Bergren Insurance Contract Administrator Arizona Department of Administration (p) 602-542-0395 (f) 602-542-4744 Chanelle.Bergren@azdoa.gov Michelle Hazelette State of Arkansas Benefits Department Stat of Arkansas Department of Finance and Administration (p) 501-682-5500 (f) 501-682-1168 Michele.hazelett@dfa.arkansas.gov

Additional Attachments Included with Response to Request for Proposal 3084 – IA Technical Proposal

- Attachment 3.11.1.4 – 3.11.1.5 Case Management Criteria and Case Types
- Attachment 3.11.1.8 - 3.11.1.9 Transplants and Centers of Excellence
- Attachment 3.11.1.11 –Letter Sample: CM Welcome and Consent, Physician Outreach
- Attachment 3.11.2.7 - Letter Samples: UM Certification and UM Denial
- Attachment 3.11.3.5 - 3.11.4.5 Letter Samples: Concurrent and Retrospective Review
- Attachment 3.12.1 - Sample Reports: Case Management and Utilization Management
- Attachment 3.12.2 - Overview of iSuite Reporting
- Attachment 3.14.1 - PEBP American Health Pre-certification Website
- Attachment 3.15.1 PEBP Implementation Plan

Attachment 3.11.1.4 / 3.11.1.5

Case Management Case Types

Cases are assigned to case type according to the level of nursing assessment, coordination, planning and evaluation requirements, the severity of illness and/or the number of co-morbidities, the complexity of treatment plan, the anticipated length of case duration, and the client's need for medical information, cost projection or prognosis.

Definitions

Large Case Management case types:

- Are patient-focused
- Have a complex treatment plan, and include:
  - Patients with complex diagnoses, multiple co-morbidities
  - Patients who require high level nursing assessment, coordination, planning, intervention and evaluation
- Patients considered for Large Case Management case types include:
  - Complex medical cases
  - Transplant
  - Rehabilitation
  - Long-term acute care
  - Acute inpatient rehabilitation
  - Neonatology/pediatrics
  - Oncology
  - Maternity
  - Pregnant patients with high-risk factors such as uncontrolled co-morbidities or a history of pre-term delivery where the patient is less than 37 weeks gestation

Continuing Care Coordination case types:

- Are patient-focused
- Have coordination of services as the primary objective
- Have a simple treatment plan, and include:
  - Patients with non-catastrophic diagnoses and minimal co-morbidities
  - Patients who require minimum to moderate level nursing assessment, coordination, planning, interventions and evaluations
- Are non-responsive to or have declined Case Management; however, will require Case Management to oversee treatments/therapies, response to treatments, medical necessity authorizations and possible negotiations
- Patients considered for Continuing Care Coordination case types include:
  - Home Health (1-2 simple services) and DME

    - Hospice Care (Inpatient and outpatient)
    - Short- term rehab after joint replacement surgery
    - Infusion therapy for medical necessity determination and negotiations
    - Outpatient therapy, with out of network providers
    - Monthly Synagis injections
    - Readmissions for complications or wound infection following surgical procedure
    - Multiple hospitalizations with a focus on controlling costs

Research and Review case types:

- Are focused on the client's need for:
    - Resolution of a single issue/question related to medical necessity
    - Medical information related to clinical status, treatment plan, prognosis and estimation of expected costs
- Include patients who are medically stable and/or with chronic disease processes who are at risk for exacerbation
- Patients may require assessments for knowledge deficits related to disease, medications and or treatment plan
- Have an expected case duration of less than two months unless approved by a supervisor
- Co-morbidities are limited
- Have a treatment plan that is moderate to non-complex
- Patients considered for Research and Review case types include:
    - Need for medical information only
    - Approval for high dollar DME
    - Retrospective medical necessity reviews
    - Claims department referrals for high utilization or high dollar claims

Medical Disclosure case types:

- Are focused on the client's need for medical information
- Include patients who have usually reached stop loss and the client requires updates on clinical status, prognosis and estimation of expected costs
- Diagnoses and co-morbidities are not relevant
- Have an estimated case duration of 3-4 days
- Complexity of treatment plan is not applicable
- Patients considered for Medical Review case types include:
    - Plan or member renewals

Behavioral Health/Substance Abuse case types:

- Include all patients whose primary diagnosis is related to Behavioral Health are assigned to this case type
- Patients considered for Behavioral Health/Substance Abuse case types include:
    - Drug/substance abuse
    - Suicide attempts
    - Mental Health

Maternal Newborn case types:

- This is a wellness program for client's who have purchased this program
- Include pregnant patients who are less than 34 weeks gestation and who are enrolled in this program and participate until they deliver
- Patients in this program, who develop complications, can be transitioned to a Large Case
- Management case by closing out the Maternal Newborn case and opening a new case

Short-Term Case Management (STCM) case types:

- Are focused on the client's need for negotiations or certification services
- Have a short case duration limited to the time it takes to get an answer to the specific question
- Diagnoses and co-morbidities are not relevant to this case type determination
- Patient's considered for this case type are PHCS certification of outpatient services or for a specialized rate negotiation program

Attachment 3.11.1.8 / 3.11.1.9

Transplants and Centers of Excellence

American Health's Case Management program targets those cases requiring more attention, resulting in better medical outcomes for members and greater cost savings for employers. Our criteria and systems are specifically designed to identify catastrophic and complex illnesses, transplants and trauma cases. They also prompt our review specialists to ask questions about seemingly routine, uncomplicated cases that may reveal increased risk. Once high-risk cases are identified, American Health's Case Management matches the level and method of our services to the intensity of the case in the most cost-efficient manner possible.

Dealing with a serious illness changes lives of both the patient and the family members. Deciding on the right treatment options can be difficult, and it is important for everyone who is involved in the patient's life—including the claims payer—to understand the patient's disease and the options for treatment. In order to serve the long-term needs of the patient, our Transplant Specialists coordinate with the medical team through the entire care process. They work even closer with the patient, the patient's family, and support network to provide comprehensive assistance in all areas relating to ongoing education, medical history, medications, development of support systems, lifestyle changes and behavior modifications, and financial options.

If a client or stop-loss contract requires a referral to a specific network, our Transplant Specialists will work with the member and recommend an in-network transplant facility with the best services and location. They can access all available networks on a case-by-case basis in order to achieve the best discounts for our clients without an access fee. In most situations, since contracts exist between the Centers of Excellence and claims payers, Transplant Specialists act as liaisons between the two parties. When contracts are unavailable, they have the ability to work with Transplant Centers of Excellence, financial coordinators, reinsurance carriers and claims offices to coordinate services and negotiate discounts that range from 10 to 30 percent.

Transplant Case Management Process

The following is a summary of the procedures followed by our Transplant Specialists when contacting the various stakeholders involved in a potential transplant case.

Client Contact

- Verify patient eligibility with the plan
- Clarify transplant benefit language and limitations of the plan
- Discuss potential transplant financial costs to the plan
- Discuss use of transplant networks vs. PPO use to facilitate savings
- Discuss clinical status of the patient and potential transplant plan of care

- Obtain permission to discuss the case with the reinsurance carrier to assure proper payment to the claims payor according to the stop loss coverage
- Confirm authorization process and appeal process
- Maintain contact throughout the transplant case to discuss medical plan of care, physician review determination and clinical status of the patient

Physician/Transplant Facility Contact

- Verify center of excellence status of the facility
- Encourage verification of patient eligibility/coverage
- Confirm patient referral /transplant evaluation process/progress
- Discuss financial strategies for transplant related care
- Obtain transplant protocol/ informed consent
- Maintain contact throughout transplant process
- Obtain ongoing clinical status /medical plan of care
- Provide necessary authorizations for care delivery
- Follow patient for at least 100 days post-transplant procedure

Patient and Family Contact

- Assess knowledge base of disease/ treatment plan
- Educate about potential treatment process, financial responsibilities, and the medical plan of care
- Encourage patient to discuss transplant with family members
- Discuss transplant centers of excellence and the importance of network provider use
- Discuss use of clinical trials, off label use of medications, experimental/ investigational treatment
- Review transplant approval process
- Encourage knowledge of benefit plan language as it relates to transplant care
- Maintain ongoing contact with the patient and/ or family throughout the transplant process to provide support and education
- Explore available community resources including medication assistance if necessary

Physician Review Process, Role of our Case Manager

- Receives transplant evaluation and protocol from facility/MD
- Reviews the clinical information/ transplant protocol according to accepted medical standard criteria, reviews medications according to FDA approval for the patient's diagnosis
- Formulates review questions for the specialist physician reviewer relative to medical necessity, standard of care and investigational/experimental aspects of the proposed treatment regimen
- Forwards all information to the independent physician reviewer for evaluation
- Receives physician review determination and discusses the determination with the claims payor, reinsurance carrier representative, the patient and the patient's physician
- Assists with any appeals if transplant found not to be medically necessary or standard of care or if found to be investigational/ experimental or part of a clinical trial

Post-Transplant Follow-Up

- Maintain ongoing contact with providers to obtain ongoing treatment plan and clinical response to the transplant procedure for approximately one year post transplantation
- Authorize medically indicated care to address any post-transplant needs
- Maintain ongoing contact with the patient to provide support and education
- Discuss the patient status and medical needs with the claims payor and reinsurance representative

Investing in Healthier Outcomes

Return on Investment (ROI) for Transplant Case Management is calculated based on savings from price negotiations for services and use of alternative settings or services. ROI for American Health's Transplant Case Management is currently 18:1.

(Contact CompanyName)
(Contact CombinedContactName)
(Contact Address1)
(Contact Address2)
(Contact Address3)
(Contact City), (Contact State) (Contact PostalCode)

PATIENT:	(LCMI PFN) (LCMI PMN) (LCMI PLN)
CARDHOLDER:	(LCMI CHFN) (LCMI CHMN) (LCMI CHLN)
CASE ID#:	(LCMI RefNumber)
GROUP:	(LCMI GroupName)

(Contact SalutationName) (Contact CombinedContactName),

I am a Case Manager working on behalf of your health plan. They have asked that I contact you because case management services could be of assistance to you. These services are a part of your benefits package.

As a Case Manager, I work with you, your family and your health care team to assist in coordinating delivery of services recommended by your health care professionals. I have enclosed a brochure with this letter, which you might find helpful in further explaining Case Management services.

I will be calling you in the near future to discuss my role, but feel free to call me toll-free 1 (LCMI CMPhoneCombo), if you have any questions about my services. If you reach voicemail, be assured that it is confidential and you may leave a message. I will return your call promptly. If at any time you have difficulty contacting me or have a complaint, please call toll-free 1 (LCMI CMPhone) and ask our operator to direct your call to a case management supervisor. You may also call me at the number listed above if you have any questions about why you were chosen for the Case Management program.

In order for me to help coordinate any services recommended by your health care professionals, and obtaining medical and other information from your doctor and health care team, I am asking you for your written permission. Please sign the enclosed form, Consent for Case Management Services and Authorization for Release of Medical Information, and return it to me in the enclosed self-addressed envelope. While waiting on your response, I will begin coordinating the services recommended by your health care professionals to avoid delays in your treatment.

Your participation in Case Management is voluntary and you may decline services at any time by contacting me at the phone number above. I look forward to working with you.

Respectfully,(LCMI CMFN) (LCMI CMLN)

Consent for Case Management Services
and Authorization for Release of Medical Information

(LetterInfo LetterDate)

PATIENT: (LCMI PFN) (LCMI PMN) (LCMI PLN)
CARDHOLDER: (LCMI CHFN) (LCMI CHMN) (LCMI CHLN)
CASE ID#: (LCMI RefNumber)
GROUP: (LCMI GroupName)

I authorize (LCMI KnownAsName) to evaluate my health care needs under the Case Management Program.

I authorize any physician, hospital, service agency, or other health care provider involved in my care to release all medical records and other information to (LCMI KnownAsName).

I understand that this may include interviews with my family, physician, and other health care providers. Also, it may require a review of my medical records and history pertinent to my care for the purpose of assessing my needs and developing appropriate case management plans.

I understand that there may be times when medical information may be shared with the claims payor or others, when necessary to assist in claims payment, determining available benefits or other authorized health care operations or treatment matters.

I understand that I will be notified, in writing, of any adverse determinations or medical necessity that are made by (LCMI KnownAsName) related to services that have been reviewed in the Case Management program.

All information will be kept confidential as required, and shall not be improperly used or disclosed.

This consent is subject to revocation by the patient at any time, but will not apply to any information already released in accordance with this consent.

_____ Accept Case Management **_____ Decline Case Management**

_____ _____
Patient or Guardian Signature Date

Please provide a phone number where case management can reach you.

Phone #: _____ Best Time to Call: _____

(Contact CompanyName)
(Contact CombinedContactName)
(Contact Address1)
(Contact Address2)
(Contact Address3)
(Contact City), (Contact State) (Contact PostalCode)

CONFIDENTIAL
(LetterInfo LetterDate)

PATIENT: (LCMI PFN) (LCMI PMN) (LCMI PLN)
PATIENT DOB:
CARDHOLDER: (LCMI CHFN) (LCMI CHMN) (LCMI CHLN)
MEMBER ID: (LCMI PatientID)
GROUP: (LCMI GroupName)

(Contact SalutationName) (Contact CombinedContactName),

This letter is to inform you that I am a Case Manager, working on behalf of the health plan for the above named patient. My role as a Case Manager involves contacting physicians and other health care professionals to gather health information and treatment plans. This information is necessary to assist with the coordination and arrangement of services, supplies and equipment as well as the timely processing of claims.

Please feel free to contact me if you have any additional information regarding this patient or if you have any questions regarding case management services. I can be reached at (LCMI CMPhoneCombo).

Sincerely,
(LCMI CMFN) (LCMI CMLN)
Case Manager

CM-27

AmericanHealth
American Health Holding Inc

Member/Patient Name
Address1
City, State Zip

CONFIDENTIAL
Date

Ref. Number:
Patient:
Group:

Member ID:
Physician:
Facility:
Admit Date:

Dear (Contact SalutationName) (Contact CombinedContactName),

The above referenced hospitalization meets criteria for inpatient hospitalization and has been certified for an initial <DAYS CERTIFIED> day(s).. <KNOWN AS NAME> will be checking on the patient's medical progress on <FOLLOW UP DATE>

This notice is not a guarantee of payment. Benefits are subject to all eligibility, plan provisions and limitations in force at the time services are rendered. For benefit and eligibility information, please contact your benefit plan administrator at <Benefits/Customer Service Phone>.

Should you have any questions regarding this matter, please do not hesitate to call. We can be reached at <Known As Phone>.

Sincerely,

<KNOWN AS NAME>/UR-202

INPATIENT CERTIFICATION LETTER – This letter indicates that an urgent/emergency inpatient hospitalization has been certified.

Member/Patient Name
Address1
City, State Zip

CONFIDENTIAL
Date

Ref. Number:
Patient:
Group:

Member ID:
Physician:
Facility:
Admit Date:

Dear (Contact SalutationName) (Contact CombinedContactName),

This letter contains important information about rights and responsibilities involving an initial adverse medical necessity determination.

The group health plan sponsored by the above employer has certain provisions requiring medical necessity review of hospital admissions. We have conducted a careful review and are not able to certify this admission as medically necessary. It was determined this admission was not medically necessary because <NONCERT REASON>. A copy of the guideline relied upon in making this determination, and an explanation of the scientific or clinical reason for this determination, are available free of charge upon request.

This adverse determination does not mean the patient should not enter the hospital, or that medical care is not needed. Those decisions rest with the treating medical professional and the patient. **This determination was based only on medical necessity, and did not consider eligibility, available health care benefits or claims payment guidelines. Questions about such issues should be directed to the claims payer at <CLAIMS PAYER PHONE>.**

The patient or an authorized representative may request an appeal of an adverse determination within 180 days from receipt of the letter. Any additional medical or other relevant information should be included.

If a Standard Appeal is chosen, it can be requested by writing to us at the address on this letter. We will respond to this appeal within 15 days of receipt of such request. If the appeal decision is not satisfactory, a second appeal may be requested. We will respond to the second appeal within 15 days of receipt of the request.

If an Expedited Appeal is chosen (for example, where the patient has not yet been admitted, is currently hospitalized, or if urgent care is involved), it can be requested by writing or calling us at <KNOWN AS PHONE>. Please indicate the request is for an Expedited Appeal. We will respond to the Expedited Appeal within 72 hours. If the Expedited Appeal decision is not satisfactory, the claimant has a right to file legal action against the Health Plan under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA).

In addition to appeal rights mentioned above, if you are enrolled in a non-grandfathered health plan (as determined by the Patient Protection and Affordable Care Act), you may also be eligible to request an independent external review. To determine if you are in a non-grandfathered plan and eligible for an independent external review, you should contact <KNOWN AS NAME>. If eligible, you may request the independent external review by contacting us within four months after the date of receipt of the adverse determination. If the request is for an urgent healthcare service (i.e., an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician may experience pain that cannot be adequately controlled while you wait for a decision on your appeal, you may request an expedited external appeal by contacting <KNOWN AS PHONE>. An independent third party will then review the adverse determination along with any additional information you provide and issue a final decision.

We regret that this determination is not more favorable. If you have any questions regarding this letter you may contact us.

Sincerely,

Medical Advisor UR-223A

RESOURCES AVAILABLE TO HELP YOU

You have the right to receive the diagnosis and treatment codes (and their meanings) for the services listed on the attached letter simply by writing to us at the address listed on the attached letter.

In addition to the information listed on the attached letter, there may be other resources available to help you. You should ask your employer if your plan is subject to the health care reform law. If it is, you may also contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272) for help, if your health plan is provided by your employer.

ADMISSION NON-CERT LETTER – This letter is sent to the physician, facility and member/patient. This letter is used to notify parties that we are unable to certify based on medical necessity for the entire admission/length of stay. This letter informs the parties of appeal rights.

Member/Patient Name
Address1
City, State Zip

CONFIDENTIAL
Date

Ref. Number:
Patient:
Group:

Member ID:
Physician:
Facility:
Admit Date:

Dear (Contact SalutationName) (Contact CombinedContactName),

The above referenced hospitalization meets criteria for inpatient hospitalization and has been certified for a total of <DAYS CERTIFIED> day(s).

This notice is not a guarantee of payment. Benefits are subject to all eligibility, plan provisions and limitations in force at the time services are rendered. For benefit and eligibility information, please contact your benefit plan administrator at <Benefits/Customer Service Phone>.

Should you have any questions regarding this matter, please do not hesitate to call. We can be reached at (LIAI KnownAsPhoneNum).

Sincerely,

<KNOWN AS NAME>/UR-203

RETROSPECTIVE INPATIENT CERTIFICATION LETTER – This letter indicates that a hospitalization that occurred in the past has been certified. Patient has already been discharged.

Member/Patient Name
Address1
City, State Zip

CONFIDENTIAL
Date

Ref. Number:
Patient:
Group:

Member ID:
Physician:
Facility:
Admit Date:

Dear (Contact SalutationName) (Contact CombinedContactName),

This letter contains important information about rights and responsibilities involving an initial adverse medical necessity determination.

The group health plan sponsored by the above employer has certain provisions requiring medical necessity review of hospital admissions. We have conducted a careful review and are not able to certify this admission as medically necessary. It was determined this admission was not medically necessary because <NONCERT REASON>. A copy of the guideline relied upon in making this determination, and an explanation of the scientific or clinical reason for this determination, are available free of charge upon request.

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If a Standard Appeal is chosen, it can be requested by writing to us at the address on this letter. We will respond to this appeal within 15 days of receipt of such request. If the appeal decision is not satisfactory, a second appeal may be requested. We will respond to the second appeal within 15 days of receipt of the request.

If an Expedited Appeal is chosen (for example, where the patient has not yet been admitted, is currently hospitalized, or if urgent care is involved), it can be requested by writing or calling us at <KNOWN AS PHONE>. Please indicate the request is for an Expedited Appeal. We will respond to the Expedited Appeal within 72 hours. If the Expedited Appeal decision is not satisfactory, the claimant has a right to file legal action against the Health Plan under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA).

In addition to appeal rights mentioned above, if you are enrolled in a non-grandfathered health plan (as determined by the Patient Protection and Affordable Care Act), you may also be eligible to request an independent external review. To determine if you are in a non-grandfathered plan and eligible for an independent external review, you should contact <KNOWN AS NAME>. If eligible, you may request the independent external review by contacting us within four months after the date of receipt of the adverse determination. If the request is for an urgent healthcare service (i.e., an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician may experience pain that cannot be adequately controlled while you wait for a decision on your appeal, you may request an expedited external appeal by contacting <KNOWN AS PHONE>. An independent third party will then review the adverse determination along with any additional information you provide and issue a final decision.

We regret that this determination is not more favorable. If you have any questions regarding this letter you may contact us.

Sincerely,

Medical Advisor UR-223A

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ADMISSION NON-CERT LETTER – This letter is sent to the physician, facility and member/patient. This letter is used to notify parties that we are unable to certify based on medical necessity for the entire admission/length of stay. This letter informs the parties of appeal rights.

Group-Level Standard Reports

The following is a summary of our standard reports. We are able to create customized reports and make changes to standard reports for an hourly fee. Reports are subject to change to reflect enhancements and/or changes to the product offering or processes.

Utilization Management Reports

Utilization Management Summary

- Aggregate report summarizes all Utilization Management activity
- Includes statistical impact, comparison with benchmarks, and savings associated with the program
- Frequency: Quarterly

Daily Patient Activity

- Detailed listing of cases reviewed by the Utilization Management department
- Includes patient-specific information such as admission activity, discharge activity, diagnoses, providers, Case Management triggers and length of services certified
- Report can be run by notification date, admission/start date or discharge/end date
- Frequency: Available upon client request

Certification Activity

- Detailed listing of all cases reviewed by the Utilization Management department
- Includes a patient activity update detailing length of stay, diagnoses, services provided, providers and physicians, as well as authorization information and whether the case triggered for Case Management
- Report captures all certification activity, including TPA notes, for cases in which a decision has been rendered
- Frequency: Available upon client request

Extended Length of Stay

- Detailed listing of cases reviewed by the Utilization Management department shows cases in which the length of acute stay exceeded a number of days agreed upon with the client (typically 5-7 days)
- Includes patient-specific information such as length of stay, diagnoses, services provided, providers and physicians, as well as authorization information and whether the case triggered for Case Management, and nurse notes
- Frequency: Available upon client request

Case Management Referral Activity

- Detailed listing of Utilization Management cases in which a patient's diagnosis triggered referral to Case Management or required monitoring during concurrent review
- Includes information on length of stay, diagnoses, services provided, providers and physicians, as well as authorization information
- Frequency: Available upon client request

Inpatient Facility Distribution

- Summarizes inpatient activity by facility
- Includes total admissions, total days utilized and average length of stay
- Frequency: Available upon client request

Case Management Reports

Case Management Summary

- Aggregate report summarizes all Case Management activity
- Includes patient-specific information, such as diagnosis and referral source, and financial impact of Case Management, such as savings detail and negotiated and managed savings
- Frequency: Quarterly

Open Case Listing

- Group-level report identifies the number of patients enrolled in Case Management
- Includes detail on diagnoses, intensity of services, the date the case was opened, and the Case Manager assigned to each case
- Frequency: Available upon client request

Clinical Case Management

- Patient-specific, detailed clinical report
- Includes history, care plan, interventions, savings and prognosis of the participant
- Frequency: Monthly or bimonthly

Nevada PUBLIC EMPLOYEES' BENEFITS PROGRAM
PEBP
Health Matters.

AmericanHealth
American Health Holding, Inc

Precertification Request
Clinical Update Request

Welcome to American Health.

Nevada PUBLIC EMPLOYEES' BENEFITS PROGRAM
PEBP
Health Matters.

AmericanHealth
American Health Holding, Inc

Introduction
Patient Information
Service Information
Service Details
Provider Information
Facility Information
Summary
Submission

Return to Main

Certification Request Form

Welcome to the American Health certification website. This online certification process is designed to improve the response time for completing your request for review.

The information you may be asked to provide is required to ensure the accuracy of your request and to prevent unnecessary delays in the review process.

If you have an urgent/emergent case please call 800-555-1212.

Please have the following information available before you begin:

- Member Identification number
- Patient's full name, address and phone number
- Diagnosis code(s)
- CPT codes (if applicable)
- Admitting/Ordering physician's full name, address, phone number and tax ID
- Facility name, address, phone number and tax ID

After completing this form, you will be contacted regarding the outcome of your request. If additional information is needed to complete the review, you will be contacted within one business day.

Next

Nevada PUBLIC EMPLOYEES' BENEFITS PROGRAM

PEBP

Health Matters.

AmericanHealth

American Health Holding Inc

Introduction
Patient Information
Service Information
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Provider Information
Facility Information
Summary
Submission

Return to Main

Certification Request Form

Please provide the following information. Fields marked with an * are required.

Person completing form

Name: * John Smith
Phone: * (614)888-2212
Email: jsmith@testcompany.com
Source: * Provider of Care

Patient Information

Member ID: * 1231231
Name: * Sam (First) (Middle) * Houston (Last)
Birth Date: * 01/02/1940 **Gender:** * Male Female
Address: * 123 Somewhere Drive
City: * Little Rock **State:** * Arkansas
Postal Code: * 77012

Next

Nevada PUBLIC EMPLOYEES' BENEFITS PROGRAM

PEBP

Health Matters.

AmericanHealth

American Health Holding Inc

Introduction
Patient Information
Service Information
Service Details
Provider Information
Facility Information
Summary
Submission

Return to Main

Certification Request Form

Please provide the following information. Fields marked with an * are required.

Service Information

Setting: * Physician **Service:** * Diagnostic Test **Urgency:** * Elective

Primary	Procedure Code	Delete
	Procedure Code:	☑ Primary Add

Primary	Diagnosis Code	Delete
X	250	Delete
	Diagnosis Code:	☐ Primary Add

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PEBP

Health Matters.

AmericanHealth

American Health Holding Inc

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Certification Request Form

Please provide the following information. Fields marked with an * are required.

Clinical Information and Notes

Date of Service: * 01/05/2011

Estimate LOS (days): *

Characters used: 23 out of 1000

Signs/Symptoms: Elevated glucose levels

Characters used: 0 out of 1000

Diagnostics and Results:

Characters used: 48 out of 1000

Treatments Tried: previously tried restricted diet with not impact

Characters used: 49 out of 1000

Proposed Treatment Plan: conduct blood screening and start RX for diabetes

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Certification Request Form

Please provide the following information. Fields marked with an * are required.

Physician Information

Name: * Joe (First) * Smith (Last)

Address: * 1121 Ft. Little Rock Drive

City: * Little Rock **State:** * Arkansas

Postal Code: * 77202

Phone: * (562)112-1231

Tax ID:

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Please provide the following information. Fields marked with an * are required.

Facility Information

In Physicians Office: ☑

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Certification Request Form

Person completing form Edit

Name:	John Smith
Phone:	(614)888-2212
Email:	jsmith@testcompany.com
Referral Source:	Provider of Care

Patient Information Edit

Member ID:	1231231
Name:	Sam Houston
Birth Date:	01/02/1940
Gender:	Male
Address:	123 Somewhere Drive
City/State/Zip:	Little Rock, AR 77012

Service Information Edit

Setting/Service/Urgency:	Physician / Diagnostic Test / Elective

Primary	Diagnosis Code
X	250

Service Detail Edit

Date of Service:	01/05/2011
Estimate LOS (days):	1
Signs/Symptoms:	Elevated glucose levels
Diagnostics and Results:	
Treatments Tried:	previously tried restricted diet with not impact
Proposed Treatment Plan:	conduct blood screening and start RX for diabetes

Physician Information Edit

Name:	Joe Smith
Address:	1121 Ft. Little Rock Drive
City/State/Zip:	Little Rock, AR 77202
Phone:	(562)112-1231
Tax ID:	

Facility Information Edit

In Physicians Office:	Yes

Submit

Nevada PUBLIC EMPLOYEES' BENEFITS PROGRAM

PEBP

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Certification Request Form

Thank you for completing this online certification request on behalf of patient Sam Houston on January 03, 2011 2:13 PM EST. You may print this page for your records.

IMPORTANT: Please read.

- This certification process will not be finalized until the clinical information submitted has been reviewed.
- You will be contacted regarding the outcome of this request.
- If additional information is needed to complete the review, you will be contacted within one business day.
- This review and determination is limited to medical necessity only. Accordingly, this determination does not guarantee payment of charges. Payment of benefits will be subject to all of your health plan conditions, limitations and exclusions affecting coverage, as well as the patient's eligibility on the date services are actually provided.

Return to Main

Task	Task Description	Status	Start	Finish	AHH Responsible	Client Resp	Comments
1	**AHH Implementation Coordination**						
1.1	Sales sends proposal and yes form to Impl Mgr	Open	03/01/14	03/01/14	AHH Sales		
1.2	Confirm client demographics	Open	03/05/14	03/05/14	Impl Mgr		
1.3	Distribute client information within AHH	Open	03/05/14	03/05/14	Impl Mgr		
1.4	Assign Account Executive	Open	03/05/14	03/05/14	VP Client Svcs		
1.5	Assign CM Supervisor	Open	03/05/14	03/05/14	Director of CM		
1.6	Assign CM Coordinator	Open	03/05/14	03/05/14	Director of CM		
1.7	Assign IT representative	Open	03/05/14	03/05/14	Director of Data Mgmt		
1.8	Assign Business Support Team representative	Open	03/05/14	03/05/14	AVP, Bus Support		
1.9	Preliminary meeting with AHH staff	Open	03/05/14	03/05/14	Impl Mgr		
1.10	Introductory client contact	Open	03/31/14	04/04/14	AE	Client	
1.11	Review implementation plan with client	Open	03/31/14	04/04/14	Impl Mgr	Client	
1.12	Determine client contact/s for implementation meetings	Open	03/31/14	04/04/14	Impl Mgr	Client	
1.13	Determine implementation meeting schedule	Open	03/31/14	04/04/14	Impl Mgr	Client	
1.14	Confirm specific product lines being implemented	Open	03/31/14	04/04/14	Impl Mgr, AE	Client	
1.15	Provide AHH contact sheet	Open	03/31/14	04/04/14	Impl Mgr		
1.16	Assessment of staffing needs	Open	03/01/14	03/01/14	Ops Directors		
1.17	Service agreement/amendment drafted	Open	03/03/14	03/31/14	Legal	Client	
2	**Client Discovery**						
2.1	Determine hours of operation	Open	04/01/14	04/08/14	Impl Mgr	Client	
2.2	Determine number of groups	Open	04/01/14	04/08/14	Impl Mgr	Client	
2.3	Identify number of employee lives managed per product	Open	04/01/14	04/08/14	Impl Mgr	Client	
2.4	Provide new business client profile form	Open	04/01/14	04/04/14	Impl Mgr		
2.5	Complete & return client profile form	Open	04/04/14	04/15/14		Client	
2.6	Review completed client profile form	Open	04/15/14	04/22/14	Impl Mgr, AE	Client	
2.7	Distribute completed client profile form	Open	4/22/14/	04/22/14	Impl Mgr		
2.8	Provide copy of member ID card	Open	06/02/14	06/02/14		Client	
2.9	Provide copy of member SPD	Open	05/02/14	05/06/14		Client	
2.10	Determine private labeling requirements	Open	04/15/14	04/22/14	Impl Mgr, AE	Client	
2.11	Provide logo	Open	05/02/14	05/06/14		Client	
2.12	Provide letterhead	Open	05/02/14	05/06/14		Client	
2.13	Prepare mock-up of private label documents	Open	05/09/14	05/13/14	Impl Mgr		
2.14	Obtain client approval of private label documents	Open	05/16/14	05/20/14	Impl Mgr	Client	
3	**i-Suite System**						
3.1	Identify set-up hierarchy	Open	05/02/14	05/06/14	Business Support	Client	
3.2	Create/Load client	Open	05/15/14	05/15/14	Business Support		
3.3	Create/Load groups	Open	05/15/14	05/15/14	Business Support		
3.4	Create/Load networks	Open	05/15/14	05/15/14	AHH IT		
3.5	Create/Load logo	Open	05/15/14	05/15/14	AHH IT		
3.6	Create/Load letterhead	Open	05/15/14	05/15/14	AHH IT		
3.7	Create/Load billing schedule	Open	06/01/14	06/15/14	AHH IT		
4	**Imports/Eligibility**						
4.1	Identify claims system utilized	Open	04/08/14	04/08/14	Impl Mgr	Client	
4.2	Determine how eligibility will be received	Open	04/08/14	04/08/14	AHH IT	Client	
4.3	Determine file frequency	Open	04/08/14	04/08/14	AHH IT	Client	
4.4	Identify full file vs. update file	Open	04/08/14	04/08/14	AHH IT	Client	
4.5	Identify number of files that will be sent	Open	04/08/14	04/08/14	AHH IT	Client	

Task	Task Description	Status	Start	Finish	AHH Responsible	Client Resp	Comments
4.6	Terminations must be sent on file (leave on for two cycles)	Open	04/08/14	04/08/14	AHH IT	Client	
4.7	Provide electronic eligibility file format specification (3.1 layout)	Open	04/04/14	04/04/14	AHH IT		
4.8	Provide electronic eligibility test file	Open	05/15/14	06/14/14		Client	
4.9	Load groups to i-Suite test system	Open	05/15/14	05/15/14	AHH IT		
4.10	Load eligibility file	Open	06/15/14	06/15/14	AHH IT		
4.11	Define Eligibility Error Reporting	Open	05/15/14	05/15/14	AHH IT		
4.12	Obtain report parameters	Open	05/15/14	05/15/14	AHH IT		
4.13	Error report generated	Open	05/15/14	05/15/14	AHH IT		
5	**Exports/Pre-cert file**						
5.1	Determine file frequency	Open	04/08/14	04/08/14	AHH IT	Client	
5.2	Define export formats	Open	04/15/14	04/15/14	AHH IT	Client	
5.3	Identify types of cases expected in file (IP, OP)	Open	04/15/14	04/15/14	AHH IT	Client	
5.4	Identify types of cases expected in file (Open, Closed, Pend)	Open	04/15/14	04/15/14	AHH IT	Client	
5.5	Create file formats	Open	04/15/14	04/15/14	AHH IT		
5.6	Create and send test files	Open	05/22/14	05/22/14	AHH IT		
5.7	Document test results	Open	05/22/14	05/22/14	AHH IT	Client	
5.8	Obtain client approval of file	Open	06/05/14	06/05/14	AHH IT		
6	**Electronic Interface Transmission**						
6.1	Provide FTP/SFTP specifications	Open	04/08/14	04/08/14	AHH IT		
6.2	Identify FTP/SFTP site and login information for Client	Open	04/22/14	04/22/14	AHH IT		
6.3	Create FTP/SFTP directory	Open	04/22/14	04/22/14	AHH IT		
6.4	Send Client AHH PGP key	Open	04/22/14	04/22/14	AHH IT		
6.5	Client send AHH PGP key	Open	04/22/14	04/22/14	AHH IT	Client	
6.6	Drop test file to FTP/SFTP site	Open	04/29/14	04/29/14	AHH IT		
6.7	Document test results	Open	04/29/14	04/29/14	AHH IT		
6.8	Confirm file received and decrypted appropriately	Open	04/29/14	04/29/14	AHH IT		
7	**i-Suite Rules**						
7.1	Review plan requirements	Open	05/01/14	05/01/14	AHH UM	Client	
7.2	Send precert requirements to "rules" for coding	Open	05/08/14	05/08/14	AHH UM		
7.3	Write rules for i-Suite	Open	05/08/14	05/08/14	Rules Analyst		
7.4	Review rules with client	Open	05/15/14	05/21/14	Impl Mgr, AE	Client	
7.5	Obtain sign-off on rules	Open	05/22/14	05/22/14		Client	
7.6	Test rules	Open	06/01/14	06/14/14	AHH IT		
7.7	Deploy rules	Open	06/15/14	06/15/14	AHH IT		
8	**Utilization Management**						
8.1	Provide new business group profile form (UM/CM)	Open	04/01/14	04/04/14	Impl Mgr		
8.2	Complete & return group profile forms	Open	04/04/14	04/15/14		Client	
8.3	Review completed group profile forms	Open	04/15/14	04/22/14	Impl Mgr, AE	Client	
8.4	Distribute completed group profile forms	Open	4/22/14/	04/22/14	Impl Mgr		
8.5	Determine program known as name	Open	04/22/14	04/22/14	Impl Mgr, AE	Client	
8.6	Confirm UM model applicable	Open	04/08/14	04/08/14	AHH UM	Client	
8.7	Determine pre-certification process	Open	04/08/14	04/08/14	AHH UM	Client	
8.8	Retrospective review process	Open	04/08/14	04/08/14	Impl Mgr	Client	
8.9	"On the fly" requirement	Open	04/08/14	04/08/14	Impl Mgr	Client	
8.10	Network steerage requirement	Open	04/08/14	04/08/14	Impl Mgr	Client	
8.11	Review any special UM workflow	Open	04/08/14	04/08/14	AHH UM	Client	
8.12	Review any carve out programs	Open	04/08/14	04/08/14	AHH UM	Client	

Task	Task Description	Status	Start	Finish	AHH Responsible	Client Resp	Comments
8.13	Transplant program	Open	04/08/14	04/08/14	AHH UM	Client	
8.14	Maternity management	Open	04/08/14	04/08/14	AHH UM	Client	
8.15	Mental health program	Open	04/08/14	04/08/14	AHH UM	Client	
8.16	Substance abuse program	Open	04/08/14	04/08/14	AHH UM	Client	
8.17	Employee assistance program	Open	04/08/14	04/08/14	AHH UM	Client	
8.18	Disease Management program	Open	04/08/14	04/08/14	AHH UM	Client	
8.19	Wellness program	Open	04/08/14	04/08/14	AHH UM	Client	
8.20	Determine reinsurer communication process	Open	04/08/14	04/08/14	Impl Mgr, AE	Client	
8.21	Provide reinsurance carrier information	Open	04/08/14	04/08/14		Client	
8.22	Determine appeal process	Open	04/08/14	04/08/14	AHH UM	Client	
8.23	Determine number of appeal levels	Open	04/08/14	04/08/14	AHH UM	Client	
8.24	Who handles appeals (AHH vs Claims Dept)	Open	04/08/14	04/08/14	AHH UM	Client	
8.25	Determine transition of open UM cases	Open	05/15/14	05/15/14	AHH UM	Client	
8.26	Review approximate # of UM cases that will transition	Open	06/01/14	06/01/14	Impl Mgr		
8.27	Obtain report of UM open cases	Open	06/22/14	06/22/14		Client	
8.28	UM enters cases into i-Suite	Open	06/23/14	06/29/14	AHH UM		
8.29	UM communicates client information to AHH corporate staff	Open	06/29/14	06/29/14	AHH UM		
9	**Case Management**						
9.1	Provide new business group profile form (UM/CM)	Open	04/01/14	04/04/14	Impl Mgr		
9.2	Complete & return group profile forms	Open	04/04/14	04/15/14		Client	
9.3	Review completed group profile forms	Open	04/15/14	04/22/14	Impl Mgr, AE	Client	
9.4	Distribute completed group profile forms	Open	4/22/14/	04/22/14	Impl Mgr		
9.5	Determine program known as name	Open	04/22/14	04/22/14	Impl Mgr, AE	Client	
9.6	Review CM model	Open	04/08/14	04/08/14	AHH CM		
9.7	Review CM acuity levels	Open	04/08/14	04/08/14	AHH CM		
9.8	Review CM FAQs	Open	04/08/14	04/08/14	AE		
9.9	Review CM brochure	Open	04/08/14	04/08/14	AE		
9.10	Review CM billing process with client	Open	04/08/14	04/08/14	AE		
9.11	Review any special CM workflow	Open	04/08/14	04/08/14	AHH CM	Client	
9.12	Determine any special CM triggers	Open	04/08/14	04/08/14	AHH CM	Client	
9.13	CM permission for service requirements/contact	Open	04/08/14	04/08/14	AHH CM	Client	
9.14	Determine reinsurer communication process	Open	04/08/14	04/08/14	Impl Mgr, AE	Client	
9.15	Provide reinsurance carrier information	Open	04/08/14	04/08/14		Client	
9.16	Determine transition of open CM cases	Open	05/15/14	05/15/14	AHH CM	Client	
9.17	Review approximate # of CM cases that will transition	Open	06/01/14	06/01/14		Client	
9.18	Obtain report of CM open cases	Open	06/22/14	06/22/14		Client	
9.19	CM enters cases into i-Suite	Open	06/23/14	06/29/14	AHH CM		
9.20	CM communicates client information to AHH corporate staff	Open	06/29/14	06/29/14	AHH CM		
10	**Telecommunications**						
10.1	Determine telecomm sites	Open	04/15/14	04/15/14	Impl Mgr, AHH IT	Client	
10.2	Provide telephone number/s - UM	Open	04/15/14	04/15/14	Impl Mgr		800-641-5566
10.3	Provide telephone number/s - CM	Open	04/15/14	04/15/14	Impl Mgr		800-641-3224
10.4	Identify ownership of phone numbers	Open	04/15/14	04/15/14	Impl Mgr	Client	
10.5	Identify if RespOrg is required, or if phone # can be pointed	Open	04/15/14	04/15/14	Impl Mgr	Client	
10.6	If new #, add to Call Center Reports	Open	05/15/14	05/15/14	Call Center Mgr		
10.7	Review greetings and scripts	Open	04/29/14	04/29/14	Impl Mgr	Client	
10.8	Design call flow	Open	04/29/14	04/29/14	Impl Mgr, AHH IT		
10.9	Obtain client approval of call flow	Open	04/29/14	05/15/14	Impl Mgr	Client	

Task	Task Description	Status	Start	Finish	AHH Responsible	Client Resp	Comments
10.10	Program call flow	Open	06/01/14	06/01/14	AHH IT		
10.11	Test telephone lines	Open	06/01/14	06/01/14	Impl Mgr, AHH IT	Client	
10.12	Provide fax numbers - UM	Open	04/15/14	04/15/14	Impl Mgr		614-818-3236
10.13	Provide fax numbers - CM	Open	04/15/14	04/15/14	Impl Mgr		866-440-3487
10.14	Test fax lines	Open	04/15/14	04/15/14		Client	
10.15	Identify after hours phone coverage (weekends & holidays)	Open	04/15/14	04/15/14	Impl Mgr, AHH IT	Client	
11	**Letters**						
11.1	Provide sample letters - UM	Open	04/08/14	04/08/14	Impl Mgr		
11.2	Provide sample letters - CM	Open	04/08/14	04/08/14	Impl Mgr		
11.3	Review sample letters	Open	04/15/14	04/15/14		Client	
11.4	Obtain client approval of letters	Open	04/22/14	04/29/14	Impl Mgr		
11.5	Identify which letters should be sent (i.e. cert letters, D/C notice)	Open	04/29/14	04/29/14	Impl Mgr	Client	
11.6	Identify letter recipients (i.e. mbr, physician, claims contact)	Open	04/29/14	04/29/14	Impl Mgr	Client	
11.7	Identify delivery method (i.e. FTP, fax, mail, e-mail)	Open	04/29/14	04/29/14	Impl Mgr	Client	
11.8	Create letter sets	Open	05/15/14	05/15/14	Business Support		
11.9	Assign letter sets	Open	05/15/14	05/15/14	Business Support	Client	
11.10	Create letter batch	Open	05/15/14	05/15/14	Business Support		
12	**Reports**						
12.1	Provide sample reports - UM	Open	04/08/14	04/08/14	Impl Mgr		
22.2	Provide sample reports - CM	Open	04/08/14	04/08/14	Impl Mgr		
22.3	Determine reporting schedule	Open	05/15/14	05/15/14	Impl Mgr, AE	Client	
22.4	Determine report delivery method (FTP site, EZ Reports, other)	Open	05/15/14	05/15/14	Impl Mgr, AE	Client	
12.5	Determine report contacts	Open	05/15/14	05/15/14	Impl Mgr, AE	Client	
13	**i-Suite Access**						
23.1	Provide information on i-Suite user roles	Open	06/01/14	06/01/14	Impl Mgr		
23.2	User access forms provided	Open	06/01/14	06/01/14	Impl Mgr		
23.3	Complete user access forms	Open	06/01/14	06/15/14		Client	
23.4	Add client views	Open	06/15/14	06/15/14	Business Support		
23.5	Assign client staff views	Open	06/15/14	06/15/14	Business Support		
13.6	Designate AHH corporate views	Open	06/15/14	06/15/14	Ops Directors		
13.7	Assign AHH corporate views	Open	06/15/14	06/15/14	Business Support		
14	**Training**						
14.1	EZ Reports training	Open	06/22/14	06/22/14	AE	Client	
14.2	Group management process training	Open	06/29/14	06/29/14	AE, Impl Mgr	Client	
15	**On-Site Staffing**						
25.1	Assessment of staffing needs	Open	04/08/14	04/08/14	AHH HR		
15.2	Determine leased or non-leased	Open	04/08/14	04/08/14	AHH HR	Client	
15.3	Determine if staff are telecommuters	Open	04/08/14	04/08/14	AHH HR		
15.4	Determine recruiting responsibilities	Open	04/08/14	04/08/14	AHH HR	Client	
15.5	Determine performance evaluation process	Open	04/08/14	04/08/14	AHH HR, Field Dir	Client	
15.6	Determine back-up coverage provisions	Open	04/08/14	04/08/14	Field Director		
15.7	Provide training schedule	Open	05/01/14	05/01/14	Sr Dir Field Ops		
25.8	Identify travel arrangements	Open	05/01/14	05/01/14	Sr Dir Field Ops	Client	
15.9	i-Suite training	Open	05/01/14	05/01/14	AHH Training	Client	
15.10	Staff benefits review	Open	06/22/14	06/22/14	AHH HR	Client	
15.11	Policy and procedure training	Open	06/22/14	06/22/14	Ops Directors	Client	
16	**Equipment (for on-site operations)**						

Task	Task Description	Status	Start	Finish	AHH Responsible	Client Resp	Comments
16.1	Forward "System Specifications" document to Client IT	Open	04/08/14	04/08/14	AHH IT		
16.2	Provide i-Suite connection specifications	Open	04/08/14	04/08/14	AHH IT		
16.3	Test ISP connections	Open	06/01/14	06/01/14	AHH IT	Client	
16.4	Document and report results	Open	06/01/14	06/01/14	AHH IT	Client	
26.5	Identify needed supply of computers and phones	Open	05/01/14	05/08/14	AHH IT		
16.6	Setup work areas	Open	06/01/14	06/15/14		Client	
16.7	Test work areas	Open	06/01/14	06/15/14		Client	
16.8	Work area active	Open	06/15/14	06/29/14		Client	
16.9	Setup active directory and e-mail for employees	Open	06/15/14	06/29/14		Client	
17	**Financial**						
17.1	Provide Payment Information documentation	Open	06/01/14	06/01/14	Impl Mgr	Client	
17.2	Determine billing arrangement and billing contact(s)	Open	06/01/14	06/01/14	Impl Mgr	Client	
27.3	Arrange meeting with Finance/Billing contact(s)	Open	06/01/14	06/01/14	Impl Mgr, Finance Mgr	Client	
17.4	Finance to review pricing with client	Open	06/01/14	06/01/14	Impl Mgr, Finance Mgr	Client	
	Go-Live Date			**X**			
	Open Tasks	**186**					
	Closed Tasks	**0**					
	Total	**186**					
	Percent complete	**0%**					
28	**Post Implementation**						
28.1	Send post implementation survey to Client	Open			Impl Mgr	Client	

SAMPLE

Note: *This is a sample Executive Summary report as produced by AHH Business Intelligence. The report intent is to provide unique insights into medical management outcomes and is prepared/customized for large groups. As such, each report follows a general guideline for content; however, actual group report content may vary depending upon the report time period, service lines and specific cost containment outcomes.*

<Group Name>

Medical Management
Executive Summary Report

Month DD, YYYY

AmericanHealth
American Health Holding Inc

Q4 2012 Review – Table of Contents

SAMPLE

- **Executive Overview**
  - Return on Investment
  - 2012 – Key Trends and Metrics
- **Medical Management Summary**
  - Utilization Management
  - Case Management
  - Maternity Management
  - Disease Management

AmericanHealth

SAMPLE

Executive Overview

AmericanHealth
American Health Holding Inc

Executive Overview

SAMPLE

Return on Investment – January, 2012 through December, 2012

	2012		
	Fees	Savings	ROI
Utilization Management	$287,414	$5,124,549	**17.8 to 1**
Case Management	$383,244	$6,920,022	**18.0 to 1**
Total	**$670,658**	**$12,044,571**	**17.9 to 1**

Utilization Management Breakout

- Inpatient Savings = **$2,980,061**
- Outpatient Savings = **$2,144,488**

AmericanHealth

Executive Overview

SAMPLE

2012 – Key Trends and Metrics

- *Acute inpatient cases and hospital days are down approximately **11%** and **13%** respectively from 2011*
- *Psychiatric cases consumed the most number of acute inpatient actual days in both 2011 (**656 days**) and 2012 (**601 days**)*
- *The number of requested outpatient radiology procedures has increased over **16.5%** between 2011 and 2012*
- *The number of acute inpatient substance abuse cases is up from **15** in 2011 to **29** in 2012*
- *Of all Maternity Management cases closed in 2012 (123), **67%** were closed because we were unable to reach the patient*

Medical Management Summary
Utilization Management

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Utilization Management – Overall Summary

SAMPLE

Overall Summary – All Plans

Setting	# Cases Q3 2012	# Cases Q4 2012	Variance	# Cases 2011	# Cases 2012	Variance
Acute Inpatient	286	248	-13.3%	1,263	1,119	-11.4%
Other Inpatient	20	20	-	56	68	+21.4%
Total Inpatient	**306**	**268**	**-12.4%**	**1,319**	**1,187**	**-10.0%**
Outpatient	**2,433**	**2,462**	**+1.2%**	**9,804**	**9,948**	**+1.5%**

Total UM Savings Q4 2012 = $1,283,892

- Inpatient savings = **$700,881** from **210** saved days
- Outpatient savings = **$583,011** from **2,008** saved services/units

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Utilization Management
Inpatient Summary

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Utilization Management – Inpatient

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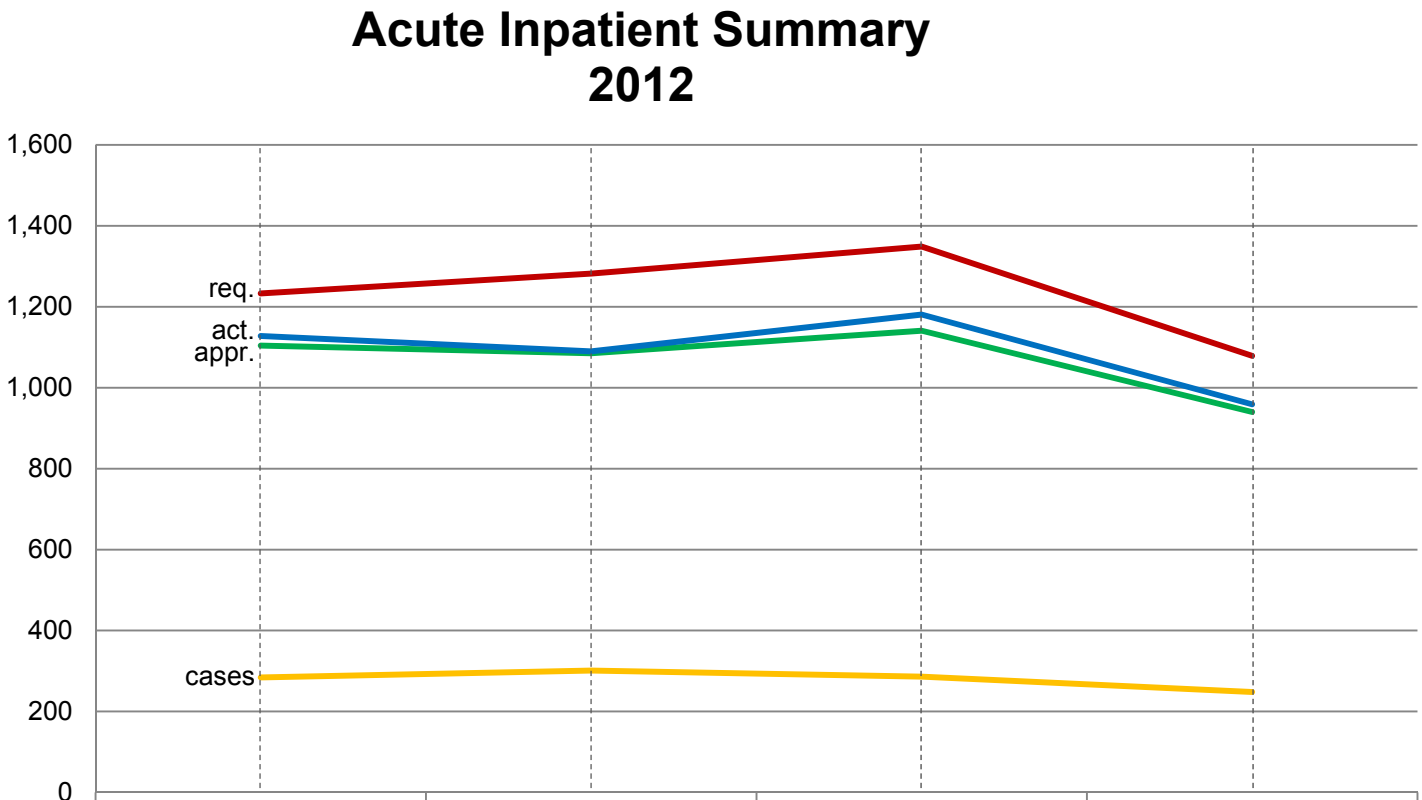

	Q1 2012	Q2 2012	Q3 2012	Q4 2012	Totals
Req. Days	1,233	1,282	1,349	1,079	4,943
Appr. Days	1,104	1,085	1,141	940	4,270
Actual Days	1,128	1,090	1,181	959	4,358
Cases	284	301	286	248	1,119

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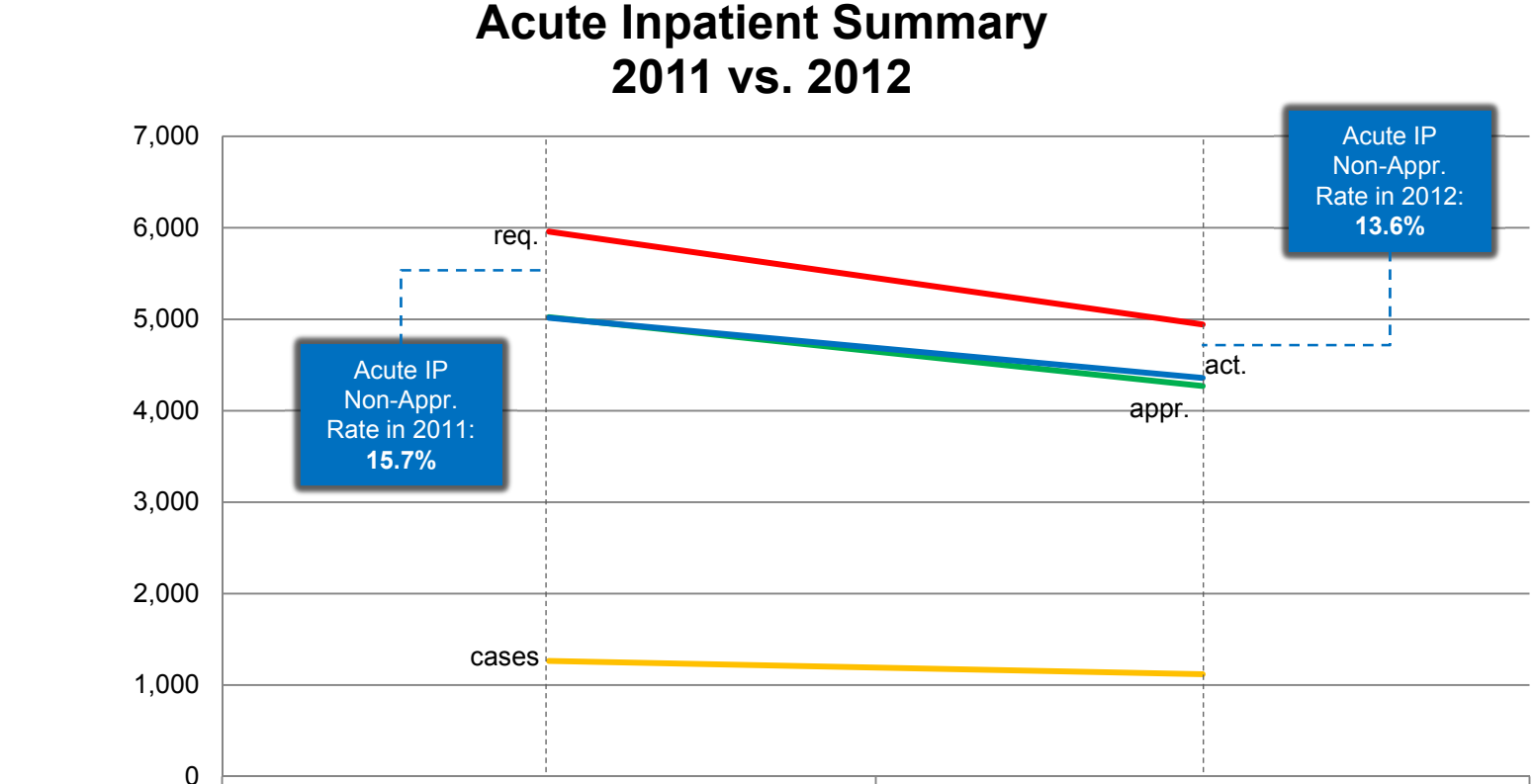

	2011	2012	Var.
Req. Days	5,958	4,943	-17.0%
Appr. Days	5,023	4,270	-15.0%
Actual Days	5,016	4,358	-13.1%
Cases	1,263	1,119	-11.4%

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Utilization Management – Inpatient

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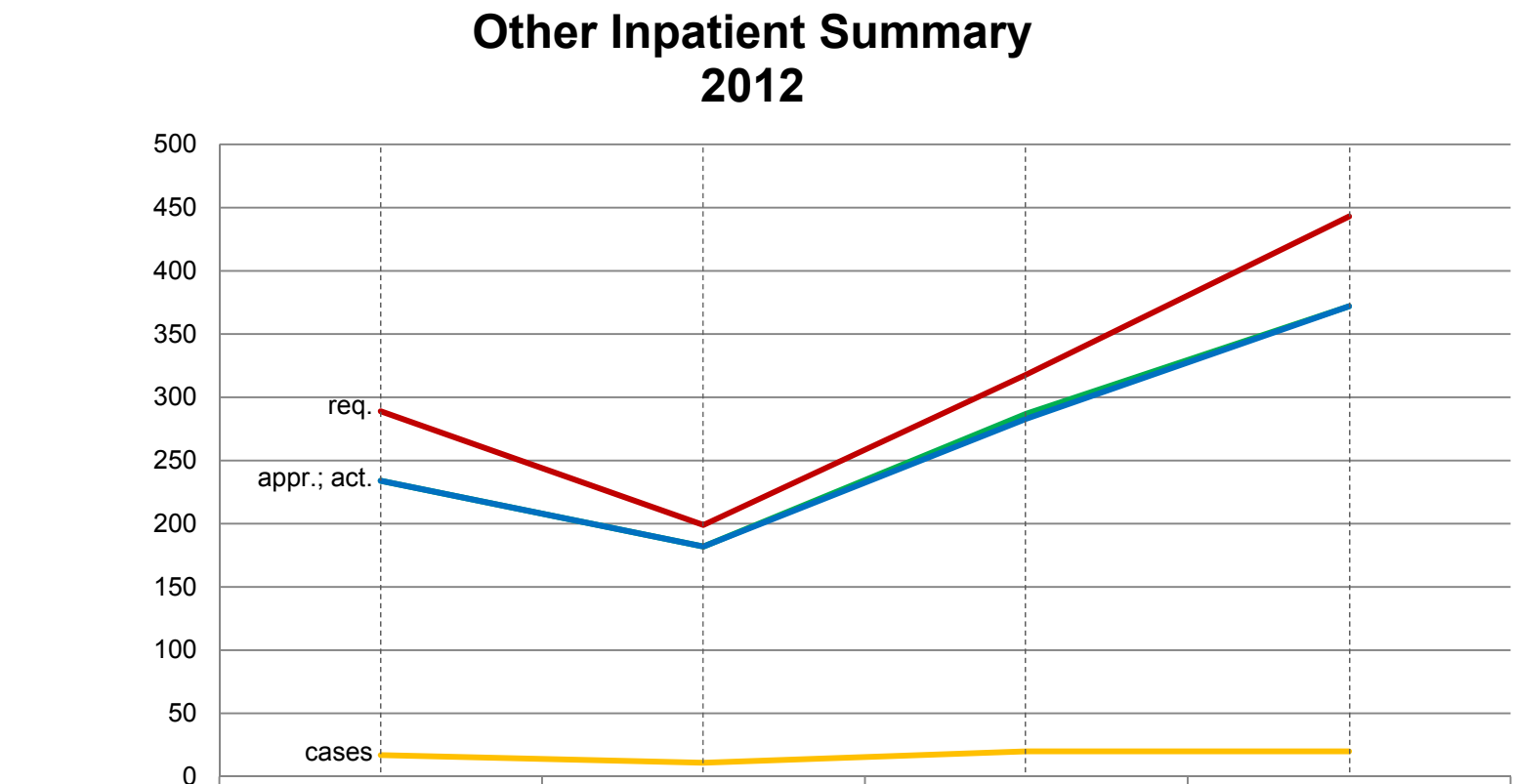

	Q1 2012	Q2 2012	Q3 2012	Q4 2012	Totals
Req. Days	289	199	318	443	1,249
Appr. Days	234	182	287	372	1,075
Actual Days	234	182	283	372	1,071
Cases	17	11	20	20	68

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Utilization Management – Inpatient

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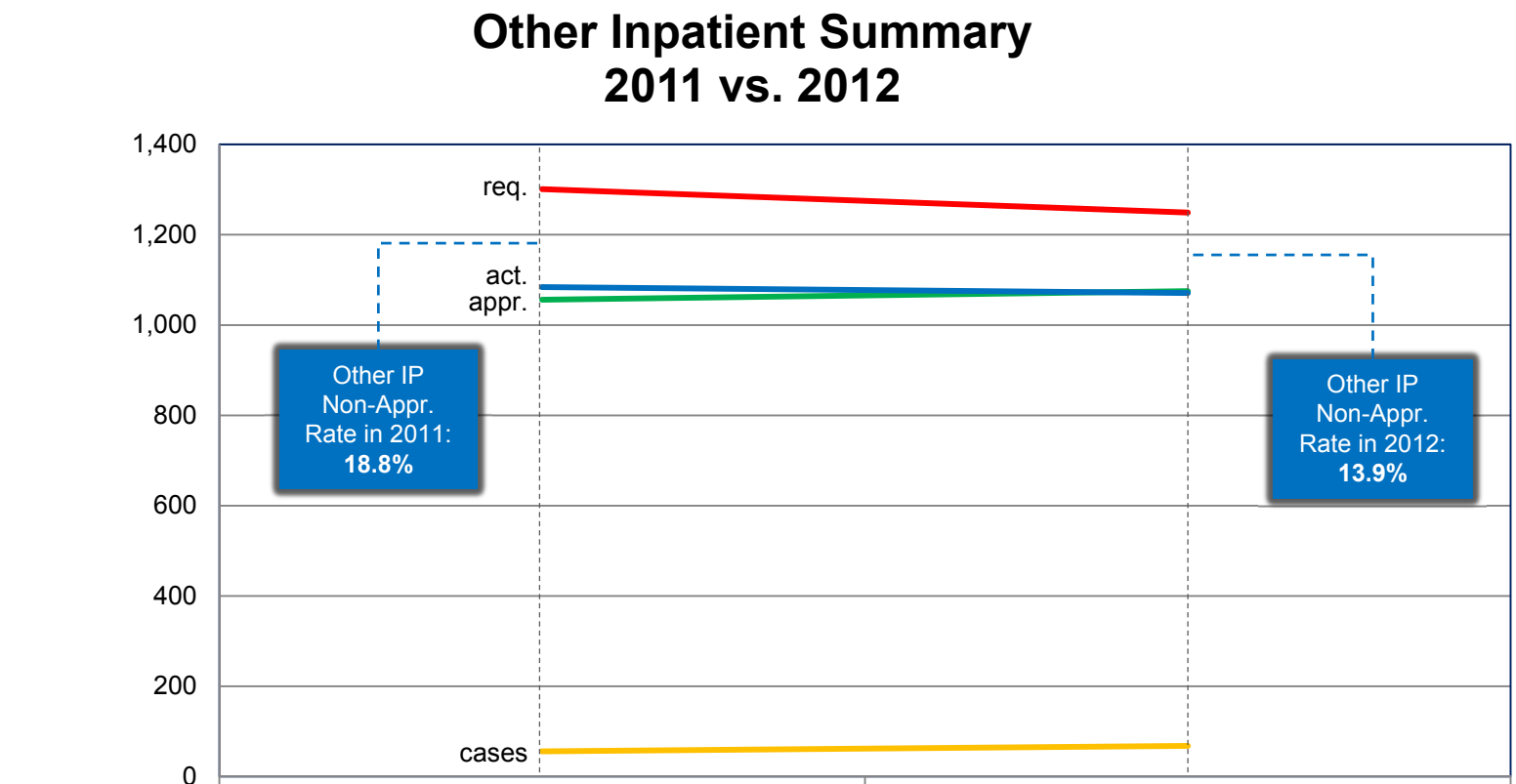

	2011	2012	Var.
Req. Days	1,301	1,249	-4.0%
Appr. Days	1,056	1,075	+1.8%
Actual Days	1,084	1,071	-1.2%
Cases	56	68	+21.4%

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Utilization Management – Inpatient

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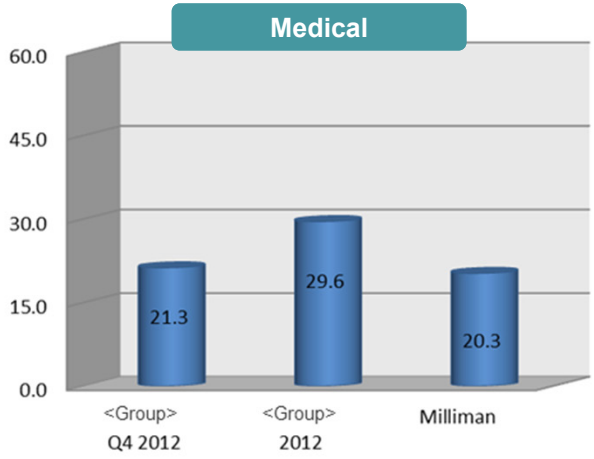
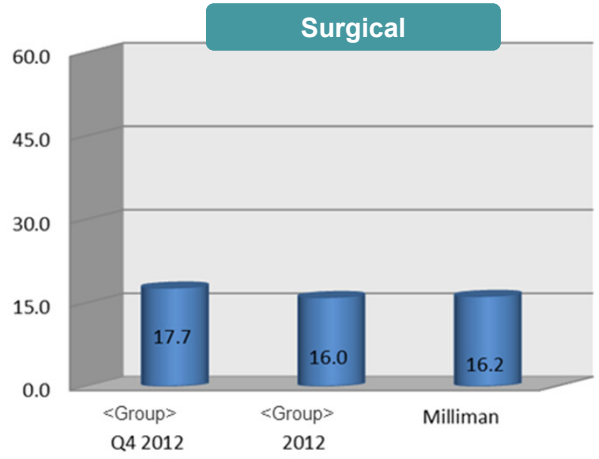
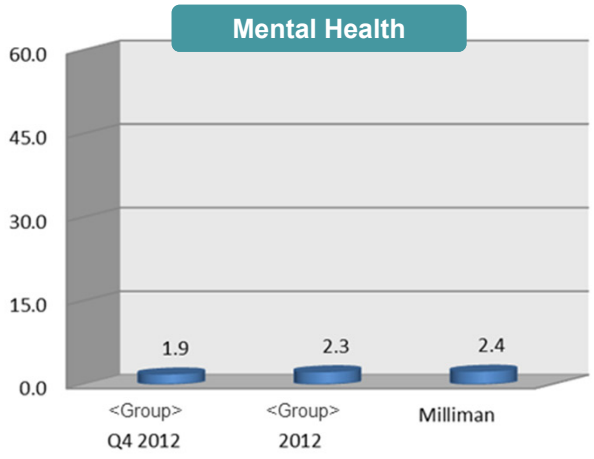
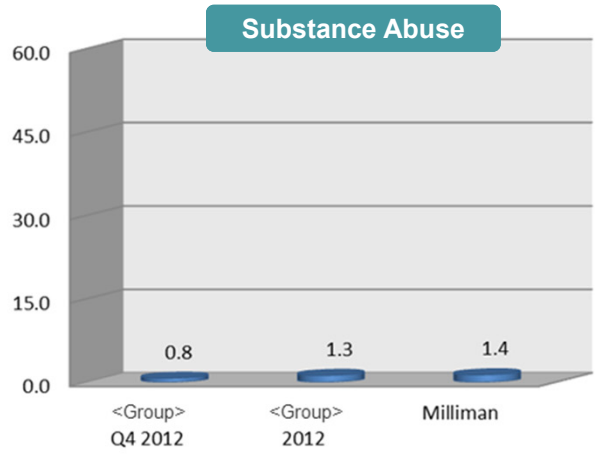
Acute Inpatient Statistics – Admits/1000









- ✓ Although **Medical** admits/1000 in 2012 were **45.8%** higher than the benchmark, the number of cases (**657**) has decreased **23.9%** from 2011 (**863** cases)
- ✓ **Surgical**, **Mental Health** and **Substance Abuse** admits/1000 in 2012 were slightly below their respective category benchmarks:

  Surgical = **357** cases
  MH = **53** cases
  SA = **29** cases

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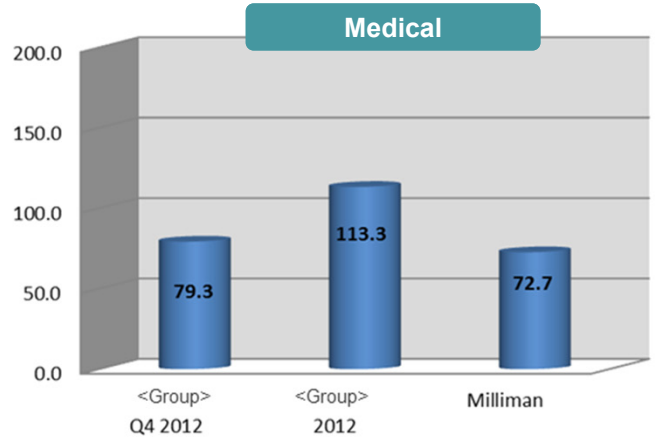
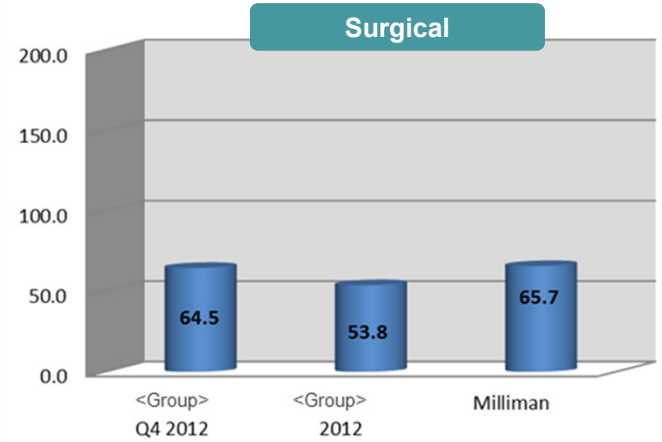
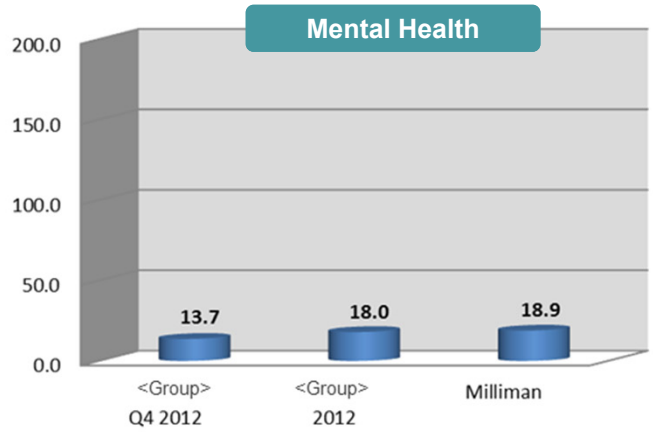
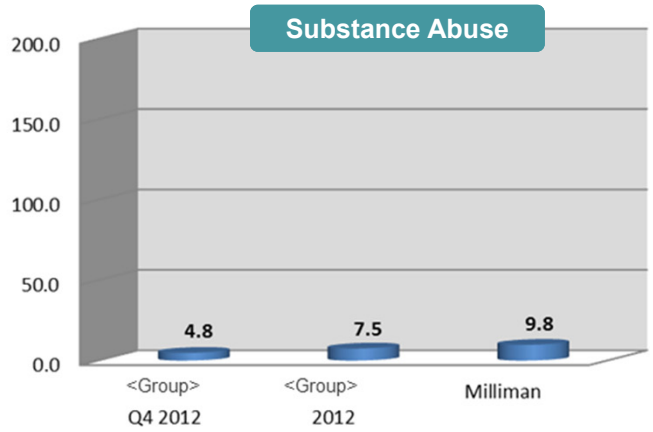
Acute Inpatient Statistics – Days/1000









- ✓ Although **Medical** days/1000 in 2012 were **55.8%** higher than the benchmark, the number of actual days (**2,513**) was **27.4%** lower than 2011 (**3,462** actual days)
- ✓ **Surgical** days/1000 in 2012 were **18.1%** lower than the benchmark (**1,194** days)
- ✓ **Substance Abuse** days/1000 in 2012 were **23.5%** lower than the benchmark (**167** days)
- ✓ **Mental Health** days/1000 in 2012 were **4.8%** lower than the benchmark (**401** days)

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Utilization Management – Inpatient

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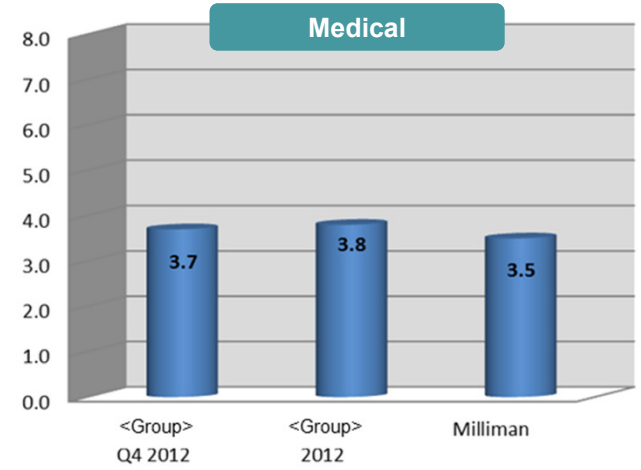
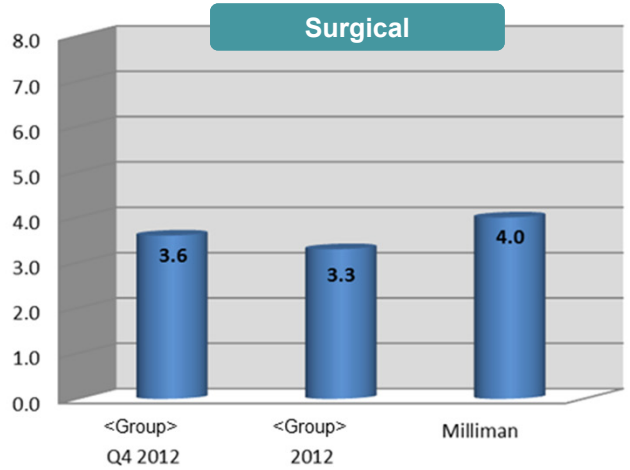
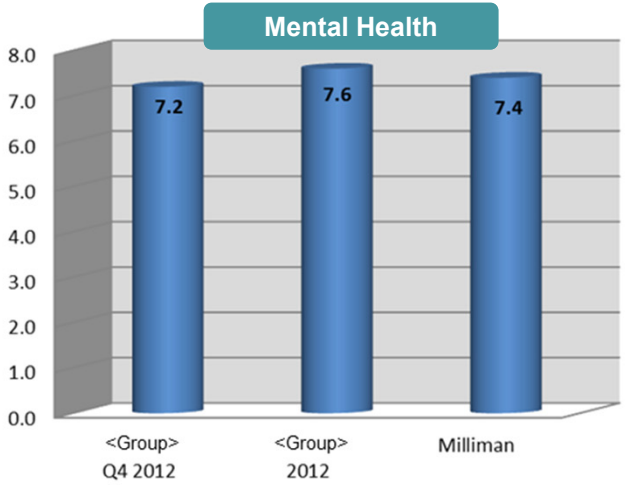
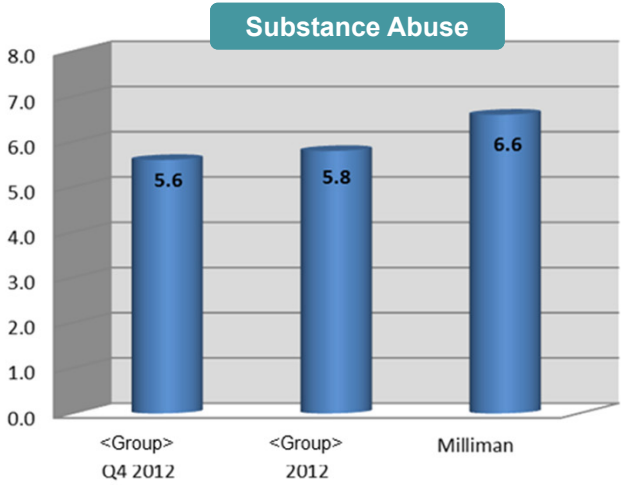
Acute Inpatient Statistics – Average Length of Stay









- ✓ Although Medical admits/1000 and days/1000 exceeded the benchmark by approx. **50%** in 2012, the **Medical ALOS** was only **.3** days above the benchmark, providing evidence that Utilization Management may be working effectively
- ✓ **Surgical** ALOS was **17.5% lower** than the benchmark in 2012, at **3.3** days
- ✓ **Substance Abuse** ALOS was **12.1% lower** than the benchmark in 2012, at **5.8** days
- ✓ **Mental Health** ALOS was **.2 days** above the benchmark in 2012

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Utilization Management – Inpatient

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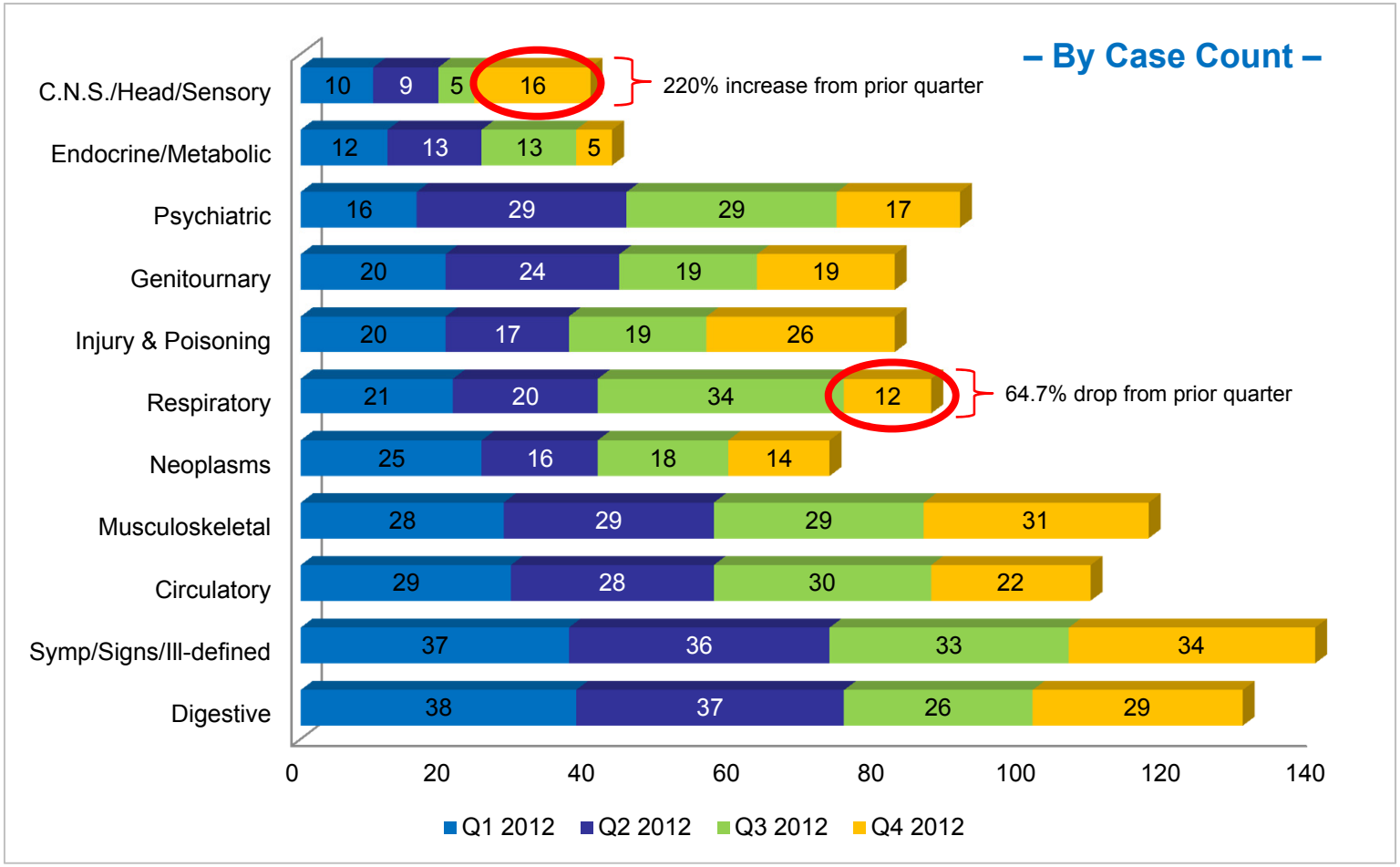
Acute Inpatient Summary – Most Common Diagnosis by Major Category



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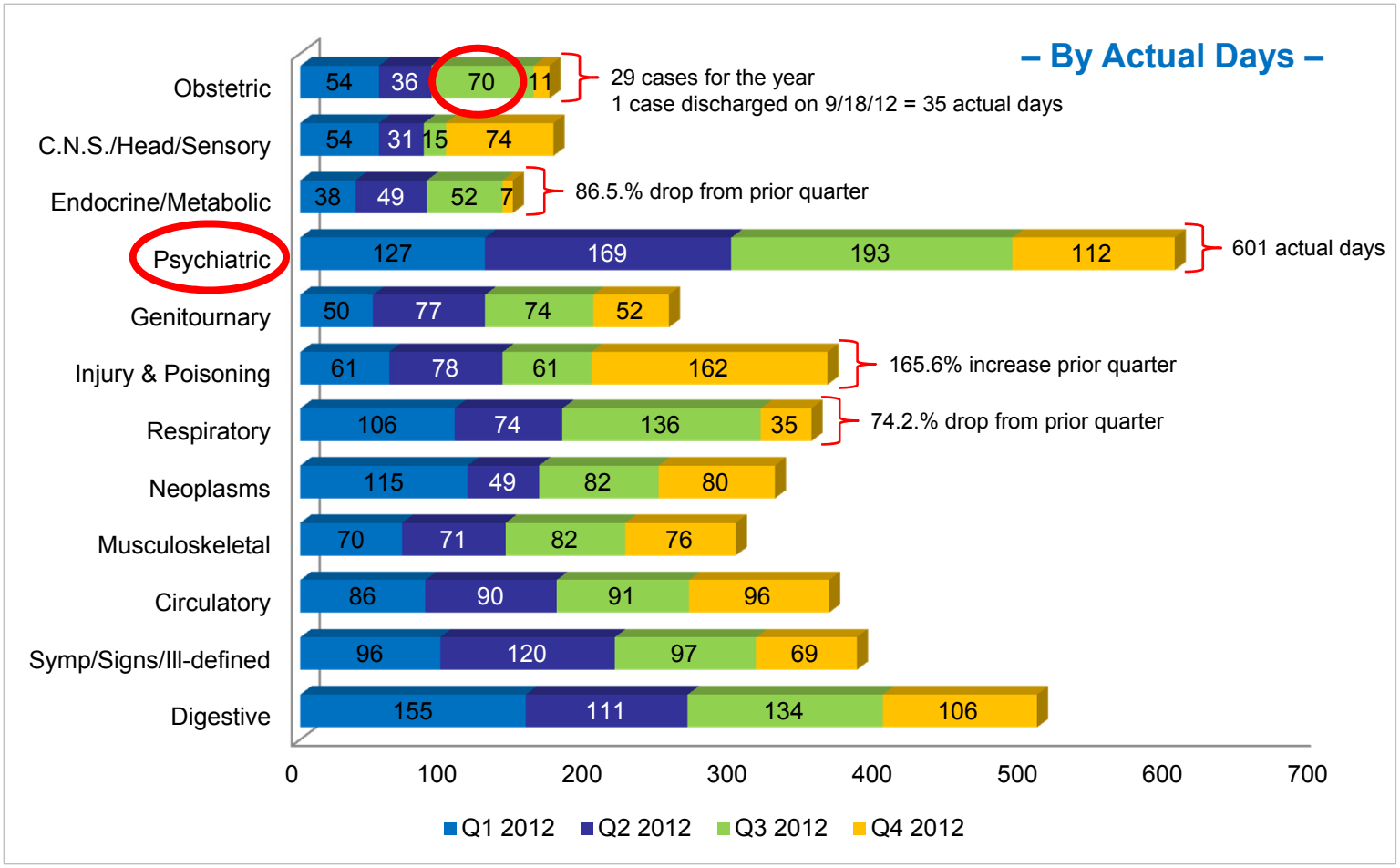
Acute Inpatient Summary – Most Common Diagnosis by Major Category



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Acute Inpatient Summary – 2012 Primary Diagnosis Breakout

– Top 10 Discharges by Actual Days –

Case	Primary Diagnosis	Admit Date	Discharge Date	Actual Days
nnnnnnn	Anorexia nervosa	08/08/12	09/14/12	37
nnnnnnn	Early or threatened labor	08/14/12	09/18/12	35
nnnnnnn	Mood disorder in conditions classified elsewhere	04/11/12	05/16/12	35
nnnnnnn	Malignant neoplasm of pancreas, part unspecified	01/18/12	02/20/12	33
nnnnnnn	Obstructive chronic bronchitis, with (acute) exacerbation	01/23/12	02/24/12	32
nnnnnnn	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, with state of consciousness unspecified	11/16/12	12/17/12	31
nnnnnnn	Opioid type dependence, unspecified	01/12/12	02/11/12	30
nnnnnnn	Mild or unspecified pre-eclampsia	04/24/12	05/22/12	28
nnnnnnn	Burn of unspecified site, unspecified degree	11/16/12	12/12/12	26
nnnnnnn	Anorexia nervosa	10/04/12	10/29/12	25
			TOTAL TOP 10	**312**

- **7.1%** of all acute IP days in 2012 were from **10** cases (312 total days)
- **12.0%** of all acute IP days in 2012 were from **20** cases (523 total days)
- **16.0%** of all acute IP days in 2012 were from **30** cases (699 total days)
- **19.5%** of all acute IP days in 2012 were from **40** cases (851 total days)
- **22.6%** of all acute IP days in 2012 were from **50** cases (987 total days)

2012 Acute IP Statistics
1,119 cases with 4,358 actual days

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Facility Break-Out: Top Ten Facilities (Acute Inpatient)

– Where Members Were Admitted –

Facility		# IP Cases 2012
nnnnnnnnn	Xxx Medical Center	95
nnnnnnnnn	Xxx Regional Medical Center	85
nnnnnnnnn	Xxx Healthcare	66
nnnnnnnnn	Xxx Clinic	56
nnnnnnnnn	Xxx Medical Center	53
nnnnnnnnn	Xxx Hospital and Medical Center	53
nnnnnnnnn	Xxx Medical Center	48
nnnnnnnnn	Xxx Medical Center	44
nnnnnnnnn	Xxx Medical Center	38
nnnnnnnnn	Xxx Hospital	37
	Total Top 10 IP Facilities	**575 (51.4%)**
	All Other Facilities (97)	**544 (48.6%)**
	Grand Total	**1,119 (100%)**

– Where Members Consumed Days –

Facility		Actual Days 2012
nnnnnnnnn	Xxx Regional Medical Center	359
nnnnnnnnn	Xxx Medical Center	294
nnnnnnnnn	Xxx Medical Center	286
nnnnnnnnn	Xxx Hospital and Medical Center	249
nnnnnnnnn	Xxx Healthcare	245
nnnnnnnnn	Xxx Clinic	203
nnnnnnnnn	Xxx Children's Hospital (35 cases)	185
nnnnnnnnn	Xxx Medical Center	183
nnnnnnnnn	Xxx Medical Center	174
nnnnnnnnn	Xxx Medical Center	141
	Total Top 10 IP Facilities	**2,319 (53.2%)**
	All Other Facilities (97)	**2,039 (46.8%)**
	Grand Total	**4,358 (100%)**

Note: Facility grouping was performed using only Tax ID

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Top Members with Multiple Acute IP Admissions in 2012

Member	iSuite Auth ID	Facility Name	Admit Date	Discharge Date	Actual Days
1	nnnnnnn	Xxx Medical Center	01/22/12	01/26/12	4
	nnnnnnn	Xxx Medical Center	02/16/12	03/01/12	14
	nnnnnnn	Xxx Medical Center	07/27/12	07/31/12	4
	nnnnnnn	Xxx Medical Center	08/27/12	08/27/12	0
	nnnnnnn	Xxx Medical Center	08/29/12	09/03/12	5
	nnnnnnn	Xxx Medical Center	09/07/12	09/15/12	8
	nnnnnnn	Xxx Medical Center	10/02/12	10/05/12	3
2	nnnnnnn	Xxx Hospital	04/13/12	04/16/12	3
	nnnnnnn	Xxx Hospital	04/26/12	04/26/12	0
	nnnnnnn	Xxx Hospital	05/12/12	05/15/12	3
	nnnnnnn	Xxx Hospital	05/15/12	05/17/12	2
	nnnnnnn	Xxx Hospital	05/18/12	05/22/12	4
	nnnnnnn	Xxx Hospital	05/22/12	05/28/12	6
	nnnnnnn	Xxx Hospital	07/22/12	07/27/12	5
3	nnnnnnn	Xxx Medical Center	02/20/12	02/23/12	3
	nnnnnnn	Xxx Medical Center	02/24/12	02/28/12	4
	nnnnnnn	Xxx Medical Center	03/04/12	03/07/12	3
	nnnnnnn	Xxx Medical Center	03/18/12	03/21/12	3
	nnnnnnn	Xxx Medical Center	04/15/12	04/20/12	5
	nnnnnnn	Xxx Medical Center	05/25/12	05/30/12	5
	nnnnnnn	Xxx Medical Center	08/24/12	08/29/12	5

Utilization Management – Inpatient

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Top Members with Multiple Acute IP Admissions in 2012

Member	iSuite Auth ID	Facility Name	Admit Date	Discharge Date	Actual Days
4	nnnnnnn	Xxx Medical Center	03/20/12	03/24/12	4
	nnnnnnn	Xxx Medical Center	04/03/12	04/08/12	5
	nnnnnnn	Xxx Medical Center	04/13/12	04/22/12	9
	nnnnnnn	Xxx Medical Center	05/24/12	06/01/12	8
	nnnnnnn	Xxx Medical Center	06/13/12	06/16/12	3
	nnnnnnn	Xxx Medical Center	06/24/12	06/28/12	4
	nnnnnnn	Xxx Medical Center	09/06/12	09/11/12	5

2012 Member Admission Statistics

- **4** members had **7** separate acute inpatient admissions (displayed above)
- **4** members had **5** separate acute inpatient admissions (2 of these were related to Banner facilities)
- **10** members had **4** separate acute inpatient admissions
- **39** members had **3** separate acute inpatient admissions
- **93** members had **2** separate acute inpatient admissions
- **728** members had **1** acute inpatient admission each

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Case Management Referrals

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Utilization Management – CM Referrals

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Case Management Referrals from UM – 2012

	Inpatient	Outpatient
# Cases Referred to CM	528	2,080
# Cases Deemed Appropriate for CM	149	170
Case Acceptance % from UM Referrals	**28.2%**	**8.2%**

Accumulated CM Savings from 2012 Referrals:

- **$1,507,620** — Inpatient
- **$1,968,616** — Outpatient

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Utilization Management
Outpatient Summary

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Utilization Management – Outpatient

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Outpatient Summary – All Plans – Q4 2012

Outpatient Service	# Cases Q4 2012	# of Requested Services	# of Certified Services	Savings
Elective Diagnostic Testing	1,209 (49.1%)	1,648	1,604	$35,046
Elective Surgery	618 (25.1% of all cases)	1,057	1,040	$13,904
Med Treatment	287 (11.7% of all cases)	7,830	7,794	$41,572
DME	178 (7.2% of all cases)	14,718	14,276	$0[1]
Total Top 4 OP Services	**2,292 (93.1% of all cases)**			**$90,522**
All Other Services	170 (6.9% of all cases)			$492,489
Total Outpatient	**2,462**			**$583,011**

Outliers:
2 Home Health cases with **$475,837** in total savings

[1]*Savings from non-certification of 23 Hour Observation cases are not calculated at the current time*
[2]*Includes **DME** and **Home Health** services (e.g. each day a device is certified counts as 1 requested service item in this table)*

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Outpatient Outlier Analysis – 2012 – Top 5 Non-Certs. by Savings[1]

Auth. ID	Service	Facility	Physician	Units Req.	Units Appr.	Savings	
nnnnnnn	Med Treatment	Xxxxxx	Xxxxxxx	246	0	**$577,937**	Q3
nnnnnnn	Home Health	Xxxxxx	Xxxxxxx	1,428	423	**$289,226**	Q4
nnnnnnn	Med Treatment	Xxxxxx	Xxxxxxx	78	0	**$210,307**	Q2
nnnnnnn	Home Health	Xxxxxx	Xxxxxxx	660	360	**$186,611**	Q4
nnnnnnn	Med Treatment	Xxxxxx	Xxxxxxx	54	11	**$147,625**	Q2
					Total Top 5 (65.9% of all 2012 OP Savings)	$1,411,704	

[1]*Based on procedure code match to Milliman benchmarks*

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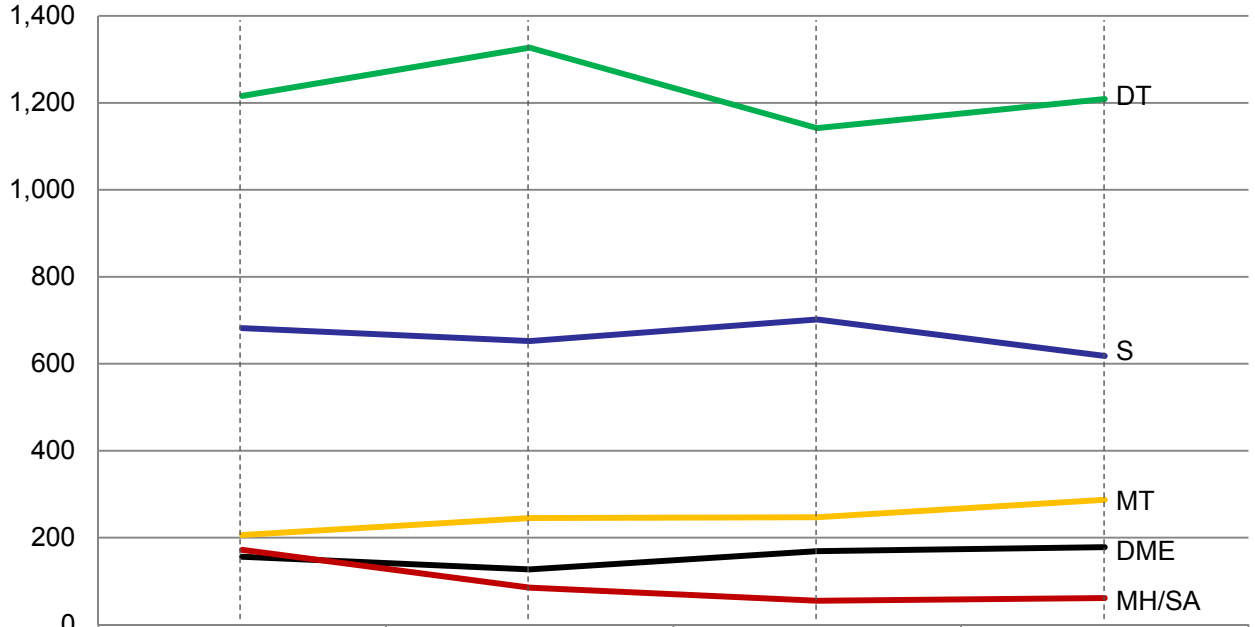
Outpatient Summary – Top 5 Services by Case Count 2012



	Q1 2012	Q2 2012	Q3 2012	Q4 2012	Totals
Diagnostic Tests - Elective	1,216	1,327	1,142	1,209	4,894
Surgery - Elective	682	652	702	618	2,654
Med. Treatment	206	245	247	287	985
DME	156	127	169	178	630
MH/SA Office Visits	172	85	55	61	373

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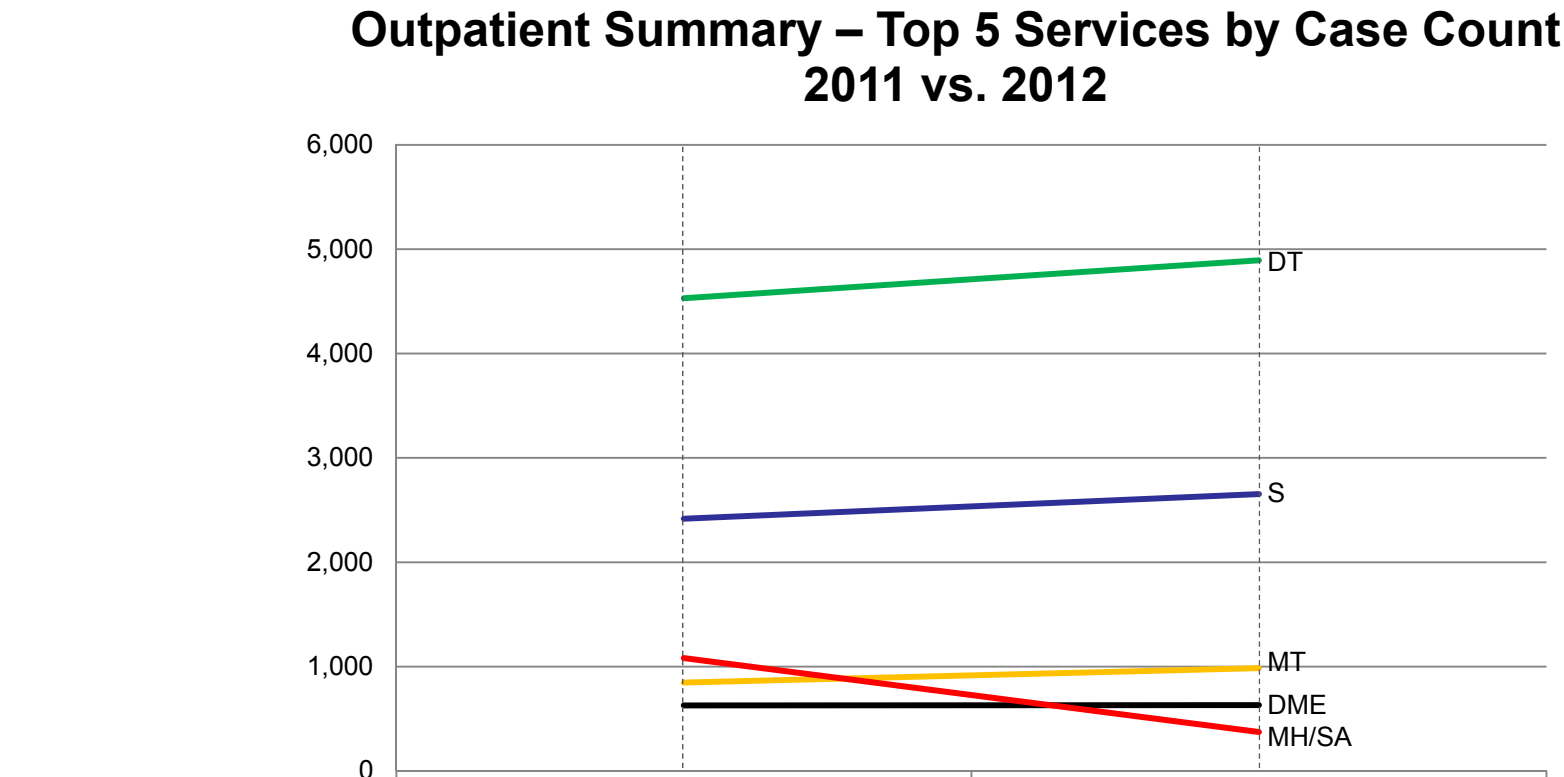

	2011	2012	Var.
Diagnostic Tests - Elective	4,531	4,894	+8.0%
Surgery - Elective	2,417	2,654	+9.8%
Med. Treatment	847	985	+16.3%
DME	628	630	+0.3%
MH/SA Office Visits	1,081	373	-65.5%

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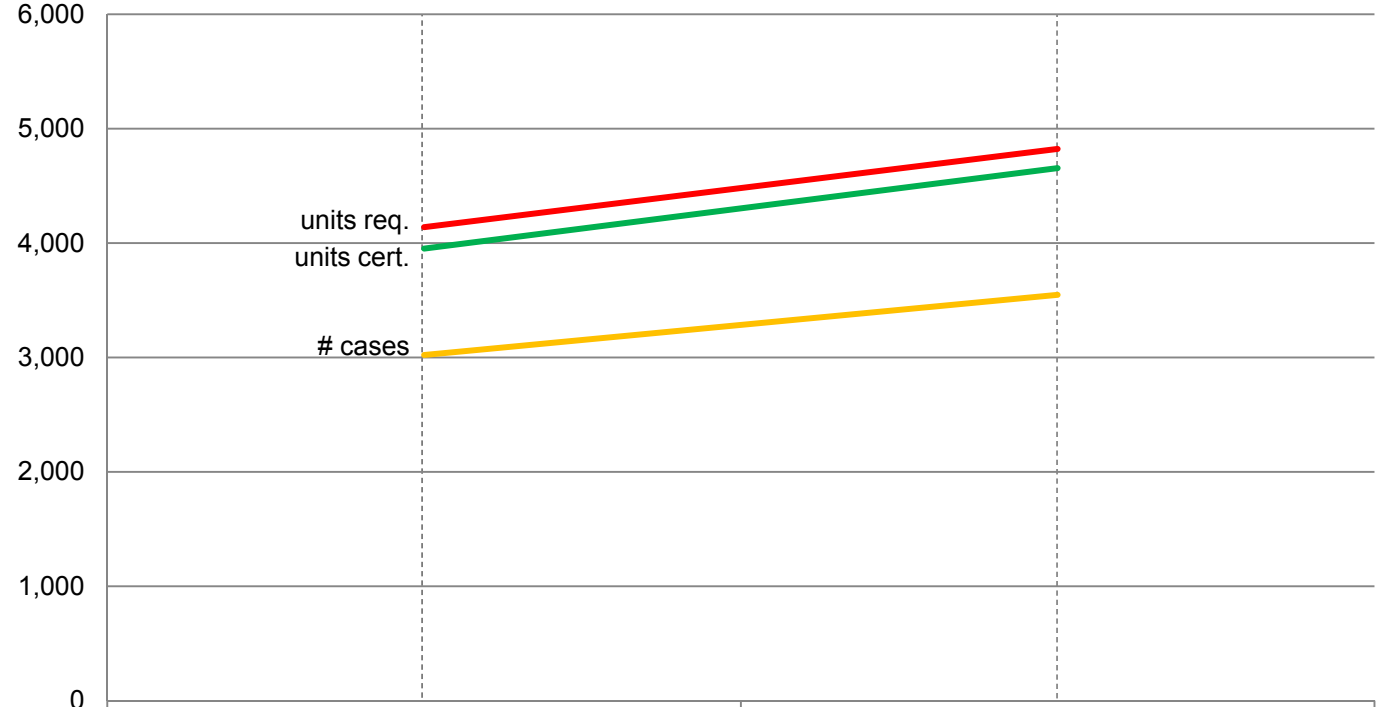

	2011	2012	Var.
Units Requested	4,139	4,824	+16.5%
Units Certified	3,952	4,655	+17.8%
# Cases	3,021	3,547	+17.4%

Outpatient authorizations were scanned for 125 of the most common radiology CPT codes; grouping was performed regardless of setting/service/urgency

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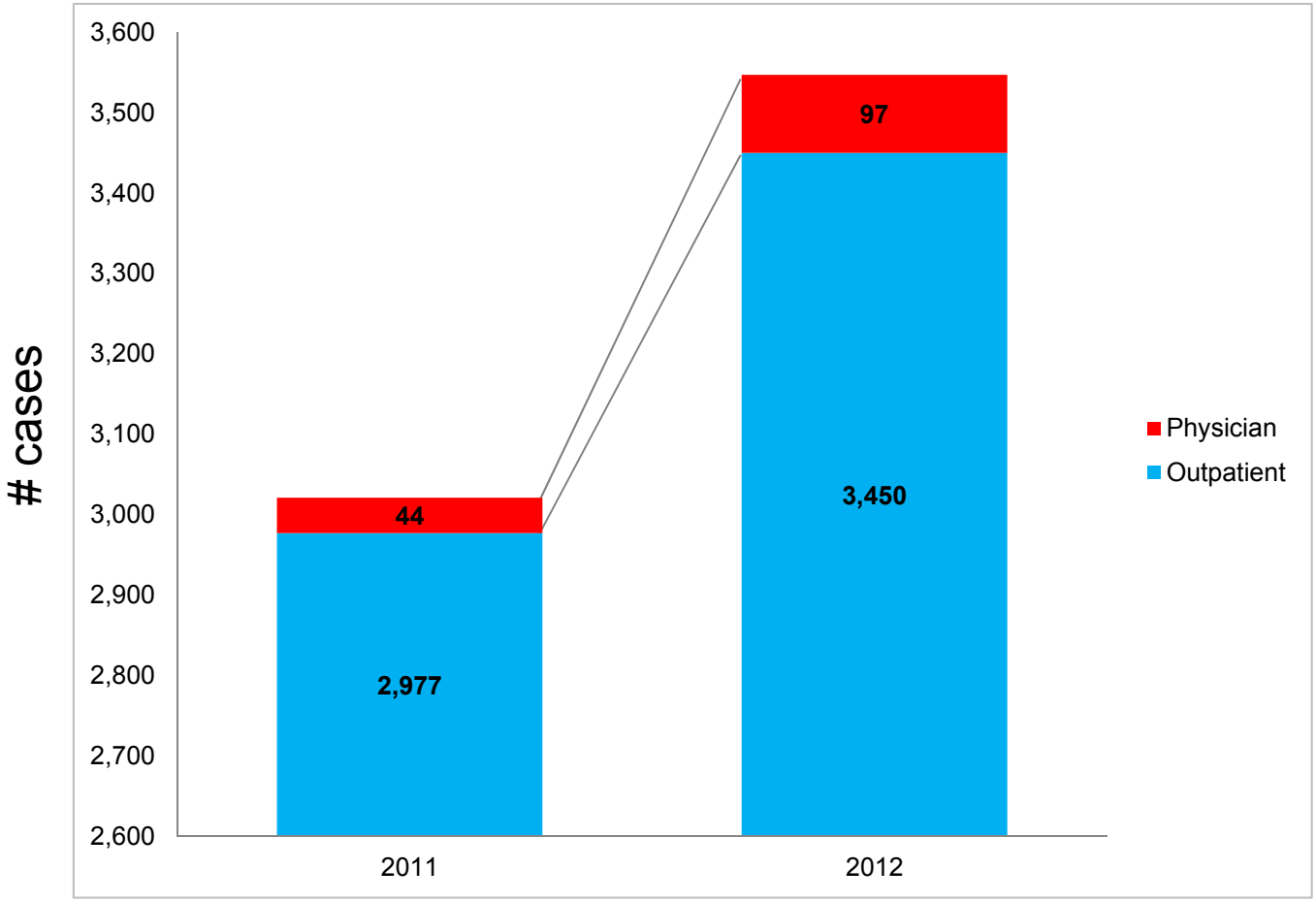
Radiology Procedures – Setting Analysis – 2011 vs. 2012



- ✓ Radiology testing procedures performed in the Physician setting have increased **over 120%** between 2011 and 2012, although the volume is **less than 3%** of the overall total
- ✓ **Over 97%** of radiology procedures are still performed in the Outpatient setting

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Medical Management Summary
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Activity Summary – All Plans

Case Activity	Q1– Q3 2012	Q4 2012
Beginning	**200**	**197**
Opened	**278**	**75**
Closed	**281**	**99**
Ending	**197**	**173**

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Savings Summary – All Plans

	Q1 – Q3 2012	Q4 2012	Total 2012
CM Savings	**$5,526,006**	**$1,394,016**	**$6,920,022**

Average Savings per Case = **$13,924**
(based on 497 cases with an open status for at least 30 days between 1/1/12 and 12/31/12)

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CM Savings Summary – By Plan

Plan Name	Total Savings Q1 – Q3 2012	Total Savings Q4 2012	Total Savings 2012
Xxxxxx	$4,295,277	$1,376,021	$5,671,298
Xxxxxx	$559,610	$6,765	$566,375
Xxxxxx	$657,214	$11,230	$668,444
Xxxxxx	$13,905	$0	$13,905
Total All Plans	**$5,526,006**	**1,394,016**	**$6,920,022**

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Case Type Summary – All Plans

Case Type	# of Cases Opened in 2012
Continuing Care Coordination	92
Research and Review	63
Psych/SA	43
Medical Case Management	41
Oncology	40
Short Term Case Management	28
Maternity Case Management	16
Rehabilitation	13
Neonatology/Peds	11
Transplant	3
Transplant – Network Access	3
Medical Disclosure	-
Total	**353**

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Cost Savings

We follow guidelines prescribed by the Case Management Society of America (CMSA)

Managed Savings reflect avoidance of potential charges that are realized through the intervention/actions of the Case Manager.

This includes:

- Alternative payer source identified
- Averted inpatient admission
- Averted usage of services
- Averted medical complications
- Days saved via CM intervention
- Development of alternative care plan
- Recommended benefit exception
- Referral to specialist/med consultant
- Referral to community resources
- Transition to alternative level of care
- Services reduced via CM intervention
- Steerage to network provider

Negotiated Savings reflect actual cost avoidance achieved by the Case Manager through negotiated price reductions, lower rates, discounts, etc.

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Cost Savings – Sources

Reason For Savings	Savings Q1 – Q3 2012	Savings Q4 2012	Total Savings 2012	Total Savings 2011
Averted Usage of Services	$2,786,720	$23,859	$2,810,579	$2,753,221
Averted Inpatient Admission	$1,064,557	$286,718	$1,351,275	$992,974
Averted Medical Complications	$599,323	$753,885	$1,353,208[1]	$375,955
Services Not Medically Necessary	$530,633	$80,850	$611,483	$525,564
Days Saved via Intervention	$242,143	$40,037	$282,180	$228,427
Services Reduced via intervention	$65,149	$45,244	$110,393	$363,419
Transition to Alternate Level of Care	$36,958	$92,478	$129,436	$74,282
Alternative Payer Source Identified	$29,635	-	$29,635	$213,025
Steerage to Network Providers	$10,555	$67,950	$78,505	$92,426
Recommended Benefit Exceptions	$10,530	-	$10,530	
Development of Alternate Care Plan	$4,130	-	$4,130	$32,255
Referral to Community Resource	-	-	-	$12,000
Referral to Specialist/Medical Consultant	-	-	-	$17,406
Total Managed Savings	**$5,380,333**	**$1,391,021**	**$6,771,354**	**$5,680,954**
Transplant	$78,544	-	$78,544	$1,066,829[2]
Pre-Transplant	$51,291	-	$51,291	$160,090
Post-Transplant	$14,115	$2,995	$17,110	$95,193
Other	$1,723	-	$1,723	$3,910
Total Negotiated Savings	**$145,673**	**$2,995**	**$148,668**	**$1,326,022**
Total Savings	**$5,526,006**	**$1,394,016**	**$6,920,022**	**$7,006,976**

[1]Case #nnnnnnn (Maternity CM) = $515,970 in savings from 130 averted NICU days.
[2]There were 13 cases in 2011 with Transplant savings reason > $30,000; 4 of these were > $100,000.

AmericanHealth

-- CONFIDENTIAL --
April 13, 2011

ABC Corporation
123 Jackson Street
Atlanta, GA 12345

PATIENT: Patient Name
CARDHOLDER: Cardholder Name
ID#: 11111 11111
GROUP: ABC Corporation
REFERRAL SOURCE: UR Dept.
REFERRAL REASON: Dx has Potential for High Dollar Claims
DIAGNOSIS: CNS DEMYELINATION NOS
DATE OPENED: February 06, 2011

REPORTING PERIOD: March 2, 2011-April 13, 2011

HISTORY: This patient is a 38 year-old female with a history of CNS Demyelination. She was admitted on March 5, 2011 to Howard County Hospital with a diagnosis of encephalitis and an intracranial abscess. She was then transferred to Kernan Hospital for admission to their acute inpatient rehabilitation program with an estimated discharge date of April 6, 2011.

CURRENT MEDICAL STATUS/TREATMENT PLAN: The patient had lost use of her legs and was using a sliding board for transfers. She required moderate assistance for bed mobility and transfers. The patient made good functional gains in the acute rehabilitation setting. She was independent with transfers with her sliding board and supervision with bed mobility. She was able to tolerate standing 20 minutes in a standing frame and was independent in bathing and dressing at the wheelchair level.

Due to her progress and desire to go home, the Case Manager assisted the discharge planner in coordinating outpatient therapy for this patient and she was discharged to home on March 26, 2011. Her parents are staying with her at this time.

When the Case Manager contacted the patient to see how her therapy was going, it was discovered that the facility discharge planner did not coordinate this patient's therapy with the network providers that were supplied for them. The patient essentially had nothing in place, so the Case Manager made several calls and coordinated the patient's outpatient therapy. The patient reported to the Case Manager that she had a custom wheelchair on order and that the cost was $3,000. After discussion with the patient related to the purpose of the chair and explanation of medical necessity, the patient agreed that she did not need this chair and that a rental wheelchair would be fine. The Case Manager arranged for a rental wheelchair for the patient and the order for the custom wheelchair was cancelled.

The patient began her outpatient physical therapy on April 5, 2011, and is to attend three times a week. The estimated length of treatment is three months. The patient reports that she is doing really well and is gaining back the use of her legs.

PROGNOSIS: Stated rehabilitation potential is good.

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CASE MANAGEMENT INTERVENTIONS:

- Received the case and reviewed medical information.
- Contacted benefits to obtain benefit information.
- Established and maintained contact with the inpatient rehabilitation unit to monitor the patient's progress, review her plan of care, identify needs, and authorize needed services. The Case Manager facilitated her early discharge from rehabilitation to home.
- Attempted to negotiate a rate with the out-of-network rehabilitation facility. The facility declined.
- Contacted the patient to monitor her progress and plan of care, and to provide education and support.
- Coordinated her outpatient physical therapy with an in-network provider.
- Coordinated monthly rental of a wheelchair.
- Issued vendor agreement to reflect discounted rates.
- Averted purchase of a custom wheelchair for this patient.

COST SAVINGS: Cost savings will be associated with the Case Manager's steerage to a network provider for the patient's outpatient physical therapy.

MANAGED SAVINGS:

Early discharge from an acute rehabilitation program by proactive Case Manager review of the patient's progress and coordinating outpatient physical therapy. The estimated length of stay was 3/5/05-4/6/05. The Case Manager facilitated the patient's discharge 11 days early. Rehab facility reported average charges of $1,100 per day x 11 days = $12,100.

Averted purchase of a $3,000 custom wheelchair, minus the cost of a three month rental ($79/mo x 3 months = $237) = $2,763.

PROVIDER/SERVICE	POTENTIAL COSTS	SAVINGS
Total Savings This Reporting Period	Early discharge from acute rehabilitation. 3 month rental of wheelchair in lieu of purchase of a custom wheelchair.	$12,100 $2,763
Total Savings Previous Reporting Period	$0	
Total Savings		$14,863

POTENTIAL CARE COSTS:

ANTICIPATED SERVICES	ANTICIPATED DURATION	ANTICIPATED COST IF KNOWN
Outpatient Physical Therapy	2 months	Per PHCS PPO Network
Physician Follow-up Appointments		

CM RECOMMENDATIONS / ACTION ITEMS:

- The Case Manager finds that the acute rehabilitation stay was appropriate for this patient's diagnosis.
- The Case Manager finds that outpatient physical therapy is appropriate for this patient's diagnosis.
- The Case Manager finds that a custom wheelchair is not appropriate for this patient at this time. It is anticipated that she will recover from this exacerbation of her illness and will not be wheelchair-bound.
- The Case Manager will continue to monitor this patient's progress and plan of care, assist with coordination of services, review for medical necessity and monitor for further cost savings opportunities.

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NEXT REPORT DUE: On or about May 13, 2011

Please feel free to contact me if you have any questions regarding this case. I can be reached at 800-641-3224 x1000.

Respectfully submitted,

Nancy Joseph, RN, BSN, CCM

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ABC Company

Case Management Summary

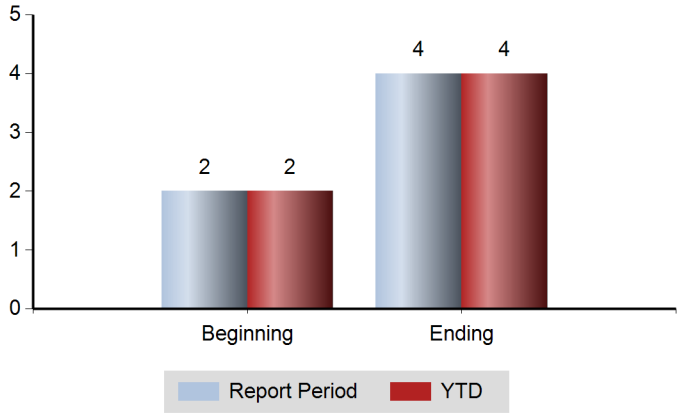
01/01/2013 to 08/31/2013

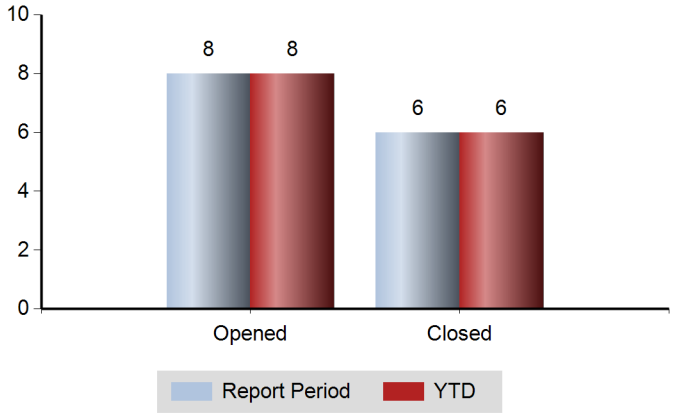
Case Counts

	Beginning	Ending
Report Period	2	4
YTD	2	4

Case Activity

	Opened	Closed
Report Period	8	6
YTD	8	6





Case Types by Acuity Levels

	Report Period Statistics				Year-To-Date Statistics			
Case Type	**# of Cases**	**High Acuity**	**Medium Acuity**	**Low Acuity**	**# of Cases**	**High Acuity**	**Medium Acuity**	**Low Acuity**
Oncology	3	1	1	1	3	1	1	1
Research and Review	3	3	0	0	3	3	0	0
Transplant	2	0	2	0	2	0	2	0
Continuing Care Coordination	1	0	0	1	1	0	0	1
Neonatology/Peds	1	1	0	0	1	1	0	0

Referral Source Summary

Case Management cases can be referred for services from a variety of sources. The table below presents case counts and percentages for each type of referral source.

	Report Period Statistics		Year-To-Date Statistics	
Referral Source	**# of Cases**	**% of Cases**	**# of Cases**	**% of Cases**
Utilization Review	9	90.0%	9	90.0%
Transitioned from other vendor	1	10.0%	1	10.0%
Total	10	100%	10	100%

Referral Reason Summary

Case Management cases can be referred for services for a variety of reasons. The table below presents case counts and percentages for each type of referral reason.

	Report Period Statistics		Year-To-Date Statistics	
Referral Reason	**# of Cases**	**% of Cases**	**# of Cases**	**% of Cases**
System trigger for diagnosis	6	60.0%	6	60.0%
Catastrophic Diagnosis	2	20.0%	2	20.0%
System Trigger for patient previously being in CM	1	10.0%	1	10.0%
System trigger for procedure	1	10.0%	1	10.0%
Total	10	100%	10	100%

Diagnosis Summary

A member engaged in Case Management is identified with a primary diagnosis, and any number of secondary diagnoses or comorbidities. Each specific diagnosis belongs to a Major Diagnostic Category. The table below illustrates the number of cases with conditions in each Major Diagnostic Category, by primary and secondary diagnoses.

	Report Period Statistics				Year-To-Date Statistics			
Major Diagnostic Category	**# with Primary Diagnosis**	**% with Primary Diagnosis**	**# with Secondary Diagnosis**	**% with Secondary Diagnosis**	**# with Primary Diagnosis**	**% with Primary Diagnosis**	**# with Secondary Diagnosis**	**% with Secondary Diagnosis**
Neoplasms	4	40.0%	0	0.0%	4	40.0%	0	0.0%
Symp/Signs/Ill-defined	3	30.0%	3	33.3%	3	30.0%	3	33.3%
Digestive	2	20.0%	0	0.0%	2	20.0%	0	0.0%
Perinatal	1	10.0%	1	11.1%	1	10.0%	1	11.1%
Genitourinary	0	0.0%	3	33.3%	0	0.0%	3	33.3%
Circulatory	0	0.0%	1	11.1%	0	0.0%	1	11.1%
Other	0	0.0%	1	11.1%	0	0.0%	1	11.1%
Blood & Lymphatic	0	0.0%	0	0.0%	0	0.0%	0	0.0%
C.N.S./Head/Sensory	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Congenital Anomalies	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Dermatology	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Endocrine/Metabolic	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Infectious	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Injury & Poisoning	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Musculoskeletal	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Obstetric	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Psychiatric	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Respiratory	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Totals	**10**	**100.0%**	**9**	**100.0%**	**10**	**100.0%**	**9**	**100.0%**

Savings Summary

Savings	Report Period	YTD	Accumulated Savings
Negotiated	$7,770	$7,770	$7,770
Managed	$72,472	$72,472	$78,237
Total	$80,242	$80,242	$86,007

Negotiated Savings - Report Period

Managed Savings - Report Period

Case Detail

Patient: **********
Member ID: **********

Opened: 03/31/2013 **Closed:**
Case Number: ********

Case Information
Type:
Acuity:
Case Mgr:

Referral Information
Source:
Reason:

Diagnosis
MALIGNANT NEO ARYEPIGLOTTIC FOLD

Closure Reason
Benefits/group termed (Oncology)
Patient's condition has stabilized (Oncology)

Savings Type	Report Period	YTD	Accumulated Savings
Negotiated	$0	$0	$0
Managed	$30,000	$30,000	$30,000
Total	$30,000	$30,000	$30,000

Savings Source

Date	Savings Source	Savings Type	Amount
4/29/2013	Averted Medical Complications	Managed	$30,000

Savings Detail

4/29/2013 Averted Medical Complications Managed $30,000

This patient initially refused chemoradiation treatment recommendations and opted to receive radiation therapy only. Case management provided patient teaching regarding why these recommendations are made, disease recurrence rates with and without chemotherapy and encouraged the patient to speak with her physician further regarding the recommended treatment plan. The patient did eventually accept concurrent chemoradiation treatment, thus decreasing her chances for disease recurrence or progression. Potential avoidance of an additional course of chemoradiation therapy estimated at $30,000 based on cost of current treatment plan. Total potential savings of $30,000 using Milliman Oncology Benchmarks and Redbook Online AWP for drug costs.

Case Detail

Patient: **********
Member ID: **********

Opened: 7/2/2012
Closed:
Case Number: ********

Case Information

Type: Transplant
Acuity: Medium
Case Mgr: **********

Referral Information

Source: Transitioned from other vendor
Reason: Catastrophic Diagnosis

Diagnosis

CIRRHOSIS LIVER WO ALCOHOL

Closure Reason

Savings Type	Report Period	YTD	Accumulated Savings
Negotiated	$7,770	$7,770	$7,770
Managed	$0	$0	$5,765
Total	$7,770	$7,770	$13,535

Savings Source

Date	Savings Source	Savings Type	Amount
1/10/2013	Pre-transplant	Negotiated	$7,770

Savings Detail

1/10/2013 Pre-transplant Negotiated $7,770

Through CM coordination with PPO for liver transplant at Banner Good Samaritin savings were realized. Liver transplant – pre transplant (evaluation) phase per 2008 Milliman is $25,900, estimated 30% savings or $7,770.

Case Detail

Patient: **********
Member ID: **********

Opened: 3/1/2013
Closed: 4/29/2013
Case Number: *******

Case Information

Type: Neonatology/Peds
Acuity: High
Case Mgr: **********

Referral Information

Source: Utilization Review
Reason: System trigger for diagnosis

Diagnosis

OT RESPIRATORY PROBLEM AFTER BIRTH
OTHER PRETERM INFANTS UNS

Closure Reason

No further cost savings opportunities (Neonatology/Peds)
Patient's condition has stabilized (Neonatology/Peds)

Savings Type	Report Period	YTD	Accumulated Savings
Negotiated	$0	$0	$0
Managed	$7,392	$7,392	$7,392
Total	$7,392	$7,392	$7,392

Savings Source

Date	Savings Source	Savings Type	Amount
3/28/2013	Averted Inpatient Admission	Managed	$7,392

Savings Detail

3/28/2013 Averted Inpatient Admission Managed $7,392

By providing education to this child's mother regarding Respiratory Syncytial Virus, including risk factors, signs and symptoms, and preventative measures, a potential inpatient admission was averted. Milliman guidelines state the goal length of stay for this type of admission is one day. Benchmark pricing (Milliman 2012) is $7,392 per day.

Glossary of Terms

Managed Savings

- **Managed Savings**- An avoidance of potential charges that are realized through the intervention/actions of the case manager
- **Alternate Payer Source-** Identified separate responsible party such as Medicare or Worker's Compensation
- **Averted Inpatient Admission-** Assessed patient education, environment, and compliance and acted accordingly to reduce unnecessary admissions
- **Averted Medical Complication-** Prevented usages of services related to complications/exacerbations
- **Averted Usage of Services-** Lead to early discharge or decrease in services
- **Days Saved via Intervention-** Treatment provided at a less restrictive environment or early discharge or care continued at an alternate lower cost location/provider
- **Development of Alternate Care Plan**- Analysis determined a lower level of care would be appropriate
- **Recommended Benefit Exception**- Analysis showed that a benefit exception could result in cost savings
- **Referral to Community Resources** - Referred patient to community based programs (Diabetes, Alzheimer, Cancer) which then lead to a reduction in costs to primary insurance
- **Referral to Specialist/Medical Consultant**- Ensured patient had the most appropriate physician treatment plan
- **Services not Medically Necessary**- Approved only appropriate services
- **Services reduced via Interventions** - Negotiated a reduction in services or a timely discharge to next appropriate level of care
- **Steerage to Network Providers**- Facilitated the transitions to network providers
- **Transition to Alternate Level of Care**- Facilitated a timely transfer to a lower level of care

Negotiated Savings

- **Negotiated Savings** - Savings off actual charges that are negotiated by the case manager with an individual provider. This includes **Price Reductions, Negotiated Rates, Discounts, or Prompt -Pay Break** in any of the following categories:

  - Acute Care
  - DME/ Supplies
  - Home Health Care Hospice
  - Infusions/ Medications
  - LTAC Negotiated
  - Other
  - Outpatient Diagnostic Treatment
  - Outpatient Therapies
  - Physician
  - Post-Transplant
  - Pre-Transplant
  - Rehab
  - Residential Treatment
  - SNF Transplant
  - Transportation

- **Negotiated -Other as a Savings Source**- Initially, cases in iSuite only used "Negotiated" to indicate various negotiated savings sources. Improvements to iSuite over time brought about additional selections for Case Managers to show the source of the negotiated rate.

Accumulated Savings

- Sum total of savings from case inception to the end of the report period. When there are two report periods displayed, accumulated savings always refers to the report period listed first.

Report Parameters

Label	Option
Report Name	Case Management Summary
Company	ABC Company
Report Group	ABC Company
Case Status	Open, Closed
Period Start Date	01/01/2013
Period End Date	08/31/2013
YTD Option	Calendar Year-to-Date
YTD Start Date	01/01/2013
YTD End Date	08/31/2013
Show Confidential	False
Savings Explanations	Not Suppressed
Branding Option	Meritain Health

Client Name

Case Management Referral

10/12/2011 To 10/12/2011

Patient	**Member**	**Provider**	**Physician**	**Auth Information**
Patient Name	Cardholder Name	Provider Name	Physician Name	Reference #: 99999999 Status: Open
Patient ID: 1111111111	Address Line 1	Tax ID: 222222222	Tax ID: 333333333	Type: LT Acute
DOB : 8/20/1955 Female Spouse		Address Line 1	Address Line 1	Notify: 10/7/2011 [X] On Time
Emp: Employer Group	City, State Zip Code			Case Mgmt: N 10/7/2011
TPA : Client Name		City, State Zip Code	City, State Zip Code	Admit: 10/10/2011 Phy Ref: N
PCP :	Member ID: 11111111	Phone: (111) 111-1111	Phone: (111) 111-1111	Disch:
Oth Ins:		Fax:	Fax:	
			INTERNAL MEDICINE	

Length of Stay Act: 0 Req: 7 Apr: 7 NonCert: 0 Disp: N/A

Diagnosis	**Description**
*586	RENAL FAILURE UNSPEC
707	Chronic ulcer of skin
995.91	SEPSIS

Remarks

Nurse Notes

10/10/11 Completed Req: 7 Apv: 7 NCert: 0

10/10/11 12:16 pm Cara Skaggs FAX Received Attachment

This is to notify you that there is a new attachment. The attachment is dated: 10.10.2011 12:16

10/7/11 5:32 pm Cara Skaggs FAX Received Attachment

This is to notify you that there is a new attachment. The attachment is dated: 10.07.2011 17:32

10/7/11 4:18 pm Dawn Chahin Other

Build cert and refer to case management.

10/7/11 4:13 pm Dawn Chahin Other Initial Request

Caller: Caller Name/111-111-1111/Corp Office/Facility: Verified all information including facility TIN; facility is in network; stated will fax clinical

Total Authorizations : 1