State of Nevada
Department of Administration

Purchasing Division

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Carson City, NV 89701

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Governor

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State of Nevada

Purchasing Division

Request for Proposal: 3084

For

UTILIZATION MANAGEMENT AND LARGE CASE MANAGEMENT SERVICES

Release Date: September 25, 2013

Deadline for Submission and Opening Date and Time: December 3, 2013 @ 2:00 PM

Refer to Section 8, RFP Timeline for the complete RFP schedule

For additional information, please contact:

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(TTY for Deaf and Hard of Hearing: 1-800-326-6868
Ask the relay agent to dial: 1-775-684-0199V.)

Refer to Section 9 for instructions on submitting proposals

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	***Hometown Health Providers, Inc.***

V2	Street Address	***830 Harvard Way***

V3	City, State, ZIP	***Reno, NV 89502***

V4	Telephone Number		
	Area Code: ***775***	Number: ***982-3100***	Extension:

V5	Facsimile Number		
	Area Code: ***775***	Number: ***982-3090***	Extension:

V6	Toll Free Number		
	Area Code: ***800***	Number: ***336-0123***	Extension:

V7	***Contact Person for Questions / Contract Negotiations, including address if different than above***
	Name: ***Ty Windfeldt***
	Title: ***Vice President***
	Address: ***830 Harvard Way***
	Email Address: ***twindfeldt@hometownhealth.com***

V8	Telephone Number for Contact Person		
	Area Code: ***775***	Number: ***982-3105***	Extension:

V9	Facsimile Number for Contact Person		
	Area Code: ***775***	Number: ***982-3090***	Extension:

V10	***Name of Individual Authorized to Bind the Organization***	
	Name: ***Ty Windfeldt***	Title: ***Vice President***

V11	Signature ***(Individual must be legally authorized to bind the vendor per NRS 333.337)***	
	Signature:	Date: ***12/30/2013***

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A Request for Proposal (RFP) process is different from an Invitation to Bid. The State expects vendors to propose creative, competitive solutions to the agency's stated problem or need, as specified below. Vendors' technical exceptions and/or assumptions should be clearly stated in *Attachment B, Technical Proposal Certification of Compliance with Terms and Conditions of RFP*. Vendors' cost exceptions and/or assumptions should be clearly stated in *Attachment J, Cost Proposal Certification of Compliance with Terms and Conditions of RFP*. Exceptions and/or assumptions will be considered during the evaluation process; however, vendors must be specific. Nonspecific exceptions or assumptions may not be considered. The State reserves the right to limit the Scope of Work prior to award, if deemed in the best interest of the State per NRS 333.350(1).

Prospective vendors are advised to review Nevada's ethical standards requirements, including but not limited to, NRS 281A and the Governor's Proclamation, which can be found on the Purchasing Division's website (http://purchasing.state.nv.us).

1. PROJECT OVERVIEW

The State of Nevada's Purchasing Division, on behalf of the Board of the Public Employees' Benefits Program (PEBP), headquartered in Carson City, Nevada, is soliciting proposals for a Utilization Management (UM) and Large Case Management vendor to provide (but will not be limited to) pre-certification services, utilization management, large case management, and other medical management services described in this RFP for the participants of the PEBP self-funded consumer driven health plan (CDHP).

The effective date of the contract resulting from this RFP is anticipated to be July 1, 2014 (subject to approval by the State of Nevada Board of Examiners [BOE]); however, PEBP reserves the right to initiate service at an earlier date dependent upon proposal responses. The length of the contract will be five (5) years. The contract termination date, pursuant to this RFP, will be June 30, 2019. PEBP reserves the right to renegotiate price terms as market conditions warrant. Possible term extensions may be entertained depending upon the successful vendor's performance. No contract is deemed effective until approved by the Nevada State Board of Examiners (NRS 284.173).

2. ACRONYMS/DEFINITIONS

For the purposes of this RFP, the following acronyms/definitions will be used:

Acronym	Description
AFP	Alphafetoprotein
Assumption	An idea or belief that something will happen or occur without proof. An idea or belief taken for granted without proof of occurrence.
Awarded Vendor	The organization/individual that is awarded and has an approved contract with the State of Nevada for the services identified in this RFP.
BAA	PEBP's Business Associate Agreement
BOE	State of Nevada Board of Examiners

CDHP	Consumer Driven Health Plan
CFR	Codified Federal Regulations
Confidential Information	Any information relating to the amount or source of any income, profits, losses or expenditures of a person, including data relating to cost or price submitted in support of a bid or proposal. The term does not include the amount of a bid or proposal. Refer NRS 333.020(5) (b).
Contract Approval Date	The date the State of Nevada Board of Examiners officially approves and accepts all contract language, terms and conditions as negotiated between the State and the successful vendor.
Contract Award Date	The date when vendors are notified that a contract has been successfully negotiated, executed and is awaiting approval of the Board of Examiners.
Contractor	The company or organization that has an approved contract with the State of Nevada for services identified in this RFP. The contractor has full responsibility for coordinating and controlling all aspects of the contract, including support to be provided by any subcontractor(s). The contractor will be the sole point of contact with the State relative to contract performance.
Cross Reference	A reference from one document/section to another document/section containing related material.
CVS	Chorionic Villus Sampling
Division/Agency	The Public Employees' Benefits Program (PEBP)
EDI	Electronic Data Interchange
EOB	Explanation of Benefits
Evaluation Committee	An independent committee comprised of a majority of State officers or employees established to evaluate and score proposals submitted in response to the RFP pursuant to NRS 333.335.
Exception	A formal objection taken to any statement/requirement identified within the RFP.
Goods	The term "goods" as used in this RFP has the meaning ascribed to it in NRS §104.2105(1) and includes, without limitation, "supplies", "materials", "equipment", and "commodities", as those terms are used in NRS Chapter 333.
HIPAA	Health Insurance Portability and Accountability Act of 1996

Key Personnel	Vendor staff responsible for oversight of work during the life of the project and for deliverables.
LCB	Legislative Counsel Bureau
LOI	Letter of Intent - notification of the State's intent to award a contract to a vendor, pending successful negotiations; all information remains confidential until the issuance of the formal notice of award.
May	Indicates something that is recommended but not mandatory. If the vendor fails to provide recommended information, the State may, at its sole option, ask the vendor to provide the information or evaluate the proposal without the information.
MPD	Master Plan Document
Must	Indicates a mandatory requirement. Failure to meet a mandatory requirement may result in the rejection of a proposal as non-responsive.
NAC	Nevada Administrative Code –All applicable NAC documentation may be reviewed via the internet at: **www.leg.state.nv.us.**
NOA	Notice of Award – formal notification of the State's decision to award a contract, pending Board of Examiners' approval of said contract, any non-confidential information becomes available upon written request.
NRS	Nevada Revised Statutes – All applicable NRS documentation may be reviewed via the internet at: **www.leg.state.nv.us.**
Pacific Time (PT)	Unless otherwise stated, all references to time in this RFP and any subsequent contract are understood to be Pacific Time.
Participant	An individual enrolled in benefit plans provided by the State of Nevada, Public Employees' Benefits Program.
Pay Center	Entity established for managing payroll and human resource records, e.g., Department of Personnel, Central Payroll, Department of Transportation, Nevada System of Higher Education, Legislative Counsel Bureau, State Board, Public Employees' Retirement System (actives), or other local governmental groups (for example, Southern Nevada Health District).
PEBP	Public Employees' Benefit Program
PPPM	Per Participant Per Month
Proprietary Information	Any trade secret or confidential business information that is contained in a bid or proposal submitted on a particular contract. (Refer to NRS 333.020 (5) (a).

Public Record	All books and public records of a governmental entity, the contents of which are not otherwise declared by law to be confidential must be open to inspection by any person and may be fully copied or an abstract or memorandum may be prepared from those public books and public records. (Refer to NRS 333.333 and NRS 600A.030 [5]).
Redacted	The process of removing confidential or proprietary information from a document prior to release of information to others.
RFP	Request for Proposal - a written statement which sets forth the requirements and specifications of a contract to be awarded by competitive selection as defined in NRS 333.020(8).
Shall	Indicates a mandatory requirement. Failure to meet a mandatory requirement may result in the rejection of a proposal as non-responsive.
Should	Indicates something that is recommended but not mandatory. If the vendor fails to provide recommended information, the State may, at its sole option, ask the vendor to provide the information or evaluate the proposal without the information.
State	The State of Nevada and any agency identified herein.
Subcontractor	Third party, not directly employed by the contractor, who will provide services identified in this RFP. This does not include third parties who provide support or incidental services to the contractor.
Trade Secret	Information, including, without limitation, a formula, pattern, compilation, program, device, method, technique, product, system, process, design, prototype, procedure, computer programming instruction or code that: derives independent economic value, actual or potential, from not being generally known to, and not being readily ascertainable by proper means by the public or any other person who can obtain commercial or economic value from its disclosure or use; and is the subject of efforts that are reasonable under the circumstances to maintain its secrecy.
UM	Utilization Management
URAC	Utilization Review Accreditation Committee
User	Department, Division, Agency or County of the State of Nevada.
Vendor	Organization/individual submitting a proposal in response to this RFP.
Will	Indicates a mandatory requirement. Failure to meet a mandatory requirement may result in the rejection of a proposal as non-responsive.

2.1 STATE OBSERVED HOLIDAYS

The State observes the holidays noted in the following table. When January 1st, July 4th, November 11th or December 25th falls on Saturday, the preceding Friday is observed as the legal holiday. If these days fall on Sunday, the following Monday is the observed holiday.

Holiday	Day Observed
New Year's Day	January 1
Martin Luther King Jr.'s Birthday	Third Monday in January
Presidents' Day	Third Monday in February
Memorial Day	Last Monday in May
Independence Day	July 4
Labor Day	First Monday in September
Nevada Day	Last Friday in October
Veterans' Day	November 11
Thanksgiving Day	Fourth Thursday in November
Family Day	Friday following the Fourth Thursday in November
Christmas Day	December 25

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.

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

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.

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.

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.

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.

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.

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.

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.

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.

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***.

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?

Hometown health has provided case management and large case management services to our insured for the past twenty five years. Based on the insured's population and risk, we have been able to customize programs to reduce healthcare costs, improve the quality of member care, and improve member satisfaction.

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

Hometown Health's location is 830 Harvard Way, Reno, NV 89502. This is where our staff, including our case management nurses work from on a daily basis.

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

Hometown health provides a blend of telephonic case management services across a continuum of care as well as on site concurrent review case management services for our insured's located within Washoe and Carson counties. If this contract was to be awarded, we would also hire full time staff to be present on site in the Las Vegas area to help manage inpatient admissions and initiate discharge planning services.

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.

Hometown Health has the ability to review pre-certifications and based on diagnosis, locations of service, and potential for disease progression as well as member or physician request, offer enrollment into case management programs. In addition, we work in collaboration with your third party administrator, Healthscope and assist with management of any high dollar, high cost member that is identified at time of claim payment.

Each member is assessed in five domains for opportunities to participate in case management. These domains include medical, psychosocial, financial and plan benefit design, spiritual and home environment safety needs. Based on the findings identified in the above domains, case management intervention is offered and a member specific plan of care is developed if the member agrees.

Our case management team is staffed by registered nurses as well as clinical social workers. Based on member need the team collaborates with the member's primary care provider to identify needed services to keep the member as independent and safe in the environment that best meets their needs.

Coordination of care and keeping members safe may include sending a member from an inpatient setting to rehab if strengthening and complex medical management is required to improve member's ability to function safely at home.

Case Management services include but are not limited to:

- ***Care Transitioning from one setting to an alternate setting***
- ***Coordination of all DME & home care/hospital services***
- ***Coordination of follow up appointments***
- ***Collaboration with community based programs***
- ***Supporting physician's plan of care***
- ***Assessing and educating members on disease process, medication compliance and physician's plan of care***

Hometown Health has policies &procedures in place, defining criteria for case management services. In addition, members may self refer to case management.

Please see attachments marked 3.11.1.4 as an overview of our triage, assessment, and case management intervention process.

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.

Please see attachments for section 3.11.1.4

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.

Hometown Health encourages member and customer referrals for case management interventions. We acknowledge at times, the member may reach out to many contacts at their plan benefit team seeking assistance and having the ability for real time, live, referrals from multiple sources to benefit the member is key to delivering sound case management services for our membership. These referrals will be managed at no additional cost to PEBP.

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.

Hometown Health believes in making a genuine difference in the lives we touch by optimizing our member's healthcare experience. We strive to manage our benefits consistently in an environment that is win-win for providers and patients. We strive to manage service and patient care with compassion and understanding. Hometown Health is consistently looking for ways to improved service for our members. We listen to their needs and make adjustments as necessary.

Hometown Health monitors the patient's clinical progress, both on inpatient and outpatient basis to evaluate patient's response to therapies, results of diagnostic testing, potential vulnerabilities and

overall prognosis. We look for risks to progress including safety and support in the hone environment. We work closely with physicians to be sure services are appropriate and that these are paid appropriately. We also review opportunities for savings within the patient's clinical situation especially when complex conditions would generate less than predictably good outcomes.

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.

Hometown Health takes a team approach to transplant evaluation, coordination, and monitoring to include the PEBP plan benefit team, TPA, Providers of health care services, reinsurance carrier if need be, transplant networks to channel to centers of excellence of PEBP choice, and member and family wishes. We truly believe that by taking a coordinated approach, we find a center of excellence that meets the member and family needs, we will have improved transplant outcomes.

Please see attachment 3.11.1.8.

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?

Hometown Health works with many transplant centers of excellence programs for our customers. We are more than willing to work with any vendor or transplant program that you would like us to collaborate with. Some of our current Transplant networks include Cigna, Interlink, and Lifetrac.

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?

Based on the current PEBP membership of 34,000 lives, we would anticipate screening 20% of the membership (6,800 members) for case management services. We would anticipate having 5 to 10% of these members agree to case management services (3,400 to 6,800 members over a 3 year period). This includes members who would be managed in a short term case management model as a transition from one level of care to another or have a need for homecare services.

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

Hometown Health case managers take a holistic approach to the coordination of care. We would consider the member and their family as the center of all case management services. Our goal would be to coordinate quality care in a cost effective manner in the environment of the member's choice by optimizing the PEBP networks plan benefit design.

Case managers at Hometown Health reach out to their members as frequently as needed to meet the member and family goals. PEBP as the payer is consulted when contracts are put into place for services that would disrupt continuity of care for a member and/or family. Hometown Health would anticipate participating in team collaborative meetings with PEBP staff, TPA staff, pharmacy benefit management staff as well as any ancillary staff such as our social worker to collaborate on the best way to deliver services within the PEBP plan benefit design to meet member needs. Hometown Health case management team consists of a registered nurse, social worker, and medical director.

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?

Hometown Health case management staff would interact with PEBP staff as needed to establish contracts with providers to prevent disruption of care or progress when the member is transitioned from one level of care to another; need to flex benefits to cover equipment and/or services that are above what is medically necessary, as well as when a PEBP member cover change occurs such as a birth or death in the insured family. Hometown Health has dedicated case managers to support the PEBP business.

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

Hometown Health Case Management team is staffed with Registered Nurses or Social Workers with a minimum of five years clinical experience. We prefer that our staff is certified as a Case Manager. Our Case Managers are extremely knowledgeable of key chronic illnesses such as heart disease, diabetes, oncology, and lung disease. They are also able to manage catastrophic injuries. We are also experts in managing risk diseases such as obesity, hypertension, and anxiety or depression.

Please see 3.11.1.13 for Job Descriptions

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

Hometown Health currently serves 135,000 customer lives. We are able to provide services to our members from wellness to illness by providing registered nurses who specialize in Triage, Wellness and Coaching, Utilization Review and Case Management. In addition to Registered Nursing Staff we have a state of Nevada licensed Chief Medical Office and Physician Reviewer who ensure that all services precertified are medically necessary. Hometown Health's current staffing ratio of all licensed staff to commercial membership is 1:6,000. However, staffing ratios can be adjusted based on membership acuity or illness burden as well as need to add additional members to the case management program.

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 is started prior to admission is we receive a request for precertification for an elective procedure. A part of the precertification process looks at the medical necessity for the procedure, need for equipment or homecare at time of discharge, and current level of function prior to surgery as well as anticipated level of function following surgery. During the precertification process, we would channel post operative care and equipment to contracted providers and place an authorization in place to prevent any delays in discharge.

If the member was admitted through the emergency room, our Case Managers would assess admission reason and initiate discharge planning from time of notification. During the discharge planning process, we would identify potential needed services or transitions of care and attempt to channel services to in network providers. If there is not network services available, we would initiate negotiations for discounted rates.

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.

Return on investment is calculated as follows:

Coordinated service cost – proposed plan
Coordinated service cost – alternate plan
Savings

We typically report gross savings and do not add in case management time into the equation as this contract

Please see a copy of the attached report labeled 3.11.1.16

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.

Hometown Health will not outsource any part of the PEBP health services contract. Our inpatient behavioral health and chemical dependency utilization reviews are completed by a registered nurse with input from our licensed social worker who has several years of behavioral health case management experience. The nurse and social worker work as a team ensuring that all medical and psychosocial needs and resources are utilized to meet the needs of the member.

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.

Hometown Health uses Milliman Care Guidelines for inpatient and alternate levels of care to ensure member meets appropriate admission criteria. If the admission criteria is not met, the case is automatically referred to our Chief Medical Officer for review and final determination. Length of stay is reviewed every two days for acute inpatient stays and may be every three days for rehabilitation or residential care.

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.

Hometown Health has licensed registered nurses in the states of Nevada and California. If we receive a request for services requiring medical necessity determinations, we have physician providers licensed in all states who can make a formal determination.

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.

Inpatient hospital notifications come to us for review as an emergent admission through an emergency room within 24 hours of admission, or as an elective admission scheduled for a medically necessary procedure or surgery. Inpatient admissions may also include transitions to lower levels of care such as skilled nursing facility, rehabilitation or long term care.

If the inpatient hospital is emergent due to an admission from the emergency room, the PEBP Master Plan Document does not require precertification prior to admission. However it does require notification of admission within twenty four hours, and Hometown Health to provide concurrent review to assess continued medical necessity and to facilitate discharge planning or transition to a lower level of care as appropriate.

If the inpatient hospital admission is for an elective procedure or surgery, the PEBP Master Plan Document requires notification at least 14 days before the expected date of service. Hometown Health would obtain the name of the hospital or facility, the name of the attending physician as well as the name of the referring physician. Based on the procedure, we would require clinical documentation of medical necessity. We would also apply Milliman Care Guidelines to ensure that the procedure requested is meeting medical necessity guidelines.

Once the procedure or admission is approved, an initial approval letter will be sent out to the provider, facility and member documenting the initial length of stay.

If the procedure is found not to be medically necessary, one of our utilization review physicians would review and additional information would be requested if needed. If again, guidelines are not met, we would provide the member and provider a copy of the denial letter and give member specific denial reasons and information on the guidelines used as well as appeal rights. Peer to peer review is routinely conducted by our Chief Medical Officer for cases that do not meet criteria for approval.

100% of rehabilitation admissions are reviewed by our medical director to ensure that the member is able to participate at a minimum 3 hours per day and that the services cannot be provided in an alternative setting.

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 it takes for Hometown Health to pre-certify inpatient hospital admissions is 6 hours once we have received the clinical information for review. If clinical information is not received timely, we reach out to the provider to obtain the needed information to make an informed decision and prevent delays in care.

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

Hometown Health would follow the PEBP Master Plan document and initiate pre-certification for outpatient surgery. Surgeries completed on an outpatient basis include foot surgeries, carpal tunnel surgery spinal surgeries done on an outpatient basis and any outpatient procedure that is considered experimental and/or investigational.

The request would be reviewed to determine if member was in network or out-of-network for the surgeon as well as facility. We would also request clinical information to apply Milliman Care Guidelines. If the provider and/or facility was out-of-network, we would offer to the member coordination of services in network if the procedure was deemed medically necessary in order to reduce their out-of-pocket expenses. If member agrees, we would channel the procedure to a contract provider and or facility. If the procedure can best be provided by that out-of-network provider because of special skills or expertise, we would review the provider to determine if they were available in the PEPB network or First Health. If member would like to stay with current provider and facility, we would review the case with PEBP staff to determine whether we had approval to implement a letter of agreement. If approved, we would proceed with the negotiation. A copy of the negotiated rates would be faxed to PEBP staff for final signature, and then forwarded on to the TPA for appropriate claim adjudication.

If the surgery did not meet the pre-certification requirements, the request and medical records are forwarded to our Chief Medical Officer for review. The Chief Medical Officer may request

additional information, initiate a doctor to doctor call, or send the request out for a second opinion with a similar board licensed specialty physician.

Based on additional information, the Chief Medical Officer may approve or deny the request. Letters of authorization or denial are sent to the requesting provider and member with appeals rights.

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 it takes for Hometown Health to pre-certify outpatient surgical services is 2 hours or less once we have received all the necessary clinical information in house for review.

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

Hometown Health utilizes established medical necessity guidelines for pre-certification to include Milliman Care Guidelines, InterQual, Hayes for new technology requests as well as literature reviewing community standards of practice. National Comprehensive Cancer Network guidelines are also used in reviewing in office chemotherapy protocols.

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.

Hometown health provides written confirmation of all pre-certification determinations whether approved or denied to the member and requesting physician.

A sample is attached for your review under Attachment 3.11.2.7

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.

Hometown Health denial rates for PPO plans are on average is 4% for inpatient services. Denials occur when the admission is not medically indicated and required pre-certification, services could be delivered at a lower level of care, or there were delays in moving the member along the continuum of care. By initiating discharge planning at time of admission, and implementing a concurrent review process, Hometown Health is proactive in managing lengths of stay and denial rates are low.

7/1/2011 to 6/30/2012 = 3%
7/1/2012 to 6/30/2013 = 4%

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

All of our precertification licensed staff are Registered Nurses who have a minimum of three years pre-certification experience. Each pre-certification nurse has a minimum of five years of clinical experience and extensive knowledge of health plan guidelines. We also utilize referral specialists for non-clinical pre-certification functions such as attaching clinical records to the file and data entry. Any denials are made by our Chief Medical Officer or Medical Director.

Please see job descriptions listed under Attachment 3.11.1.13

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

Denials occur due to lack of medical necessity according to guidelines, delays in care, and lack of plan benefit availability.

If a member is an inpatient and an admission is denied as not medically necessary, that denial decision is made by our Medical Director. Letters of denial are sent to the member, provider and facility explaining why the stay (or day) was denied and gives the member his/her appeal rights. We will follow the PEBP appeals procedure. Our denial letters always redirect the member back to their attending physician to establish an alternate level of care.

PEBP and Healthscope staff are notified of the denials so claims can appropriately adjudicate.

Outpatient denials are handled in a similar way. Denials occur due to lack of medical necessity, member has progressed to completion of program goals, or care can be delivered in an alternate safe environment. Again, all denials are made by our Medical Director. If the Medical Director agrees to the denial, a denial letter is sent to the member, provider and/or facility outlining the reason for denial as well as giving appeal rights.

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

Hometown Health would follow the PEBP Master Plan documentation Weight Loss Surgeries section (page 96) for medical necessity determination of weight loss surgeries.

Per the PEBP Master Plan document, members are limited to one obesity related surgical procedure of any type in a lifetime. Providers and facilities chosen must be identified on the Bariatric Surgery Center of Excellence List prior to precertification.

Any requests for precertification would be channeled to our Bariatric Weight Loss Case Management team for management. A detailed health history would be obtained as well as member would be directed to Center of Excellence for evaluation. The member would also be informed of the weight loss program criteria and need and requirements.

Once the member has met the requirements, we would confirm with the bariatric surgeon that goals have been met. We will work with the provider's office to schedule and approve the recommended procedure.

Post operatively, our Bariatric team would follow the PEBP members to ensure compliance and monitor progress with the surgeon's plan of care.

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.

Hometown Health precertification staff as well as case management staff have reviewed the PEBP Master Plan Document and are comfortable in implementing the pre-certification requirement.

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.

Hometown Health agrees to maintain same rates for current precertification requirements as well as any additions PEBP may wish to add based on trends.

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.

Hometown Health provides both on site and telephonic concurrent review. Concurrent review consists of ongoing review of hospitalized (including but not limited to acute care facilities, skilled nursing facilities and acute rehabilitation facilities) members through physician and/or member/family communication, on-site chart review and communication with members and other health care professionals involved in coordinating the member's care. This process incorporates the use of InterQual and Milliman Healthcare Management guidelines to assign the most appropriate level of care for continued medical treatment. These guidelines enable the Health Plan to identify situations where medical services can be provided in alternative, high quality, cost-effective settings. Concurrent Review Rounds are conducted daily to review and discuss hospitalized members and identify possible care alternatives. Rounds participants consist of the following:

1. ***Medical Director, Chief Medical Officer***

2. *Nurse Manager*
3. *Case Managers*
4. *Social Worker*

Concurrent review also includes coordinating discharge plans to assist in maximizing services available within the member's health care benefit plan, and coordination of care between third party payors and the Health Plan. Concurrent review is a mechanism to identify high-risk, high-cost cases that may require the focused interventions available through the Health Plan's case management program.

Concurrent review includes coordination of behavioral health, substance abuse and medical care during a patient's hospitalization. The facilitation and management of these types of care provides members with comprehensive coverage and improved outcomes through the coordination of services between entities.

Hometown Health Plan utilizes nationally recognized guidelines and length of stay guidelines such as Milliam and InterQual Guidelines to conduct prospective, concurrent and retrospective review. These guidelines are also used for case management. In addition, our Health Services Department and UM committee has developed custom guidelines based upon National Research and CMS guidelines.

The Health Plan utilization management staff (Health Services) uses these guidelines, along with a given patients individual factors such as:

1. *Age*
2. *Comorbidities*
3. *Complications*
4. *Progress of treatment*
5. *Psychosocial situations*
6. *Home environment when applicable*

Additionally, the Health Plan considers the local delivery systems capabilities when applying guidelines.

Hometown Health will not increase its fees from the original cost proposal to manage additional pre-certification requirements.

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

Hometown Health reassesses a patient's need for continued hospitalization based on level of care and/or acuity.

Inpatient reviews are completed concurrently in an acute setting every two days at minimum. If there are clinical concerns or discharge planning needs, reviews occur on a daily basis to ensure the member has what is needed upon discharge to keep safe in the environment of their choice.

Rehabilitation review is completed once weekly. Based on progress and ability to participate we may initiate reviews on a more frequent basis as member approaches discharge.

Skilled Nursing facility reviews are completed once weekly. Based on progress and ability to participate, we may initiate reviews on a more frequent basis as member approached discharge.

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

As noted above, Hometown Health uses Milliman Care Guidelines (MCG) for determination of medical necessity for continued hospital stay. If at any time, the member is not progressing along a "continuum of care," the Concurrent review Registered Nurse will consult with our Medical Director. The Medical Director will consult with the hospitalist and/or specialists involved in the case and determine next steps or gather additional clinical not documented in the record to justify the continued level of care or hospital stay. If the hospitalist, specialist and our Medical Director agree that the stay is no longer medically necessary but for patient convenience, a denial is issued. All days approved and denied are entered into our utilization review system so the authorization is passed appropriately to the TPA for appropriate claim adjudication as well as generation of appropriate approval and/or denial letters.

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.

Hometown Health has internal criteria based upon new technologies and procedures. These are attached for review. All internal criteria is reviewed by our Quality Committee for approval. The committee consists of community based individuals.

Please see attachment 3.11.3.4.

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

Please see attachment 3.11.3.4.

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 occur when the service and/or admission has already occurred and we are notified after the fact by the TPA, member, or provider. If the service occurred less than 7 days from the date of notification, we will handle the review as a precertification and review clinical information to determine medical necessity. If the notification occurs after 7 days, we would handle the retrospective review as a provider or member appeal.

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

If the member is still inpatient, we may handle the review on site or we may handle telephonically depending on facility and geographic location.

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

Hometown Health staff handling retrospective reviews are all licensed registered nurses. Our job description for Care Managers require that our staff have a minimum of five years of clinical experience as well as knowledge of the utilization review process. Certified Case Manager certification is recommended.

Please see attachment 3.11.1.13

3.11.4.4 How is the need for retrospective review determined?

The need for retrospective review is determined from several sources:

1) ***TPA receives a claim in which there is no authorization on file;***
2) ***The provider and/or member notifies Hometown Health that services have been delivered but there is no precertification found.***
   At the time of the above notifications, a precertification file would be initiated and based on the submission or notification timeframe, the retrospective review will be handled real time or as an appeal. We will request clinical information to document medical necessity and proceed with the precertification process as outlined in the PEBP Plan Master document.

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

Please see attachment 3.11.3.4. Please also see attachments 3.11.4.5 which include our appeal letters.

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.

Outcome Management –

- ***Level of Care Beddays per 1000 – Report shows beddays per 1000 members by month by level of care. (Mental Health/Rehab/Mother & Newborn/General Medical Surgical/ICU/NICU/Transplants)***
- ***Facility Average Length of Stay – Report shows average length of stay for inpatient acute hospital admissions by month by facility/facility group. (Renown Regional Medical Center / Renown South Meadows / In Area = other facilities in Washoe County / Out of Area = outside of Nevada and Southern Nevada / Rural = facilities in Carson City and Douglas County)***
- ***Facility Admits per 1000 – Report shows inpatient acute hospital admissions per 1000 members by month by facility. (Same facility groupings as the Facility Average Length of Stay report above.)***
- ***Actual vs. Target LOS – Report shows inpatient authorization data where the actual length of stay (LOS) exceeds the expected length of stay.***

Patterns of Care –

- ***Trigger Diagnosis – Report shows member demographics as well as associated claim data where the primary ICD9 diagnosis code could indicate a potential high dollar case or where the member may be a good candidate for case management.***
- ***Emergency Room Visit Summary – Report shows member name/ID and counts of emergency room/department visits during a specified time frame. The report also shows the associated dollar amounts corresponding to all visits.***
- ***Skilled Nursing Facility Days – Report shows member and associated admission data for members admitted to a skilled nursing facility during a specified timeframe.***
  Inpatient utilization –
- ***Level of Care Beddays per 1000 – Report shows beddays per 1000 members by month by level of care. (Mental Health/Rehab/Mother & Newborn/General Medical Surgical/ICU/NICU/Transplants)***

- ***Facility Average Length of Stay – Report shows average length of stay for inpatient acute hospital admissions by month by facility/facility group. (Renown Regional Medical Center / Renown South Meadows / In Area = other facilities in Washoe County / Out of Area = outside of Nevada and Southern Nevada / Rural = facilities in Carson City and Douglas County)***
- ***Facility Admits per 1000 – Report shows inpatient acute hospital admissions per 1000 members by month by facility. (Same facility groupings as the Facility Average Length of Stay report above.)***
- ***Daily Census with Discharges – Report shows daily census of members admitted to inpatient facilities including diagnosis, admitting provider, member PCP, admit type and admit category.***

Utilization by diagnosis –

- ***Trigger Diagnosis – Report shows member demographics as well as associated claim data for claims where the member diagnosis could indicate a potential high dollar case or where the member may be a good candidate for case management.***
- ***End Stage Renal Disease claims – Report shows members and claim(s)/service date(s) for claims with a primary diagnosis of end stage renal disease.***
- ***Dialysis claims – Report shows members, claim(s), service date(s), diagnosis and procedure information for dialysis services.***
  Case specific detail –
- ***Case Management rounds – Report shows members in case management with associated diagnosis and history by condition. (Psych/chemical dependency, bariatric, transplant and inpatient)***
  Activity and days reduced –
- ***Denied authorizations – Report shows denied authorizations and associated details such as authorization type and denial reason.***

Savings summary –

- ***Case Management – Savings Detail for Open and Closed Cases – Report shows a list of open and closed cases with associated savings by type. (Vendor negotiations, Averted adm savings, Changes in level of care, Proposed alternative plan)***

Please see attachment 3.12.1 for examples of each report

3.12.2 Are your reports available via the web?

Hometown Health maintains an existing secure FTP account with PEBP for the PPO UM business and would be willing to use either this account or PEBP's FTP account if preferred. Report requests should be directed to the account manager at Hometown Health.

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.

Ad hoc report requests should be directed to the account manager at Hometown Health and should provide sufficient detail such as requested data elements, date ranges and any exclusions. Turnaround time would depend on the complexity and format of the report. Hometown Health will provide ad hoc reports to PEBP at no additional cost.

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.

Hometown Health works extremely hard at giving PEBP members an opportunity to receive in network services and reduce their expenses whenever possible. "Channeling" starts at time of the precertification request, recommendation for services provided by our case management team, or at time of discharge planning from an acute inpatient admission. Our team or precertification nurses as well as concurrent review nurses identify contracted providers proactively and offer in network options when out of network options are requested. As described earlier, each clinical situation is evaluated on an independent basis to determine what the best plan of care for the member is. We then will write a determination of in-network versus out-of-network coverage for a recommendation to a PEBP staff member. If an in network provider is not available, we will work with the PEBP team in establishing a letter of agreement so the member is not penalized for not using in network services. If based on conversation, it is determined that the member is electing to use services outside of network for coordination of benefits with other coverage, or for other reasons, we will document that information as well and notify the TPA and PEBP for payment determinations.

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?

If an in network bed is not available, Hometown Health would make every effort to put into place a letter of agreement to prevent disruption or delays in member care. A copy of this letter of agreement would be faxed to PEBP staff for review and final approval. Once Hometown Health as received a signed approval back from PEBP, we will forward a copy of the Letter of Agreement to Healthscope, the PEBP TPA. No additional fee is required.

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

Negotiated rates are communicated to PEBP on a one page document outlining the member's demographic information, provider we are establishing Letter of Agreement with as well as CPT codes that are covered along with the negotiated rates. In establishing the negotiated rates, we would work with Healthscope as well as PEBP to ensure that we were not establishing a rate that is above what h as previously been paid. Once we have agreed upon a rate, a copy of the proposed rates would be sent to PEBP staff for review and approval. Once PEBP staff has approved the proposed rates, a copy is sent to Healthscope for their records in order to appropriately adjudicate the claim.

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

Please see attachment labeled 3.13.4

ACCOUNT SERVICE

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

Hometown Health's Customer Service hours are Monday through Friday 8:00 AM to 5:00 PM PST.

3.13.5.1 For PEBP staff?

3.13.5.2 For PEBP participants?

3.13.5.3 For providers?

Hometown Health's telephone lines for the above mentioned groups will be staffed as such: Monday through Friday 8:00 AM to 5:00 PM PST.

3.13.6 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.

Hometown Health currently provides a dedicated account manager. Windy Culver will continue to be that account manager if Hometown is awarded the PPO contract again.

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

Windy Culver works out of our only location of 850 Harvard Way, Reno, NV 89502.

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

Yes, Hometown Health can receive electronic enrollment and eligibility data and will accept it in whatever format PEBP provides it.

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

Yes, Hometown Health employs a Medical Director. Our Medical Director is Dr. Linda Ash-Jackson. She was recently promoted to Chief Medical Officer. Please see her attached resume.

IMPLEMENTATION SERVICES

3.13.10 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.

Hometown Health is the current incumbent so transition would be minimal if we were awarded the contract. Should another vendor be awarded the contract, Hometown Health will work collectively and cooperatively with PEBP and any other state entity as well as all vendors to ensure a smooth transition if one was to be requested. Hometown Health would provide all necessary reports, data, and any other information that would be requested in a timely manner. In addition, Hometown health would provide written communication to all covered members indicating when their utilization and case management services would terminate with Hometown Health.

3.13.11 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?

Hometown Health currently has an exclusive team to manage the PEBP book of business. This includes a dedicated account manager, dedicated preceritification nurse and concurrent review team as well as dedicated PEBP case managers.

We currently have 5 full time staff members dedicated to PEBP. In addition, other Hometown Health team members support the PEBP book of business based on need and specialty, including our Director, Manager and Supervisor of Health Services, our Chief Medical Officer and other staffers. A total of 8 FTE's are servicing the PEBP account.

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

Hometown Health has not had any significant issues in the past with transitioning a new account to management. Our teams including our Customer Services, Information Resources and Health Services teams have detailed implementation plans that are reviewed in detail with each customer and partner to ensure transitions go smoothly.

3.13.13 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.

Yes, the cost proposal includes all costs associated with implementation services.

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

PEBP is currently utilizing Hometown Health for utilization review and case management services. There would be no transition of services required.

3.14 DISASTER RECOVERY PLAN

3.14.1 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:

3.14.1.1 A hardware system failure/collapse;
3.14.1.2 A software system failure/collapse;
3.14.1.3 Any natural disaster or Act of God; and
3.14.1.4 Total loss of electrical/backup power.

Hometown Health has developed and maintains a Disaster Recovery Plan which covers the areas outlined herein and others, including those identified below. The structure and detail is comprises of many pages.

The Plan is maintained in both electronic and hardcopy form and is located in secure business areas and securely on a computer server complex separate from Hometown Health's other computer platforms and systems as a risk management strategy for availability. In addition, each member of the Hometown Health Senior Leadership Team has an electronic copy in their personal possession (home) for availability and access in the event of a disaster impacting other means of gaining access to the Plan. Members of the Hometown Health Senior Leadership Team also carry wallet-cards containing critical contact information for key members of Hometown Health Leadership and for team members involved in recovery activities in the event of a disaster or other issue(s) impacting Hometown's business operations.

The Plan can be made available for review and verification. Plan components include:

Business Analysis
Scope

Mission Statement
Vital Business Functions / Critical Applications
Disaster Definition
Disaster Scenarios

Teams and Responsibilities
Business Recovery Manager / Management
Damage Assessment
Network Recovery
System Software Recovery
Application / User Verification
Facilities Salvage
Team Matrix
Team Members Addresses and Phone Numbers – and other contact information

Backup Procedures
Software / Data Procedures
Hardware Configurations
Network Backup Procedures
Backup Facilities
Vital Records Facilities
Temporary Facility

Recovery Procedures
Task Overview – software and data recovery
Network Recovery Procedures
Recovery Verification / Checkout Activities

Implementation Team
Task Charts
Time Lines
Task Charts by Team

Test Plan
Test Plan Criteria
Test Objectives
Test Plan Tasks
Testing Time Line
Test Review

Recovery and Maintenance – of the Plan itself
Problem / Change Management
Periodic Review
Section Updates

Relocation and Migration
Task Charts

Appendices – including
Personnel
Computer system and platform detailed serial numbers, licenses, etc.
Maintenance agreements
Miscellaneous Notifications
Travel Accommodations

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

The Plan and expectations include that Hometown Health's disaster recovery activities will commence as soon as a loss of normal operations is experienced, requiring no more than one (1) business day to restore normal operations.

Depending on how late in the day the loss would occur, normal business processing will be restored no later than the next business day; or potentially the day following, in a situation where the loss had occurred late enough in the day where the next business day was partially impacted as the 1-day restoration activities continued.

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

The Plan was extensively updated during 2004 during Hometown Health's upgrade to a new core insurance processing system; and has also been reviewed and updated annually to remain current on updated vendor arrangements and with key personnel information. Hometown Health will continue to update the Plan as key information, such as vendor arrangements and key personnel information change, as vendor, systems, organizational infrastructure changes as business dictates and formal annual reviews will continue for completeness.

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

Hometown Health's Disaster Recovery Plan can be tailored to specific PEBP requirements; this could include special-needs and priorities on bringing business functions live to serve the needs of PEBP's members – if required more quickly than the expected 1 business-day recovery timeframe.

These could include such areas as more rapid online (Web-based) access to benefit information for Members (if impacted at all), ability for Providers to continue providing online Member Authorizations for specialty services and perform other online services for Members (if required, and if impacted at all) – Hometown's online Web services are based in different locations and platforms than the core insurance processing system as an approach to addressing risk in a potential disaster situation.

This could also include special priorities in processing of claims, if required; above-and-beyond Hometown Health's advanced technologies and high automation rates which provide high performance turnaround times as a general practice, once normal business operations are restored.

3.14.5 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.

Regularly scheduled backups are currently performed, including Daily, Weekly and Monthly cycles; and the data are stored at a secure location, offsite from Hometown Health's business operations.

3.15 PRIVACY AND SECURITY

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

Confirmed.

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

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

3.15.2.2 HIPAA Privacy and Security Rules – 45 CFR §160, §162, and §164; and ***Yes***

3.15.2.3 Audited for compliance with the HITECH Breach Rule and HIPAA Privacy and Security Rules. ***Yes***

3.15.2.4 Are corrective actions implemented by your organization for issues identified in the audit? ***Yes***

3.15.3 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.

Hometown Health agrees to the conditions set forth in Attachment M.

3.15.4 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.

See the Business Associates Agreement attached

3.16 ELECTRONIC DATA INTERCHANGE (EDI)

3.16.1 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.

Hometown Health agrees to this stipulation.

3.16.2 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.

Hometown Health agrees to this stipulation.

3.16.3 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.

Hometown Health agrees to this stipulation.

3.17 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 admin 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.

3.17.1 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.