STEVE SISOLAK
Governor

LAURA FREED
Board Chair

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
901 S. Stewart Street, Suite 1001 | Carson City, Nevada 89701
Telephone 775-684-7000 | 1-800-326-5496 | Fax 775-684-7028
www.pebp.state.nv.us

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CORE
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LAURA RICH
Executive Officer

MEETING NOTICE AND AGENDA

Name of Organization:	Public Employees' Benefits Program Board
Date and Time of Meeting:	May 28, 2020 9:00 a.m.
Place of Meeting:	Pursuant to the Governor's Emergency Directives 006, 016, and 018, this meeting will be conducted via video- and tele-conference only. This meeting can be viewed live over the Internet on the PEBP YouTube channel at https://youtu.be/rFrBkfmnFOs

Members of the public are encouraged to submit public comment in writing by emailing wlunz@peb.nv.gov at least two business days prior to the meeting.

There are two agenda items designated for public comment. If you wish to provide verbal public comment during those agenda items, please follow the instructions below:

Dial: (699) 900-6833. When prompted to provide your Meeting ID, please enter: 934 9620 6748 then press #. When prompted for a Participant ID, please enter #.

Participants that call in will be muted until it is time for public comment. A moderator will then unmute callers one at a time for public comment.

To resolve any issues related to dialing in to provide public comment for this meeting, please call (775) 684-7016 or email wlunz@peb.nv.gov

Meeting materials can be accessed here: https://pebp.state.nv.us/meetings-events/board-meetings/

AGENDA

1. Open Meeting; Roll Call

2. Public Comment

   Public comment will be taken during this agenda item. No action may be taken on any matter raised under this item unless the matter is included on a future agenda as an item on which action may be taken. Public comments to the Board will be taken under advisement but will

not be answered during the meeting. Comments may be limited to three minutes per person at the discretion of the chairperson. Additional three minute comment periods may be allowed on individual agenda items at the discretion of the chairperson. These additional comment periods shall be limited to comments relevant to the agenda item under consideration by the Board. As noted above, members of the public may make public comment by using the call-in number provided above. Persons unable to attend the meeting by telephone and persons whose comments may extend past the three minute time limit may submit their public comment in writing to PEBP Attn: Wendi Lunz 901 S. Stewart St, Suite 1001 Carson City NV 89701, Fax: (775) 684-7028 or wlunz@peb.state.nv.us at least two business days prior to the meeting. Persons making public comment need to state and spell their name for the record at the beginning of their testimony.

3. PEBP Board disclosures for applicable Board meeting agenda items. (Brandee Mooneyhan, Deputy Attorney General) (Information/Discussion)

4. Consent Agenda (Laura Freed, Board Chair) (**All Items for Possible Action**)

   Consent items will be considered together and acted on in one motion unless an item is removed to be considered separately by the Board.

   4.1 Approval of Action Minutes from the March 31, April 9, and April 27, 2020 PEBP Board Meetings.

5. Executive Officer Report (Laura Rich, Executive Officer) (Information/Discussion)

6. Presentation on impact of COVID-19 on the Plan (Stephanie Messier, Aon Hewitt) (Information/Discussion)

7. Update on Morneau Shepell Performance Improvement Plan instituted on 07/25/2019 (Morneau Shepell) (Information/Discussion)

8. Discussion and possible action of Contract Solicitation Report addressing solicitations necessary due to upcoming expiration of PEBP contracts, including:

   1) Benefits Management System

   2) Health Maintenance Organization (HMO)

   3) Dental PPO Network

   4) PPO/EPO Statewide Network

   5) Financial Auditor

   (Laura Rich, Executive Officer) (**For Possible Action**)

9. Discussion and possible action of contract amendments to Aon Hewitt and HealthSCOPE Benefits contracts (Cari Eaton, Chief Financial Officer) (**For Possible Action**)

10. Health Claim Auditors, Inc. quarterly audit of HealthSCOPE Benefits for the timeframe January 1, 2020 – March 31, 2020: (1) Report from Health Claim Auditors; (2) HealthSCOPE Benefits response to audit report; and (3) for possible action to accept audit report findings and assess penalties, if applicable, in accordance with the performance guarantees included in the contract pursuant to the recommendation of Health Claim Auditors (Robert Carr, Health Claim Auditors) (**For Possible Action**)

11. Health Claim Auditors, Inc. yearly audit of Express Scripts, Inc. (ESI) for the timeframe July 1, 2018 – June 30, 2019 (Robert Carr, Health Claim Auditors) (**For Possible Action**)
12. Public Comment

    Public comment will be taken during this agenda item. Comments may be limited to three minutes per person at the discretion of the chairperson. Persons making public comment need to state and spell their name for the record at the beginning of their testimony.
13. Adjournment

The supporting material to this agenda, also known as the Board Packet, is available, at no charge, on the PEBP website at www.pebp.state.nv.us/meetings-events/board-/meetings (under the Board Meeting date referenced above).
An item raised during a report or public comment may be discussed but may not be deliberated or acted upon unless it is on the agenda as an action item.
All times are approximate. The Board reserves the right to take items in a different order or to combine two or more agenda items for consideration to accomplish business in the most efficient manner. The Board may remove an item from the agenda or delay discussion relating to an item on the agenda at any time.
We are pleased to make reasonable efforts to assist and accommodate persons with physical disabilities who wish to participate in the meeting. If special arrangements for the meeting are necessary, please notify the PEBP in writing, at 901 South Stewart Street, Suite 1001, Carson City, NV 89701, or call Wendi Lunz at (775) 684-7020 or (800) 326-5496, as soon as possible so that reasonable efforts can be made to accommodate the request.
Copies of both the PEBP Meeting Action Minutes and Meeting Transcripts, if such transcripts are prepared, are available for inspection, at no charge, at the PEBP Office, 901 South Stewart Street, Suite 1001, Carson City, Nevada, 89701 or on the PEBP website at www.pebp.state.nv.us. For additional information, contact Wendi Lunz at (775) 684-7020 or (800) 326-5496.
Notice of this meeting was posted on or before 9:00 a.m. on the third working day before the meeting on the PEBP website at www.pebp.state.nv.us, and also posted to the public notice website for meetings at https://notice.nv.gov. In addition, the agenda was mailed to groups and individuals as requested.

1.

1. Open Meeting; Roll Call

2.

2. Public Comment

3.

3. PEBP Board disclosures for applicable Board meeting agenda items. (Brandee Mooneyhan, Deputy Attorney General)
(Information/Discussion)

4.

4. Consent Agenda (Laura Freed, Board Chair) (**All Items for Possible Action**)

   Consent Items will be considered together and acted on in one motion unless an item is removed to be considered separately by the Board.

   4.1 Approval of Action Minutes from the March 31, April 9, and April 27, 2020 PEBP Board Meetings.

4.1

4. Consent Agenda (Laura Freed, Board Chair) (**All Items for Possible Action**)

   4.1 Approval of Action Minutes from the March 31, April 9, and April 27, 2020 PEBP Board Meetings.

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
BOARD MEETING

Telephonic Open Meeting
Carson City and Las Vegas, NV

ACTION MINUTES (Subject to Board Approval)
March 31, 2020

MEMBERS PRESENT VIA TELECONFERENCE:	Ms. Laura Freed, Board Chair Ms. Linda Fox, Vice Chair Ms. Jet Mitchell, Member Mr. Don Bailey, Member Mr. Tom Verducci, Member Mr. David Smith, Member Ms. Leah Lamborn, Member Ms. Heather Korbulic, Member Dr. Marsha Urban, Member
FOR THE BOARD:	Ms. Brandee Mooneyhan, Deputy Attorney General
FOR STAFF:	Ms. Laura Rich, Executive Officer Mr. Nik Proper, Operations Officer Ms. Cari Eaton, Chief Financial Officer Mr. Brett Harvey, Chief Information Officer Ms. Nancy Spinelli, Quality Control Officer Ms. Wendi Lunz, Executive Assistant

1. Open Meeting: Roll Call
    - Board Chair Freed opened the meeting at 8:34 a.m.

2. Public Comment
    - Wendy Kelly – PEBP Participant
    - Doug Unger - Employee Benefits Representative UNLV Faculty Senate
    - Priscilla Maloney - AFSCME
    - Kevin Rand – AFSCME
    - Kent Ervin – Nevada Faculty Alliance
    - Kevin Rand – AFSCME
    - Marlene Lockard – RPEN

3. Board disclosures for applicable Board meeting agenda items. (Brandee Mooneyhan, Deputy Attorney General) **(Information/Discussion)**

4. Consent Agenda (Laura Freed, Board Chair) (**All Items for Possible Action**)
   Consent items will be considered together and acted on in one motion unless an item is removed to be considered separately by the Board.
    4.1 Approval of Action Minutes from the March 3, 2020 PEBP Board Meeting.

    4.2 Acceptance of Health Claim Auditors' quarterly audit findings for HealthSCOPE Benefits for the timeframe of October 1, 2019 – December 31, 2019.

    4.3 Acceptance of PEBP vendor quarterly reports for the timeframe of October 1, 2019 – December 31, 2019.

        4.3.1 Doctor on Demand Engagement report – February 2020

        4.3.2 The Standard Insurance – Basic Life and Long-Term Disability Insurance

        4.3.3 Willis Towers Watson's Individual Marketplace Enrollment & Performance Report
        4.3.4 Health Plan of Nevada Performance Standards and Guarantees

    4.4 Acceptance of the PEBP Chief Financial Officer quarterly reports for the period ending December 31, 2019.

        4.4.1 Budget Report

        4.4.2 Utilization Report

    4.5 Receipt of the federally mandated Summaries of Benefits and Coverage documents effective July 1, 2020 for individual coverage and family coverage for PEBP's Consumer Driven Health Plan (CDHP) and PEBP's Premier Plan (Exclusive Provider Organization – EPO).

4.5.1 Summary of Benefits and Coverage CDHP – Individual

4.5.2 Summary of Benefits and Coverage CDHP – Family

4.5.3 Summary of Benefits and Coverage EPO – Individual/Family

BOARD ACTION ON ITEM 4

MOTION: Motion to accept Item 4, 4.1, 4.2, 4.3 right down the line, with the exception of 4.3.3

BY: Member Don Bailey

SECOND: Member Leah Lamborn

VOTE: Unanimous; the motion carried.

5. Discussion and possible action of emergency COVID-19 plan benefit design changes and implementation. (Laura Rich, Executive Officer) (**For Possible Action**)

BOARD ACTION ON ITEM 5

MOTION: Motion to accept option one to cover all testing, associated office visits and treatment for COVID-19 at 100 percent of the plan's maximum allowable charge with the caveat that we would like it re-agendized for the May meeting to see where we are on plan spent on COVID-19 testing, office visit and treatment and see if we have anymore intelligence from the federal government about whether they would provide hospital direct relief or something, other things like that.

BY: Member Don Bailey

SECOND: Chair Laura Freed

VOTE: 8-1 in favor (Member Linda Fox voted No); the motion carried.

6. Discussion and possible action of the Express Scripts, Inc. Pharmacy Benefits Manager contract amendment to reduce fees and implement greater drug discounts and guaranteed drug rebates. (Laura Rich, Executive Officer) (**For Possible Action**)

BOARD ACTION ON ITEM 6

MOTION: Motion to adopt Express Scripts, Inc. Pharmacy Benefits Manager contract amendment to reduce fees and implement greater drug discounts and guaranteed drug rebates.

BY: Member Tom Verducci

SECOND: Member David Smith

VOTE: Unanimous; the motion carried

7. Discussion and possible action regarding Plan Year 2021 plan and policy changes including:

   - Cancellation of the Chronic Kidney Disease pilot program
   - Deferment of the approved CDHP HSA/HRA enhanced funding
   - Implementation of the SaveOn Copay Assistance Program to include reevaluating the current patient assistance accumulator policy

   (Laura Rich, Executive Officer) (**For Possible Action**)

BOARD ACTION ON ITEM 7
MOTION: Motion to accept the PEBP recommendation to defer the 125 dollar enhanced funding and consider it at the November 2020 PEBP Board Meeting.
BY: Member David Smith
SECOND: Member Jet Mitchell
VOTE: Unanimous; the motion carried

BOARD ACTION ON ITEM 7
MOTION: Motion to cancel the Chronic Kidney Disease pilot program.
BY: Member Leah Lamborn
SECOND: Member Don Bailey
VOTE: Unanimous; the motion carried

BOARD ACTION ON ITEM 7
MOTION: Motion to approve implementation of the SaveOn Copay Assistance to include reevaluating the current patient assistance accumulator policy.
BY: Vice Chair Linda Fox
SECOND: Member Heather Korbulic
VOTE: Unanimous; the motion carried

8. Discussion and possible action of Bill Draft Request (BDR) to address changes to NRS 287.0475 (Laura Rich, Executive Officer) (**For Possible Action**)

BOARD ACTION ON ITEM 8
MOTION: Motion to approve the recommendation by the PEBP staff on the bill draft request.
BY: Member Don Bailey
SECOND: Member David Smith
VOTE: Unanimous; the motion carried

9. Discussion and possible action to include the approval of Plan Year 2021 (July 1, 2020 – June 30, 2021) rates for state and non-state employees, retirees and dependents for the statewide Consumer Driven Health Plan (CDHP), the Southern Nevada Health Maintenance Organization (HMO) plan and the Northern and rural Exclusive Provider Organization (EPO) plan. (Laura Rich, Executive Officer) (**For Possible Action**)

BOARD ACTION ON ITEM 9
MOTION: Motion to reduce the margin load on the incurred but not paid from the current 25 percent down to ten percent thereby releasing 7.04 million and then reduce the catastrophic to 60 days on hand from its current level thereby releasing 1.4 million.
BY: Vice Chair Linda Fox
SECOND: Member Leah Lamborn
VOTE: Unanimous; the motion carried

10. Discussion and possible action of Legislative Counsel Bureau audit and corrective action plan. (Laura Rich, Executive Officer) (**For Possible Action**)

BOARD ACTION ON ITEM 10
MOTION: Motion to approve staff's recommendation.
BY: Member Tom Verducci
SECOND: Member Marsha Urban
VOTE: Unanimous; the motion carried

11. Executive Officer Report (Laura Rich, Executive Officer) ~~(**For Possible Action**)~~ (For Information Only)

12. Public Comment
    - Priscilla Maloney - AFSCME
    - Kevin Rand – AFSCME
    - Marlene Lockard – RPEN

13. Adjournment
    - Chair Laura Freed adjourned the meeting at 1:32 p.m.

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
BOARD MEETING

Telephonic Open Meeting
Carson City and Las Vegas, NV

ACTION MINUTES (Subject to Board Approval)
April 9, 2020

MEMBERS PRESENT VIA TELECONFERENCE:	Ms. Laura Freed, Board Chair Ms. Linda Fox, Vice Chair Ms. Jet Mitchell, Member Mr. Don Bailey, Member Mr. Tom Verducci, Member Mr. David Smith, Member Ms. Leah Lamborn, Member Ms. Heather Korbulic, Member Dr. Marsha Urban, Member
FOR THE BOARD:	Ms. Brandee Mooneyhan, Deputy Attorney General
FOR STAFF:	Ms. Laura Rich, Executive Officer Mr. Nik Proper, Operations Officer Ms. Cari Eaton, Chief Financial Officer Mr. Brett Harvey, Chief Information Officer Ms. Nancy Spinelli, Quality Control Officer Ms. Wendi Lunz, Executive Assistant

1. Open Meeting; Roll Call

    - Board Chair Freed opened the meeting at 10:01 a.m.

2. Public Comment

    - Kevin Ranft – AFCME
    - Priscilla Maloney – AFCME
    - Shaun Franklin-Sewell – UNLV Employee Benefits Advisory Committee
    - Kent Ervin – Nevada Faculty Alliance

3. PEBP Board disclosures for applicable Board meeting agenda items. (Brandee Mooneyhan, Deputy Attorney General) (Information/Discussion)

4. Discussion and possible action to include the approval of Plan Year 2021 (July 1, 2020 – June 30, 2021) rates for state and non-state employees, retirees and dependents for the statewide Consumer Driven Health Plan (CDHP), the Southern Nevada Health Maintenance Organization (HMO) plan and the Northern and rural Exclusive Provider Organization (EPO) plan. (Laura Rich, Executive Officer) (**For Possible Action**)

BOARD ACTION ON ITEM 4
MOTION: Motion to approve PEBP's recommendation's one and two as outlined in the staff report.
BY: Member Leah Lamborn
SECOND: Member Tom Verducci
VOTE: Unanimous; the motion carried

BOARD ACTION ON ITEM 4
MOTION: Motion to eliminate option one for consideration.
BY: Member David Smith
SECOND: Member Marsha Urban
VOTE: 7 -1 in favor (Member Jet Mitchell/No, Chair Freed Abstained); the motion carried

BOARD ACTION ON ITEM 4
MOTION: Motion to approve option two which would be the same tiering ratios that we have used as a Board in past years and continue with that and these rates contain the most current claims experience also.
BY: Member Leah Lamborn
SECOND: Chair Laura Freed
VOTE: Aye - 4, No – 5; the motion did not carry

BOARD ACTION ON ITEM 4

MOTION: Motion to approve option three and allow Laura Rich to make any technical corrections as necessary.

BY: Member Tom Verducci

SECOND: Member Don Bailey

VOTE: 7 – 2 in favor (Laura Freed, Leah Lamborn/No); the motion carried

5. Public Comment

- Kent Ervin – Nevada Faculty Alliance
- Douglas Unger – UNLV Employee Benefits Advisory Committee
- Kevin Ranft – AFSCME

6. Adjournment

- Chair Freed adjourned the meeting at 12:11 p.m.

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
BOARD MEETING

Telephonic Open Meeting
Carson City and Las Vegas, NV

ACTION MINUTES (Subject to Board Approval)
April 27, 2020

MEMBERS PRESENT VIA TELECONFERENCE:	Ms. Laura Freed, Board Chair Ms. Linda Fox, Vice Chair Ms. Jet Mitchell, Member Mr. Don Bailey, Member Mr. Tom Verducci, Member Mr. David Smith, Member Ms. Leah Lamborn, Member Dr. Marsha Urban, Member
MEMBERS EXCUSED:	Ms. Heather Korbulic, Member
FOR THE BOARD:	Ms. Brandee Mooneyhan, Deputy Attorney General
FOR STAFF:	Ms. Laura Rich, Executive Officer Mr. Nik Proper, Operations Officer Ms. Cari Eaton, Chief Financial Officer Mr. Brett Harvey, Chief Information Officer Ms. Nancy Spinelli, Quality Control Officer Ms. Wendi Lunz, Executive Assistant

1. Open Meeting; Roll Call

    - Board Chair Freed opened the meeting at 9:03 a.m.

2. Public Comment

    - Priscilla Maloney – AFSCME
    - Kent Ervin – Nevada Faculty Alliance
    - Douglas Unger – UNLV Employees Benefits Advisory Committee
    - Kevin Ranft – AFSCME

3. PEBP Board disclosures for applicable Board meeting agenda items. (Brandee Mooneyhan, Deputy Attorney General) (Information/Discussion)

4. Discussion and possible action to present Fiscal Year 2021 Budget Reserves options. (Laura Rich, Executive Officer) (**For Possible Action**)

BOARD ACTION ON ITEM 4

MOTION: Motion to approve PEBP's recommendation for option two, option three with an effective date of May 31, 2021, and option five, making five a permanent policy change, and then take the ESI Market Check savings and the SaveOn projected savings.

BY: Member Leah Lamborn

SECOND: Member Don Bailey

VOTE: Unanimous; the motion carried

5. Public Comment

    - Kevin Ranft – AFSCME
    - Priscilla Maloney – AFSCME
    - Kent Ervin – Nevada Faculty Alliance

6. Adjournment

    - Chair Freed adjourned the meeting at 10:21 a.m.

5.

5. Executive Officer Report (Laura Rich, Executive Officer) (Information/Discussion)

STEVE SISOLAK
Governor

LAURA FREED
Board Chair

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Expires 04/01/2021

LAURA RICH
Executive Officer

AGENDA ITEM

☐ Action Item
☒ Information Only

Date: May 28, 2020

Item Number: V

Title: Executive Officer Report

SUMMARY

This report will provide the Board, participants, public, and other stakeholders information on the overall activities of PEBP.

REPORT

PLAN YEAR 21 OPEN ENROLLMENT

Plan Year 21 Open Enrollment is underway and running relatively smooth despite reduced call center staffing and other COVID-19 related challenges. Under normal conditions, PEBP staff take an "all hands on deck" approach during open enrollment to address the increased call and email volume from members. With a shortened open enrollment window and social distancing workplace practices in place, both PEBP staff and members have had to adapt to the conditions but we are happy to report that we continue to serve our members with excellent customer service and support.

DEPARTMENT OF LABOR GUIDANCE

The Department of Labor (DOL) recently released COVID-19 related regulatory guidance loosening certain participant and plan deadlines. The rule requires that plans disregard any days within the outbreak period when determining periods and deadlines for group health plans such as the COBRA election period, appeal timelines and claim filing.

Although the DOL rule only applies to ERISA plans, it strongly encourages plans like PEBP to comply. PEBP has used this guidance as a roadmap and has relaxed certain deadlines in order to provide relief to members who may be unable to adhere to the plan rules due to government office closures or other COVID-19 related matters. For example, PEBP has provided deadline

extensions to members who are required to submit supporting documentation (such as a birth certificate) but have been unable to obtain the required certified copy in time to meet the deadline. These types of exceptions are handled on a case by case basis with the ultimate goal of ensuring members have access to coverage in the face of delays that are out of their control.

UNUM LONG TERM CARE

The Unum Long Term Care (LTC) policy is the last remaining voluntary policy PEBP has a direct relationship with. At the September 26, 2019 Board meeting, the PEBP Board voted to not renew the contract and instead allow the current Unum LTC contract to terminate on June 30, 2020. Although at the time, the Unum representative (broker) indicated that Unum was incapable of meeting the technical requirements necessary to transition on to the PEBP voluntary benefits portal, the option was left open to allow that transition should Unum be able to prior to the June 30, 2020 contract termination date.

AGIS, a broker of LTC products who represents Unum, and Corestream have coordinated and are in the process of fully transitioning the LTC product on to the voluntary benefit platform. Although the contract with PEBP is not being renewed, the LTC policies held by PEBP members will remain in place and the product will continue to be offered through the voluntary benefit platform on or before July 1, 2020.

BUDGET ENHANCEMENT OPTIONS

At the January 23, 2020 Board meeting the Board approved staff to perform additional analysis, including two Requests for Information (RFI), on various budget enhancement concepts. The intent was to bring the analysis back to the Board in May to discuss the FY22-FY23 agency request budget submission, however it is safe to say that the state economic conditions have changed due to the COVID-19 pandemic and as a result of budget cuts, these enhancements can no longer be considered options.

PEBP staff, vendors and several members of the Board met on May 26th and 27th for an earlier than usual strategic planning session to discuss options and considerations for the program moving forward. PEBP hopes to bring these ideas and concepts back to the Board in July.

CONCLUSION

PEBP is facing many challenges ahead. The uncertainty surrounding the economic impact of COVID-19 on the state and the rising costs of healthcare will likely force significant changes on the program. PEBP is and will continue to work with leadership to ensure the program continues to meet our mission of providing employees, retirees, and their families with access to high quality benefits at affordable prices.

6.

6. Presentation on impact of COVID-19 on the Plan
   (Stephanie Messier, Aon Hewitt)
   (Information/Discussion)

Illustrative and subject to change

Because of the very fluid nature of this epidemic and states correspondingly fluid responses to re-opening their economies, this report is a point in time, illustrative exercise of cost estimates and impact of phased re-opening activities.

COVID-19 Potential Impacts in 2020

Presentation to Public Employees' Benefits Program Board – for conversational discussion
Projections as of May 19, 2020

AON
Empower Results®

About The Model – Walking through the potential impacts of Re-Opening

- Forecasts the potential impact of the COVID-19 virus on your employee population and dependents

- **Features:**
  - Adjust for essential employees and industry-specific infection exposure
  - View population impact by geographic area over time
  - Model infection peak for each employer group
  - Estimate the number of mild cases, hospitalizations, ICU visits, and fatalities based on specific population demographics
  - Model impact of mitigation measures and mitigation end dates
  - Estimate health care costs associated with testing and treatment
  - Estimate employee days lost by case severity
  - Powered by a cloud-based platform always updated with latest data and forecasts

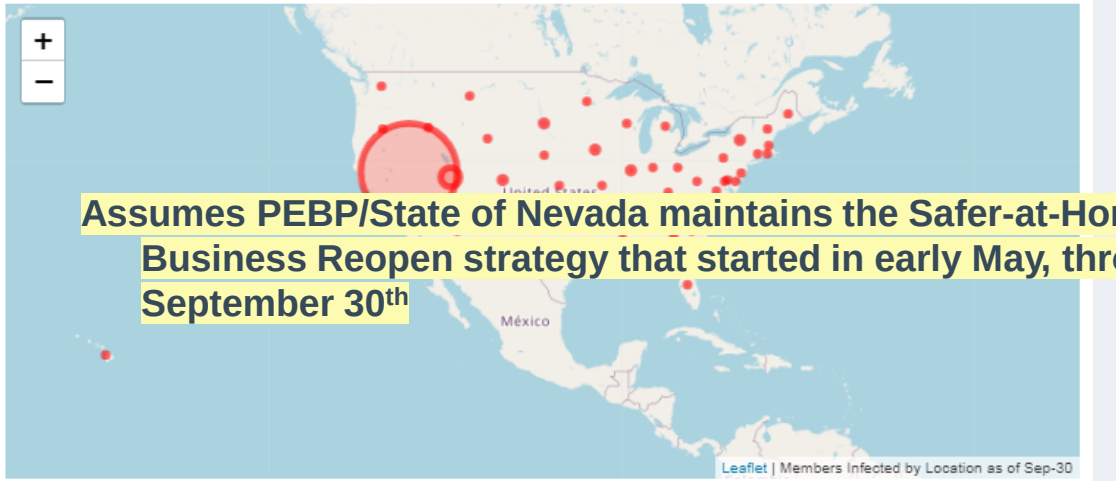
- **Methodology:**
  - Simple, non-identifiable census data from PEBP
  - Combine with geography-specific infection rates
  - Informed by epidemiologic model sources, including additional consultation with national carriers and labs
  - Reflects social distancing measures taken by local governments
  - Developed by Actuarial & Analytics, Aon Reinsurance and Retirement & Investments

Illustrative **Self-Funded** Impact by September 30th

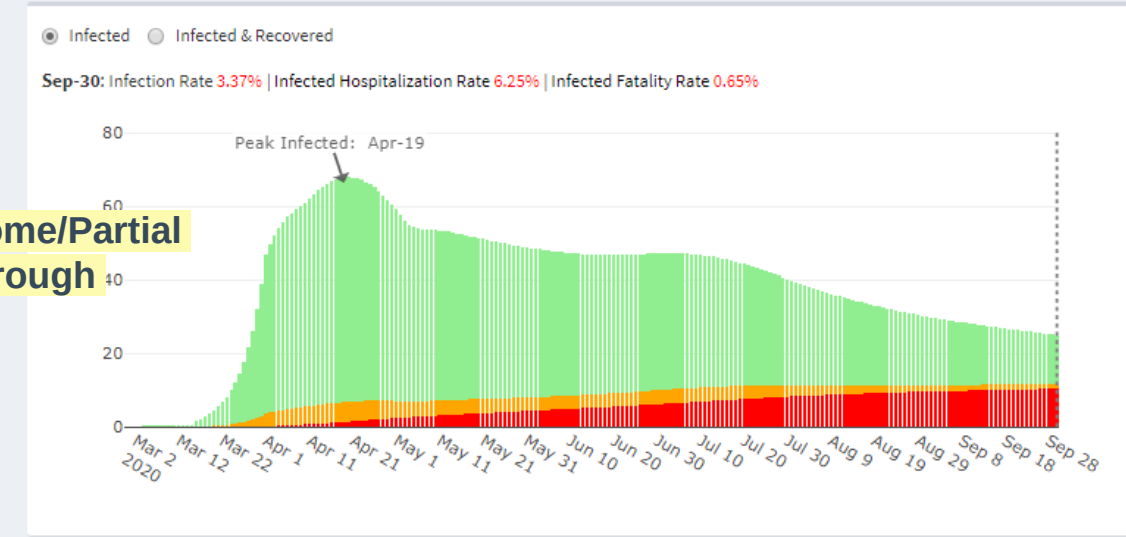
Claim costs peak in Q4 of PY20, as COVID-19 cases peaked on April 19th

Includes enrollees in HealthScope CDHP and EPO

Illustrative – to aid in discussion



Assumes PEBP/State of Nevada maintains the Safer-at-Home/Partial Business Reopen strategy that started in early May, through September 30th



	SUSCEPTIBLE	MILD (80% undetected/20% detected)	HOSPITALIZED + CRITICAL	DEATHS	TOTAL
MEMBER COUNT:	45,807	13 INFECTED 1,473 RECOVERED	1 INFECTED 99 RECOVERED	10	47,404
MEDICAL CLAIMS COST: *(excludes non-enrolled)*	$730K ($100-$200 per testing)	$529K ($0-$2,000 per case)	$3.6M ($30,000-$80,000 per case)	The medical claims cost and work days lost for cases resulting in deaths is included with the HOSPITALIZED + CRITICAL cases.	$4.9M ($103 per enrolled member)
WORK DAYS LOST:	2,640	9,382	2,054		14,076

Illustrative COVID-19: Self-Funded Medical Impact Scenarios

Net impact of COVID-19 could be a cost or a savings, depending on the level of COVID-19 claims and the level of claims suppression within PEBP's population

Illustrative – to aid in discussion

		COVID-19 Claim Costs (in Millions)		
		Low	Medium	High
Claims Suppression	Low	$2.4 ($4.7) ($2.3)	$4.9 ($4.7) $0.2	$7.3 ($4.7) $2.6
	Medium	$2.4 ($7.7) ($5.3)	$4.9 ($7.7) ($2.8)	$7.3 ($7.7) ($0.4)
	High	$2.4 ($10.8) ($8.4)	$4.9 ($10.8) ($5.9)	$7.3 ($10.8) ($3.5)

- **Assumes PEBP/State of Nevada maintains the Safer-at-Home/Partial Business Reopen strategy that started in early May**
- Estimates of COVID-19 claims and claims suppression are associated with large uncertainty
- Low scenario assumes costs are 50% of medium, high scenario assumes 150% of medium
- Claims suppression assumes 15%, 25% and 35% of medical claims will be suppressed during a 3-month lockdown, only 50% of which will return in the next 6 months
- Costs based on March 31, 2020 reprojections
- COVID-19 medium scenario reflects cost estimates from Aon's COVID-19 Employee Impact Model

Illustrative COVID-19: Self-Funded Medical Impact --- **Medium Scenario**

Under this scenario, the net impact of COVID-19 is estimated to be saving $2.8M in calendar year 2020

Illustrative – to aid in discussion

	PY20 and PY21 (in Millions)				Total
	Q3 PY20	Q4 PY20	Q1 PY21	Q2 PY21	
COVID-19 Claims	$0.2	$3.0	$1.7	$0.0	$4.9
Claims Suppression	($1.3)	($14.2)	$3.9	$3.9	($7.7)
Net Impact	($1.1)	($11.2)	$5.6	$3.9	($2.8)

- **Assumes PEBP/State of NV maintains a Safer-at-Home/Partial Business Reopen strategy that began in early May**
- COVID-19 estimated increase in claims of $4.9M, or 2.0% in calendar year 2020
- Suppression of non-COVID-19 claims estimated to save $7.7M, or 3.1% in calendar year 2020

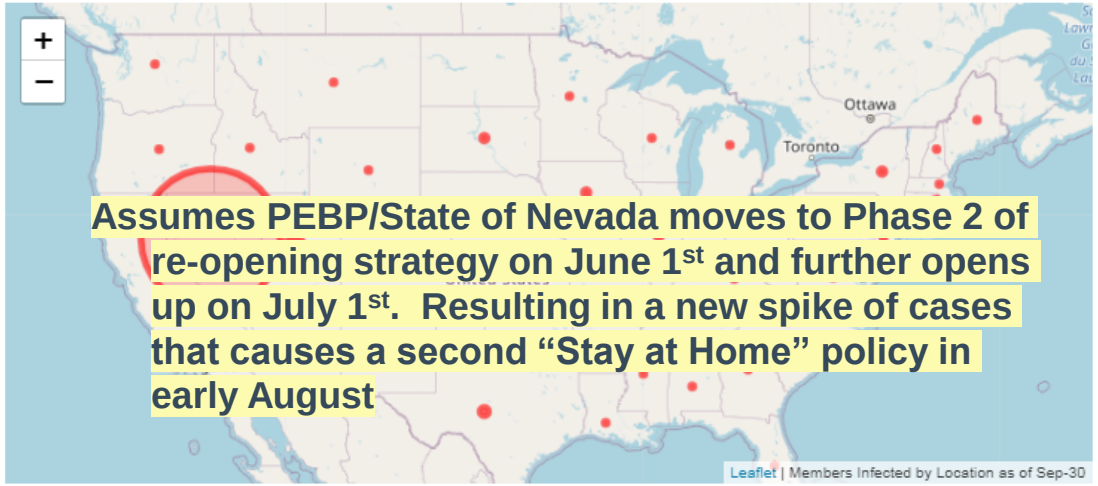
- COVID-19 claims estimate based on PEBP's own population demographics and geographic distribution
- Assumes 64% of PEBP's workforce had not been able to shelter in place and were reporting to work
- Claims suppression assumptions based on feedback from national carriers
- Actual results may vary, since the situation is very fluid, changing daily

Illustrative **Self-Funded** Impact by September 30th with additional Re-Opening

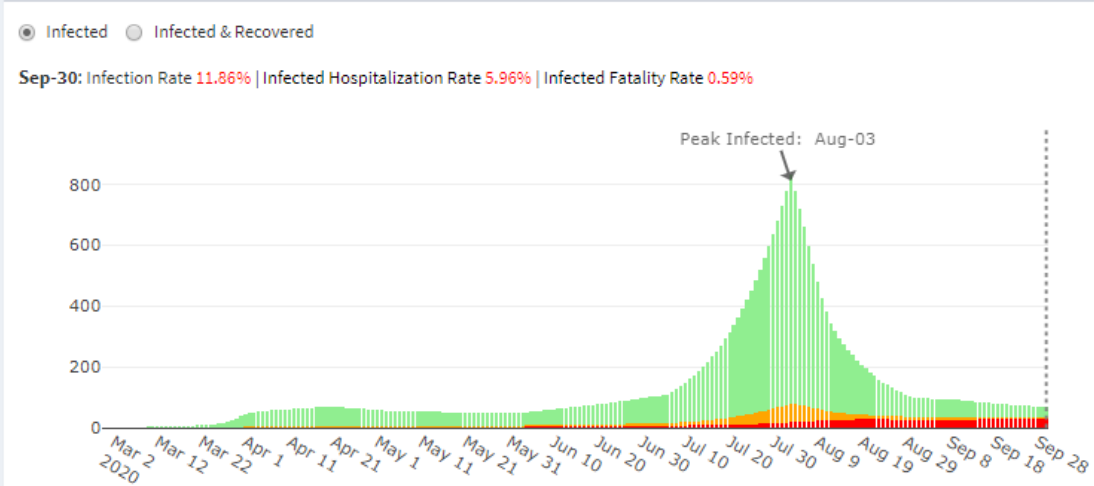
Claim costs peak after moving to phase 3 on July 1st, as COVID-19 cases peak on August 3rd and lockdown resumes

Includes enrollees in HealthScope CDHP and EPO

Illustrative – to aid in discussion



Assumes PEBP/State of Nevada moves to Phase 2 of re-opening strategy on June 1st and further opens up on July 1st. Resulting in a new spike of cases that causes a second "Stay at Home" policy in early August



	SUSCEPTIBLE	MILD (80% undetected/20% detected)	HOSPITALIZED + CRITICAL	DEATHS	TOTAL
MEMBER COUNT:	41,781	32 INFECTED 5,222 RECOVERED	3 INFECTED 332 RECOVERED	33	47,404
MEDICAL CLAIMS COST: *(excludes non-enrolled)*	$2.6M ($100-$200 per testing)	$1.9M ($0-$2,000 per case)	$11.8M ($30,000-$80,000 per case)	The medical claims cost and work days lost for cases resulting in deaths is included with the HOSPITALIZED + CRITICAL cases.	$16.3M ($343 per enrolled member)
WORK DAYS LOST:	9,493	32,983	6,859		49,336

Illustrative COVID-19: Self-Funded Medical Impact Scenario w/ Re-Opening

Net impact of COVID-19 could be a cost or a savings, depending on the level of COVID-19 claims and the level of claims suppression

Illustrative – to aid in discussion

Claims Suppression	COVID-19 Claim Costs (in Millions)		
	Low	Medium	High
Low	$8.1 ($4.7) $3.4	$16.3 ($4.7) $11.6	$24.4 ($4.7) $19.7
Medium	$8.1 ($7.7) $0.4	$16.3 ($7.7) $8.6	$24.4 ($7.7) $16.7
High	$8.1 ($10.8) ($2.7)	$16.3 ($10.8) $5.5	$24.4 ($10.8) $13.6

- **Assumes PEBP/State of Nevada moves to Phase 2 on June 1st, nearly a full open on July 1, and then back into Stay-at-home on August 1st**
- Estimates of COVID-19 claims and claims suppression are associated with large uncertainty
- Low scenario assumes costs are 50% of medium, high scenario assumes 150% of medium
- Claims suppression assumes 15%, 25% and 35% of medical claims will be suppressed during a 3-month lockdown, only 50% of which will return in the next 6 months
- Costs based on March 31, 2020 reprojections
- COVID-19 medium scenario reflects cost estimates from Aon's COVID-19 Employee Impact Model

Disclaimer and Limitations

- **Disclaimer:**
  - *This site and its contents, including all data, analysis, tables, charts and graphics, are provided by Aon strictly for educational purposes to its colleagues and clients. The site relies on publicly-available data from multiple sources, which are updated frequently, and which may not always agree with each other. The use of sources does not constitute or imply endorsement of the organizations or sources that provided the data. Aon disclaims any and all representations and warranties with respect to the site, including accuracy and fitness for use. The analysis does not reflect any change in the patterns of care for non-COVID-19 related morbidity or treatment, including elective and non-emergent procedures, and reliance on this site for any medical guidance is strictly prohibited. Furthermore, we are currently making no representations of the impact from COVID-19 on other workforce impacts and coverage such as productivity, sick time, disability, Workers Compensation or life insurance.*

- **What we don't know yet:**
  - Reductions due to suspension of non-critical medical services
  - Health care system capacity limitations
  - Impact of Federal assistance
  - Potential for new drugs or vaccinations to be developed
  - Timing and corresponding impact to lifting Stay-At-Home and Safer-At-Home guidelines

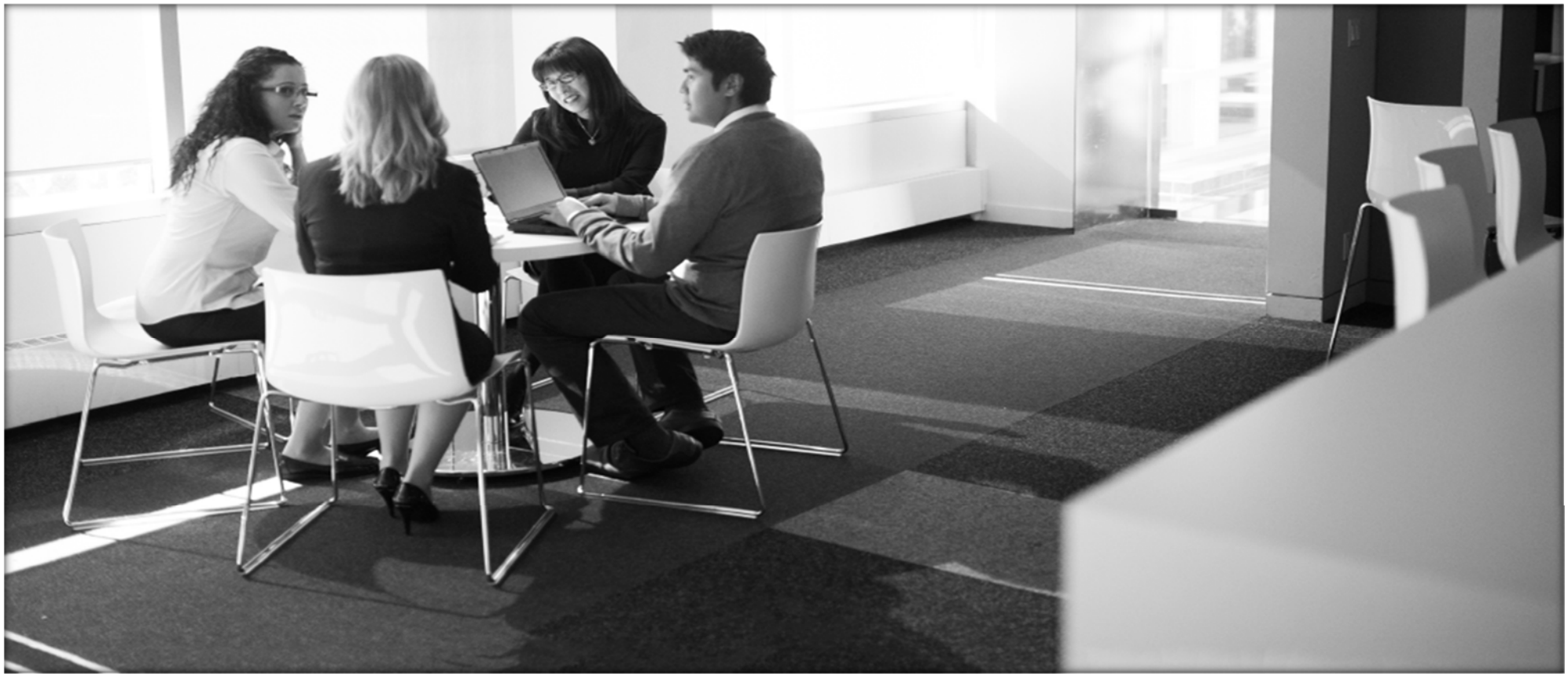
7.

7. Update on Morneau Shepell Performance Improvement Plan instituted on 07/25/2019 (Morneau Shepell) (Information/Discussion)

PEBP

Morneau Shepell Performance Improvement Plan

2020-05-19



Agenda

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3. Recent Progress 9

4. Key Performance Plan Items 10

Background

In 2018/2019, Morneau Shepell and PEBP partnered to introduce a series of enhancements to the PEBP enrollment solution, including:

- Migration to a new portal platform (MyLife 2.0);
- Implementation of a new responsive enrollment tool;
- Integration of Voluntary Benefits (VB) supported by Corestream;
- Automation of event process where no documentation requirements exist;
- Decommissioning of OCR/Document Management in AX and replacement with Morneau Shepell's Kofax/FileNet solution;
- Introduction of HRIS files and on-line data updates for agency reps to automate data collection from upstream systems (WorkDay and Central Payroll).

The project was a significant undertaking for both organizations – in terms of time and importance to the overall relationship. Project management and resources were assigned and worked to deliver on all elements of the solution. Over the course of the project, some deliverables were added to the original scope with agreement from project leadership such as migration of the hosting environment to a US data center.

Additionally, some deliverables increased in complexity or encountered delays from parties outside both organizations and were de-prioritized on agreement with leadership with intent to deliver these at a later date:

- HRIS interface and on-line data updates for agency reps;
- Decommissioning of OCR/Document Management in AX.

In addition to the above, some elements (e.g. approach to integrating Voluntary Benefits) were simplified to help reduce risk. The result of this project flux was compressed time and attention to quality assurance which impacted the level of rigor applied to this phase of the process. As such, the system delivered for open enrollment was not fully compliant with all terms in Morneau Shepell's Contract Amendment #4.

The net result of these conditions impacted the quality of the delivered solution, which created impact on PEBP participants, PEBP & Morneau Shepell staff, and our leadership teams:

Ref	Issue	Details	Impact	Participant impact	Staff impact	Leadership
Key Contributing Factors						
1	Project governance approach	Plotting and management of critical path items, buffers, and trade-offs didn't adequately capture the impact of slippage in some deliverables, which resulted in trade-offs & some items being removed from initial launch	High	N/A	Increased churn in project and deliverable planning and associated uncertainty	Loss of confidence in overall project management discipline Loss of credibility with outside stakeholders (HRIS/payroll)
2	Compressed testing time	Compression of time available for testing all elements (including end-to-end impacts of changes beyond participant User Experience) compromised ability to validate all impacts of changes on overall operating environment	High	N/A	Significant churn and uncertainty at go-live, resulting in significant challenges during OE	Impact on KPIs and overall relationship
3	Environment management – issues promoting to production	Code and configuration sign-off in User Acceptance Testing (UAT) wasn't parallel to production experience leading	High	Issues with participant website capabilities which triggered calls	Increased call and operational workload	Impact on KPIs

		to unanticipated production issues				
Resulting Issues						
Ref	**Issue**	**Details**	**Impact**	**Participant impact**	**Staff impact**	**Leadership**
4	Site access issues	Inconsistencies in behavior of participant portal between browsers, and versions of browsers, leading to login problems & inconsistencies in user experience	Medium	Limited access to self-service & triggered outreach calls	Fielded additional call volume	Impact on KPIs
5	Vendor site integration issues	Intermittent issues with SSO to HealthScope (related primarily to HealthScope technology)	Medium	Limited access to self-service	Fielded additional call volume	
6	User Experience (UX) - VB integration approach	Difficult for participants to understand what's available, enroll, and view their products & deductions	High	Limited awareness of products, drives confusion	Increased call volumes	Reduced impact of VB purchases
7	VB transition approach	Mapping from old to new polices not well orchestrated, no planned conversion of carrier VB data at go-live, and change management wasn't comprehensive in approach	High	Confusion – e.g., what is this deduction, what's it for, what is the breakdown,	Increased call volumes, reduced visibility	Increased call volumes and cancelled VB policies impacting VB revenue

				where did my old policy go?		
Ref	**Issue**	**Details**	**Impact**	**Participant impact**	**Staff impact**	**Leadership**
8	Rules for medical benefit applied to new VB products	Rule sets originally intended to support core medical elections (only) were not revisited as we added VB products	High	Confusion leading to calls to PEBP and submission of documents	Increased call volumes; increased operational tasks	Increased workload for operational teams due to poor requirements definition process
9	Operational issue management & approach to firefighting	Issues lead to many on-the-fly workaround and firefight deployment / fixes that triggered other problems as these were made without considering impact on other elements of the solution (example = flagging auto-approval of events with EOI without consideration of other document requirements for same event).	High	Confusion on what coverage was in-force and engagement to sort out what to do with errors	Significant churn & challenges in the support and operational teams leading to time-consuming investigation & rework	Impact on KPIs and overall relationship
10	Production instability during firefight support process	Rapid solutioning of workarounds and firefight deployments & bulk processes to deal with issues led to some additional unanticipated consequences	Medium	Issues with participant website capabilities which triggered calls	Increased call and operational workload	Impact on KPIs and overall relationship

As we think through the performance improvement plan, a number of key areas which have led to our current state and which need to be addressed to future-proof the solution and working relationship need to be addressed. These are outside of the steps required to catch up and regain stability and trust in the solution and prevent against future recurrence of issues. Key elements of our partnership model that we need to review include:

Item	Detail
Project management	Project plans need to reflect critical path, clear documentation of project scope to ensure clarity and agreement on deliverables, and include buffers. Project governance model needs to ensure identification and management of stakeholder impacts and input through the process.
Issue management	Our approach is too single threaded due to embedded knowledge with one person (Vanessa), which contributes to email escalations and churn
Interface validation	Not being done consistently for all interfaces - PEBP finds the issues & Vanessa then needs to research vs. Morneau Shepell ensuring quality and consistency of delivery
Solution design	Need to assign and retain a Solution Architect to ensure the end-to-end solution holds up and to re-involve when key elements of the solution or requirements change
Impact matrix	Need a formal matrix to help all team members understand what is impacted / what could break when a change is needed in one area of the solution
Quality control process	Need a more structured approach to quality management - for ongoing platform delivery, incremental changes & for large-scale ones. Test execution plans including matrix, cases, tactical plan, testing scope, support model, etc. Any significant UAT efforts (e.g. for OE) should be supported by Morneau Shepell staff on-site at PEBP.
Requirements management & change control	Need to review and update requirements document artifacts and validate with current system configuration and ensure that any changes to these are documented consistently & passed through a formal change control process.

Environment management	Need to ensure that all changes are tested and approved in UAT before promotion to production, and that production deployments are properly scheduled and validated. Client has limited testing in UAT as there are differences between UAT and production that they can't always explain. At OE, PEBP was comfortable in UAT but elements were missed in some production deployments. Issue of lack of test accounts in production that needs to be addressed.

Performance Plan Goal

PEBP desires a fully-integrated member facing intuitive portal that will improve the member experience enrolling in both standard medical offerings and Board-approved voluntary benefits. PEBP also desires an upgraded client-side system where manual processes conducted by PEBP staff are replaced with less risky, thoroughly tested and validated, automated processes for eligibility and enrollment in program services. Morneau Shepell shall create a fully integrated benefits platform incorporating voluntary benefits where possible into a dynamic, intuitive industry leading member portal and will streamline to the extent possible based on PEBP rules and procedure requirements, all in-scope client-side operations through collaboration with PEBP supported employers as well as strategic and robust automation of internal PEBP processes.

This document provides the scope and high-level plan to deliver to the above vision. Any additions or modifications to the scope of the performance improvement plan will be subject to change control process to ensure we are actively managing project risks associated with change to the scope documented herein.

Our goal was to deliver to PEBP's satisfaction on all elements contained in this Performance Improvement Plan by April 1, 2020 and we have closed out all items. This includes both tactical fixes to the existing platform, along with improved approaches and methodologies to protect against recurrence of issues in our operational model and partnership. Morneau Shepell has delivered on the Performance Improvement Plan based on a set of metrics agreed to during our planning phase of this initiative and provided completion of the initiative to PEBP's Executive Officer by April 1, 2020, beyond factors within our control, we acknowledge that PEBP may choose to: 1) develop a decommissioning plan to replace the system and terminate the contract early with no remaining financial responsibility to PEBP; 2) renegotiate contract terms and collaborate with Morneau Shepell on additional solutions; or 3) accept the system as-is and honor the remaining time and financial consideration as approved in the current contract amendment.

Recent Progress

- ✓ Completed AR Portal production rollout successfully
- ✓ Closed 98% of internal service ticket backlog
- ✓ Closed 96.5% of service tickets reported by PEBP
- ✓ Stabilized production admin portal pertaining to member data caching, blank screens and server error messages
- ✓ Completed event processing rules configuration deliverable
- ✓ Completed project management and governance deliverable
- ✓ Completed requirements management deliverable
- ✓ Completed quality assurance deliverable
- ✓ Finalized VB decoupling transition plan
- ✓ Completed Non-Voluntary Life VB Decoupling

Key Performance Plan Items

Morneau Shepell has made significant progress on these items since we began this work in September. For the 10 Key Performance Plan items listed below:

- 9 were completed by the Target Resolution Date
- 1 is temporarily in a monitoring status (item #4)

We separate the performance improvement plan into two key areas – tactical (what we need to do to stabilize) and operational (what we need to do to future-proof our long-term relationship). Following are the recommended areas of focus for each:

Tactical areas of focus

	Issue	Proposed Actions	Success Measures	Start Date	Target Resolution Date	Status
1	Event processing rules configuration	• Review & revise documentation triggers to separate VB treatment from medical plan treatment	• Formal sign-off on rulesets & comprehensive testing to ensure accuracy	10/14/19	2/27/20	**Completed**
2	Event error & issue management	• Conduct structured audits to identify and support remediation of issues with event processing since April 15 (e.g. auto-approving events, EOI issues, etc.)	• Capture of all issues and impacted participants • Successful resolution of issues impacting participant accounts	10/7/19	12/4/19	**Monitoring** • All tickets meeting criteria have been addressed • Jointly agreed to change the status to monitoring; business as usual

	Issue	Proposed Actions	Success Measures	Start Date	Target Resolution Date	Status
3	Catch-up & management of other back-log issues	• Increase bench strength of issue research & support working team to reduce key person dependencies & increase throughput	• Increase speed and accuracy of requisite fixes	9/30/19	3/31/20	**Monitoring** Catch up is complete. Core items will be included several future core releases.
4	Optimize user experience for the participant portal	• Capture & address key areas of concern to simplify the user experience and optimize in terms of overall intuitiveness for the membership	• Reduced calls related to site navigation • Increased VB uptake	9/30/19	6/30/20*	**On Track** Since the start of the Performance Improvement Plan, calls have reduced, and enrollment continues to steadily increase with the same suite of VB offerings. Also, a batch of changes are going in for the April live date. *In order to measure the success of the VB transition, PEBP and MS have agreed to extend this deliverable until after the 2020 May open enrollment.
5	Complete the decommissioning of AX	• Evaluate de-coupling AX from HRIS interface initiative & complete the implementation & conversion process	• Elimination of reliance on AX • Sign-off on new solution after stabilization period	In Progress	11/4/19	**Completed** Rolled out to production on 4-Nov-2019 PEBP to confirm date of last batch of documents.
6	Complete the HRIS interface initiative	• Complete the implementation of the HRIS files from Workday and Central Payroll • Roll-out the administrator portal to	• Testing completed with successful pass of test cases	In Progress	3/31/20	**AR Portal – Completed** A few minimal items are being addressed post go-live

	Issue	Proposed Actions	Success Measures	Start Date	Target Resolution Date	Status
		enable on-line collection of hires, status changes, and data updates to other Pay Centers	• Interface code error free in production • Reduction in operational team work effort			**HRIS Interface – On Hold** Agreed to put project on hold as a result of the revised go-live date for the On-line HRIS
7	Formally market lifestyle VB products already in production	• Subject to Morneau Shepell and PEBP comfort that existing elections are working correctly, including payroll deductions, and are not causing unexpected issues for members and PEBP staff	• Formal marketing that Lifestyle products are available to PEBP members • Increased VB uptake	10/7/19	6/30/20*	**On Track** While elections and payroll deductions are now working directly, it was decided with PEBP to hold off on any lifestyle VB marketing until 2020 open enrollment. *In order to measure the success of this marketing, PEBP and MS have agreed to extend this deliverable until after the 2020 May open enrollment.

Partnership & operational support optimization

Morneau Shepell has made significant progress on these items since we began this work in September. For the 8 items listed below:

- 7 have been Completed
- 1 is in Monitoring status

	Issue	Proposed Actions	Success Measures	Start Date	Target Resolution Date	Status
1	Project management & governance	• Establish a formal governance structure (SC, working committee, reporting cadence) and project management approach for remediation project, key events (OE, upgrades, etc.) and ongoing	• PEBP approval of project governance model • Increased confidence in project outcomes	8/29/19	9/27/19	**Completed**
2	AV tickets and overall issues management	• Add resources to reduce key person dependencies & simplify triage model during catch-up phase • Introduce on-site support in triaging issues and working with PEBP on the performance plan • Improve turnaround on reviewing and triaging AV tickets & increase rigor in assigning and managing delivery to due dates	• Turnaround time for reported AV tickets • Capture of all requests via AV to ensure patterns are more easily recognized, root causes identified, and	9/30/19	N/A	**Monitoring** • Added resource to reduce key person dependencies • Introduce on-site support for triaging issues and working with PEBP on performance plan • Implemented plan to improve turnaround on reviewing and triaging AV tickets – under monitoring

	Issue	Proposed Actions	Success Measures	Start Date	Target Resolution Date	Status
			priorities managed effectively			
3	Interface management	• Formalize the support structure for interface management & reduce dependency on PEBP	• Reduction of missed interface delivery timeframes • Reduction of interface issues	10/7/19	12/16/19	**Completed**
4	Solution design & continuity	• Assign a Solution Architect to support PEBP, including any significant future initiatives	• Improved cohesiveness of overall solution • Reduction in unintended consequences when requirements change	9/16/19	10/11/19	**Completed**
5	Requirements management	• Review and update key requirements documents to ensure reflection of current state. Ensure future change requests are captured and change controlled	• PEBP sign-off on updated requirement artifacts	9/30/19	3/18/20	**Completed**

	Issue	Proposed Actions	Success Measures	Start Date	Target Resolution Date	Status
6	Change control	• Establish a formal change control process including impact identification (matrix), risk assessment, stakeholder impact, sign-offs / workflow, etc.	• Reduction in errors or differences in understanding when changes are made	9/3/19	10/8/19	**Completed**
7	Quality assurance	• Review and optimize the overall quality control process, including approach to test planning, test members, scenario management, and overall approach and accountabilities between Morneau Shepell and PEBP • Move to a more regimented schedule to batch fixes / releases vs. deploying to production on a piecemeal basis	• Reduced errors & issues related to product or configuration changes	9/30/19	2/3/20	**Completed**
8	Environment management	• Re-baseline UAT environment and develop overall approach to syncing between environments • Review deployment procedures & determine methods to ensure correct propagation between test and production environments	• Consistency between signed-off system and configuration in UAT vs. production	9/30/19	3/31/20	**Completed**

8.

8. Discussion and possible action of Contract Solicitation Report addressing solicitations necessary due to upcoming expiration of PEBP contracts, including:

    1) Benefits Management System
    2) Health Maintenance Organization (HMO)
    3) Dental PPO Network
    4) PPO/EPO Statewide Network
    5) Financial Auditor

(Laura Rich, Executive Officer) (**For Possible Action**)

STEVE SISOLAK
Governor

LAURA FREED
Board Chair

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CORE
Expires 04/01/2021

LAURA RICH
Executive Officer

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: May 28, 2020

Item Number: VIII

Title: Contract Solicitation Report

SUMMARY

This report is intended to provide information on current PEBP contracts expiring within the next year and to address future procurements that may be necessary as a result. The lengthy solicitation process and implementation time necessary requires terminating contracts to be addressed well in advance of the contract termination dates.

The general policy of the State of Nevada is to solicit a Request For Proposal (RFP) every 4 years; however, there is a mechanism to amend existing contracts to add money, time, and even change the scope if it benefits the state. Since most of these contracts have not been solicited in well over the 4 year recommended time frame, PEBP believes that an RFP is the best way to move forward with the contracts below to confirm the program adheres to the standard procurement guidelines and to ensure the program is leveraging the greatest pricing and services available in the marketplace.

Contract	Vendor	Expiration
Dental Network	Diversified Dental Services Inc.	6/30/2021
Southern Nevada HMO	Health Plan of Nevada Inc	6/30/2021
In-State PPO/EPO Network	Hometown Health Providers	6/30/2021
Financial Auditor	Casey, Neilon & Associates	12/31/2021
Benefits Management System	Morneau Shepell LTD	12/31/2021* 12/31/2023

*As a result of Morneau Shepell not meeting the deliverables outlined in the November 2018 contract amendment, PEBP is not obligated to honor the extension provided as part of the amendment.

REPORT

ENROLLMENT AND ELIGIBILITY BENEFITS MANAGEMENT SYSTEM

PEBP contracted with Morneau Shepell LTD for Eligibility and Enrollment Benefits Management Services initially on July 1, 2006. An RFP was completed in 2013 and Morneau Shepell LTD was selected again as the winning vendor. The current contract began January 1, 2015 and was originally set to expire December 31, 2021. In November of 2018, a contract extension through 2023 was approved, however it included various vendor requirements and the ability for PEBP to cancel the extension should Morneau Shepell not meet its obligations outlined in the contract. Morneau Shepell has publicly acknowledged that it failed to meet the identified benchmarks in the contract and as a result, has been required to present a performance improvement plan to the Board and that the Board would revisit the contract amendment after PY21 Open Enrollment to decide whether PEBP would cancel the amendment or honor the amendment through 2023.

Morneau Shepell has spent the last year making improvements to the system and implementing additional enhancements. Morneau Shepell successfully helped PEBP eliminate a very manual paper process by implementing an Agency Rep portal allowing agency representatives to report employee changes in real time. They have also made various changes to the eligibility and enrollment system to address many of the defects that plagued PEBP during the initial rollout. Although staff continue to discover problems as a result of system errors, the frequency of these occurrences appear to have decreased. As of the date this report was written, the upgrades and system fixes appeared to be working as anticipated and no major problems have been reported by members throughout this open enrollment period.

Despite this, PEBP believes it is in the best interest of the program to cancel the amendment (extension) and proceed with a solicitation. This contract has been in place since 2013, which is well beyond the four year recommendation. Moreover, PEBP could be potentially setting bad precedent by honoring a contract amendment where the terms of the agreement were clearly not met by the vendor.

At the January 2020 Board meeting, PEBP recommended and the Board approved proceeding with a Request For Information (RFI) for a replacement Eligibility and Enrollment System in order to obtain pertinent information to include as part of the upcoming budget building process. PEBP received 8 responses which included estimated pricing based on the criteria outlined in the RFI. The estimated pricing for all proposals included higher per member per month (PMPM) fees than what PEBP is paying today but many of the responses also addressed that ability to develop alternative and creative solutions which could drive down the PMPM fees or reduce implementation costs.

A draft overview and scope of work for this RFP is available in Attachment A for board review and input.

PEBP Recommendation: Cancel the contract amendment dated 11/13/2018 and proceed with a Request for Proposal.

IN-STATE PPO/EPO NETWORK

PEBP contracted with Hometown Health (HTH) for In-State PPO/EPO Network services initially on July 1, 2010 and was again selected again as the winning vendor in 2013. The current contract began July 1, 2014, was extended in 2017 and is set to expire June 30, 2021. Although the contract is between PEBP and HTH, the RFP submission included a joint proposal from HTH and Sierra Health-Care Options (SHO). The partnership between HTH and SHO creates a comprehensive statewide network that allows PEBP to maximize provider contract savings throughout the state rather than having to maintain separate contracts for a northern network and southern network.

Although there are vendors with the ability to offer statewide networks, it is important to recognize there are potential vendors, both in the north and the south, that are limited geographically and are only able to offer regional provider networks. While a single statewide network is administratively less burdensome on PEBP to maintain, limiting the RFP solely to a statewide option will likely limit the pool of potential vendors and reduce the competition.

As PEBP moves forward with a solicitation, the following options have been identified:

- Option 1: Create a solicitation requesting proposals for a statewide PPO/EPO network. This option requires respondents to provide PPO/EPO network services for coverage throughout the state.
- Option 2: Create a solicitation requesting proposals by region (North and South). This option requires respondents to provide PPO/EPO network services based on region and may result in two separate contracts with two separate providers.
- Option 3: Create an open-ended solicitation that allows respondents to submit either a statewide proposal or a region-specific proposal. This potentially increases the number of proposals and access/cost options PEBP may consider and could result in the award of one statewide contract or two separate regional contracts for PPO/EPO network services.

A draft overview and scope of work for this RFP is available in Attachment B for board review and input.

PEBP Recommendation: Approve PEBP staff to proceed with a Request For Proposal for PPO/EPO Network Services using Option 3.

SOUTHERN NEVADA HEALTH MAINTENANCE ORGANIZATION (HMO)

PEBP's Southern Nevada HMO contract offered by Health Plan of Nevada (HPN) initially began July 1, 2012. An RFP was completed in 2016 and HPN was selected again as the winning vendor. The current contract began July 1, 2017 and is set to expire June 30, 2021.

In Plan Year 2018, PEBP opted to eliminate the Northern HMO and replace it with a more cost-effective EPO option, but chose to maintain the low-cost Southern Nevada HMO. The long-standing Board policy currently "blends" the higher priced Northern Nevada market costs with

the lower priced Southern Nevada market costs which creates artificially high premiums for the Southern HMO. This has caused a steady migration away from the HMO plan and is producing a problem that will eventually, if not immediately, need to be addressed.

As PEBP works with our partners to develop potential solutions, it is critical that we simultaneously move forward with an RFP to ensure PEBP is able to meet the solicitation and implementation timelines necessary should PEBP choose to continue to offer this product.

A draft overview and scope of work for this RFP is available in Attachment C for board review and input.

PEBP Recommendation: Approve PEBP staff to proceed with a Request For Proposal for a Southern Nevada Health Maintenance Organization Provider.

DENTAL NETWORK

PEBP contracted with Diversified Dental for the Dental Network services initially on July 1, 2005. An RFP was completed in 2008 and again in 2013 and Diversified Dental was selected again as the winning vendor in both of those solicitations. The current contract began July 1, 2013 and is set to expire June 30, 2021.

A draft overview and scope of work for this RFP is available in Attachment D for board review and input.

PEBP Recommendation: Approve PEBP staff to proceed with a Request For Proposal for a Dental Network Provider.

FINANCIAL AUDITOR

PEBP contracted with Casey Neilon for the Financial Auditing services which initially began January 1, 2010. An RFP was completed in 2015 and Casey Neilon was selected again as the winning vendor. The current contract began March 8, 2016 and is set to expire December 31, 2021.

A draft overview and scope of work for this RFP is available in Attachment E for board review and input.

PEBP Recommendation: Approve PEBP staff to proceed with a Request For Proposal for a Financial Auditor.

Attachment A – Enrollment and Eligibility Software Benefits System

OVERVIEW OF PROJECT

The State of Nevada, Purchasing Division, on behalf of the Public Employees' Benefits Program (PEBP), headquartered in Carson City, Nevada, is soliciting proposals for an Eligibility and Enrollment Software Benefits System vendor.

PEBP is seeking a vendor with the capability of providing a system that is web enabled and has an open architecture and is designed for easy migration to new technologies. The system must have the capability of billing premiums to multiple employers and pay centers and/or generating direct bills to participants and to administer all accounts receivable and payable. For information regarding the current benefits offered, please refer to the Master Plan Documents on PEBP's website.
https://pebp.state.nv.us/plans/plan-documents/

The successful vendor must provide PEBP with system access and interfaces as specified in this RFP. PEBP staff is responsible for performing all eligibility determinations and enrollment services by way of data entry in the Eligibility and Enrollment system. Similarly, PEBP staff is responsible for managing all accounts receivable and payable. The Eligibility and Enrollment system vendor is required to support these responsibilities by providing system access.

The effective and termination dates for the contract, pursuant to this RFP, are tentative and subject to change. The effective date will be determined, in part, by vendor implementation proposals and is anticipated to be July 1, 2021. The termination date will be determined based upon analysis of the financial proposals, as deemed to be in the State's best interest; the State is considering five to seven-year contract terms. PEBP reserves the right to renegotiate price terms as market conditions warrant.

If a new vendor is awarded this contract, PEBP expects that both the awarded vendor and incumbent vendor will work together during a six-month conversion period, July 1, 2021 through December 31, 2021. PEBP does not propose to run parallel systems but rather, this schedule is intended to ensure a smooth transition with minimal impact to PEBP's current vendors who rely on PEBP's eligibility information to process claims (e.g. third-party administrator, HMO's, and pharmacy benefits manager).

SCOPE OF WORK

The Public Employees' Benefits Program (PEBP) oversees the administration of the health insurance programs offered to eligible individuals. Eligible individuals include full-time 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. Retirees who are eligible for premium free Medicare Part A and Medicare Part B and are transitioned to an Individual Medicare Exchange. Benefits under PEBP are extended to retirees who are not Medicare age or who are not eligible for premium free Medicare Part A and their surviving spouses/ domestic partners and/or eligible dependent children.

PEBP is committed to providing the highest quality health benefits with an emphasis on customer service, preventive and wellness benefits, utilization management and promoting informed health care utilization while preserving individual choices and options. PEBP is soliciting proposals from vendors who will work in partnership with PEBP, provide exemplary services and make the desires and goals of this agency a priority.

PEBP requests information on a system solution that is capable of administering all plan eligibility and billing requirements for active employee, retiree, and COBRA participants. The goal of the system provider is to:

- Provide an intuitive and comprehensive member interface affording a positive enrollment experience.
- Provide a sophisticated eligibility rules engine with automated solutions that increase efficiency in the administration of the plan.
- Provide work management tools as well as billing and accounting functionality to properly assess employer and employee premium billing.

Vendors are encouraged to submit creative solutions regarding system integrations to complement PEBP and state of Nevada's current budget constraints.

PROPOSED TIMELINE

TASK	DATE/TIME
Release Date	June 2020
Submission Deadline	August 2020
Evaluation Period	September 2020
Contract Negotiations	November 2021
PEBP Board Ratification of Contract	January 2021
Anticipated BOE Approval	February 2021
Contract Start Date (contingent upon BOE approval)	July 2021

Attachment B – Statewide PPO Medical Network

OVERVIEW OF PROJECT

The State of Nevada, Purchasing Division, on behalf of the Public Employees' Benefits Program (PEBP), headquartered in Carson City, Nevada, is soliciting proposals for medical preferred provider organization (PPO) network(s) within the State of Nevada.

The proposals may include one Nevada statewide vendor or separate vendor proposals covering specific Nevada geographical areas or a joint venture between multiple Network vendors. PEBP currently contracts with Hometown Health Plan. Dental benefits are offered through PEBP's self-funded PPO dental plan. For information regarding the current benefits offered, please refer to the Master Plan Documents on PEBP's website.
https://pebp.state.nv.us/plans/plan-documents/

The effective date of the contract resulting from this RFP will most likely be July 1, 2021; however, PEBP reserves the right to initiate service at an earlier date dependent upon proposal responses. The length of the contract is anticipated be six (6) years. The contract termination date, pursuant to this RFP, will be June 30, 2027. PEBP reserves the right to renegotiate price terms as market conditions warrant.

SCOPE OF WORK

The Public Employees' Benefits Program (PEBP) oversees the administration of the health insurance programs offered to eligible individuals. Eligible individuals include full-time 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. Retirees who are eligible for premium free Medicare Part A and Medicare Part B and are transitioned to an Individual Medicare Exchange and are not a part of this RFP. Benefits under PEBP are extended to retirees who are not Medicare age or who are not eligible for premium free Medicare Part A and their surviving spouses/ domestic partners and/or eligible dependent children.

PEBP is committed to providing the highest quality health benefits with an emphasis on customer service, preventive and wellness benefits, utilization management and promoting informed health care utilization while preserving individual choices and options. PEBP is soliciting proposals from vendors who will work in partnership with PEBP, provide exemplary services and make the desires and goals of this agency a priority.

For the purposes of this RFP, PEBP requires Network participants to have access to a comprehensive choice of providers within the covered service area as well as outside of Nevada for emergency and specialized care. The Network should include a full complement of reputable, qualified professionals, specialists, and include centers of excellence. All plans shall include, but not be limited to, the following services and plan provisions:

- Customer Service
- Utilization review

- Concurrent review
- Disease management
- Large case management
- Wellness and preventive services benefits
- Vision benefits
- Behavioral Health benefits
- Mandated ACA health benefits

PEBP does not require vendors to duplicate the current Statewide Network benefits. Vendors are encouraged to submit creative solutions to complement to PEBP and state of Nevada's current budget constraints.

Vendors are encouraged to submit creative solutions regarding system integrations to complement PEBP and state of Nevada's current budget constraints.

PROPOSED TIMELINE

TASK	DATE/TIME
Release Date	July 2020
Submission Deadline	December 2020
Evaluation Period	January 2021
Contract Negotiations	January 2021
PEBP Board Ratification of Contract	January 2021
Anticipated BOE Approval	February 2021
Contract Start Date (contingent upon BOE approval)	July 2021

Attachment C – Southern Nevada Health Maintenance Organization (HMO)

OVERVIEW OF PROJECT

The State of Nevada, Purchasing Division, on behalf of the Public Employees' Benefits Program (PEBP), headquartered in Carson City, Nevada, is soliciting proposals for fully insured Health Maintenance Organization (HMO) services. PEBP's preference is to be able to contract for HMO services on at least a statewide (Nevada) basis.

The proposals may include one Nevada statewide vendor or separate vendor proposals covering specific Nevada geographical areas or a joint venture between multiple HMO vendors. PEBP currently contracts with Health Plan of Nevada in southern Nevada and offers a self-funded Exclusive Provider Organization plan in Northern Nevada to mirror the HMO benefits. Dental benefits are offered through PEBP's self-funded PPO dental plan. For information regarding the current benefits offered, please refer to the Master Plan Documents on PEBP's website. https://pebp.state.nv.us/plans/plan-documents/

The effective date of the contract resulting from this RFP will most likely be July 1, 2021; however, PEBP reserves the right to initiate service at an earlier date dependent upon proposal responses. The length of the contract will be four (4) years. The contract termination date, pursuant to this RFP, will be June 30, 2025. PEBP reserves the right to renegotiate price terms as market conditions warrant.

SCOPE OF WORK

The Public Employees' Benefits Program (PEBP) oversees the administration of the health insurance programs offered to eligible individuals. Eligible individuals include full-time 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. Retirees who are eligible for premium free Medicare Part A and Medicare Part B and are transitioned to an Individual Medicare Exchange and are not a part of this RFP. Benefits under PEBP are extended to retirees who are not Medicare age or who are not eligible for premium free Medicare Part A and their surviving spouses/ domestic partners and/or eligible dependent children.

PEBP is committed to providing the highest quality health benefits with an emphasis on customer service, preventive and wellness benefits, utilization management and promoting informed health care utilization while preserving individual choices and options. PEBP is soliciting proposals from vendors who will work in partnership with PEBP, provide exemplary services and make the desires and goals of this agency a priority.

For the purposes of this RFP, PEBP requires HMO participants to have access to a comprehensive choice of providers within the covered service area as well as outside of Nevada for emergency and specialized care. The plan(s) should include a full complement of reputable, qualified professionals, a variety of specialists and include centers of excellence. All plans shall include, but not be limited to, the following services and plan provisions:

- Customer Service
- Utilization review
- Concurrent review
- Disease management
- Large case management
- Wellness and preventive services benefits
- Vision benefits
- Behavioral Health benefits
- Mandated ACA health benefits

PEBP does not require vendors to duplicate the current HMO benefits. Vendors are encouraged to submit creative solutions regarding plan design to complement to PEBP and state of Nevada's current budget constraints.

PROPOSED TIMELINE

TASK	DATE/TIME
Release Date	September 2020
Submission Deadline	February 2021
Evaluation Period	February 2021
Contract Negotiations	March 2021
PEBP Board Ratification of Contract	March 2021
Anticipated BOE Approval	April 2021
Contract Start Date (contingent upon BOE approval)	July 2021

Attachment D – Dental Preferred Provider Network

OVERVIEW OF PROJECT

The State of Nevada, Purchasing Division, on behalf of the Public Employees' Benefits Program (PEBP), headquartered in Carson City, Nevada, is soliciting proposals from Dental Preferred Provider Network Organizations to provide access to dental care providers and professional services.

The proposals may include one Nevada statewide vendor or separate vendor proposals covering specific Nevada geographical areas or a joint venture between multiple Dental Network vendors. PEBP currently contracts with Diversified Dental. For information regarding the current benefits offered, please refer to the Master Plan Documents on PEBP's website.
https://pebp.state.nv.us/plans/plan-documents/

The effective date of the contract resulting from this RFP will most likely be July 1, 2021; 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, 2026. PEBP reserves the right to renegotiate price terms as market conditions warrant.

SCOPE OF WORK

The Public Employees' Benefits Program (PEBP) oversees the administration of the health insurance programs offered to eligible individuals. Eligible individuals include full-time 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. Retirees who are eligible for premium free Medicare Part A and Medicare Part B and are transitioned to an Individual Medicare Exchange and are offered dental as a voluntary benefit. Benefits under PEBP are extended to retirees who are not Medicare age or who are not eligible for premium free Medicare Part A and their surviving spouses/ domestic partners and/or eligible dependent children.

PEBP is committed to providing the highest quality health benefits with an emphasis on customer service, preventive and wellness benefits, utilization management and promoting informed health care utilization while preserving individual choices and options. PEBP is soliciting proposals from vendors who will work in partnership with PEBP, provide exemplary services and make the desires and goals of this agency a priority.

For the purposes of this RFP, PEBP requires participants to have access to a comprehensive choice of licensed dental care providers in Nevada and a national dental network outside of Nevada. The network should include a full complement of licensed dental care professionals, including general dentistry, periodontists, and other specialists. All plans include the following dental benefits:

- Preventive services
- Basic dental services
- Major dental services
-

PEBP does not require vendors to duplicate the current Dental Network benefits. Vendors are encouraged to submit creative solutions regarding plan design to complement to PEBP and state of Nevada's current budget constraints.

PROPOSED TIMELINE

TASK	DATE/TIME
Release Date	September 2020
Submission Deadline	February 2021
Evaluation Period	February 2021
Contract Negotiations	March 2021
PEBP Board Ratification of Contract	March 2021
Anticipated BOE Approval	April 2021
Contract Start Date (contingent upon BOE approval)	July 2021

Attachment E – Financial Auditor

OVERVIEW OF PROJECT

The State of Nevada, Purchasing Division, on behalf of the Public Employees' Benefits Program (PEBP), headquartered in Carson City, Nevada, is soliciting proposals from Independent Certified Public Accountants for the financial audit of PEBP's two trust funds, the Self Insurance Trust Fund and the State Retiree's Health and Welfare Benefits Trust Fund.

Proposals will only be accepted from firms licensed in the State of Nevada to perform certified financial audits. Proposing vendors are required to submit with their proposals copies of appropriate licensing and/or certification. The successful vendor must be familiar with all relevant Governmental Accounting Standards Board (GASB) Pronouncements and any other applicable rules, regulations, accounting, or governmental audit standards covering financial, as well as compliance audits for self-insured group benefits programs for a governmental entity.

The effective date of the contract resulting from this RFP will most likely be January 1, 2022; however, PEBP reserves the right to initiate service at an earlier date dependent upon proposal responses. The length of the contract will be four (4) years. The contract termination date, pursuant to this RFP, will be December 31, 2026. PEBP reserves the right to renegotiate price terms as market conditions warrant.

SCOPE OF WORK

The Public Employees' Benefits Program (PEBP) oversees the administration of the health insurance programs offered to eligible individuals. Eligible individuals include full-time 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. Retirees who are eligible for premium free Medicare Part A and Medicare Part B and are transitioned to an Individual Medicare Exchange and are not a part of this RFP. Benefits under PEBP are extended to retirees who are not Medicare age or who are not eligible for premium free Medicare Part A and their surviving spouses/ domestic partners and/or eligible dependent children.

PEBP is committed to providing the highest quality health benefits with an emphasis on customer service, preventive and wellness benefits, utilization management and promoting informed health care utilization while preserving individual choices and options. PEBP is soliciting proposals from vendors who will work in partnership with PEBP, provide exemplary services and make the desires and goals of this agency a priority.

The Self-Insurance Trust Fund of the State of Nevada and the State Retirees' Health and Welfare Benefits Fund maintain accounting records on the accrual basis of accounting, as defined by the Governmental Accounting Standards Board (GASB). No federal funding is involved, other than a prescription drug subsidy provided by the Centers for Medicare and Medicaid Services for Medicare D eligible members. The State is requesting audits of financial statements of the Self Insurance Trust Fund, from which group health benefits are administered, and the State Retirees'

Health and Welfare Benefit Fund, which accounts for the money set aside to fund retiree healthcare benefits for the fiscal years ending June 30, 2021, and forward.

The scope shall include examination of financial statements in accordance with generally accepted governmental auditing standards covering financial and compliance audits, as included in Statements on Auditing Standards published by the American Institute of Certified Public Accountants; all relevant Governmental Accounting Standards Board Pronouncements; and any other applicable rules, regulations, accounting, or government auditing standards for group benefits self-insurance for a governmental entity. It shall also include examination of PEBP's compliance with pertinent laws, regulations, PEBP policies, procedures, and contracts. Reference should be made to Nevada Revised Statutes as they apply in determining the scope of the audit. PEBP's intent is to engage the selected Auditor by June 1, 2016. Final reports shall be delivered to PEBP no later than September 30th after the end of each fiscal year. State of Nevada fiscal year is from July 1 through June 30.

Vendors are encouraged to submit creative solutions regarding plan design to complement to PEBP and state of Nevada's current budget constraints.

PROPOSED TIMELINE

TASK	DATE/TIME
Release Date	March 2021
Submission Deadline	July 2021
Evaluation Period	July 2021
Contract Negotiations	August 2021
PEBP Board Ratification of Contract	August 2021
Anticipated BOE Approval	September 2021
Contract Start Date (contingent upon BOE approval)	December 2021

9.

9. Discussion and possible action of contract amendments to Aon Hewitt and HealthSCOPE Benefits contracts (Cari Eaton, Chief Financial Officer)(**For Possible Action**)

STEVE SISOLAK
Governor

LAURA FREED
Board Chair

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
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Telephone 775-684-7000 | 1-800-326-5496 | Fax 775-684-7028
www.pebp.state.nv.us

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CORE
Expires 04/01/2021

LAURA RICH
Executive Officer

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: May 28, 2020

Item Number: IX

Title: Contract Amendment Report

SUMMARY

This report requests the Board authorize staff to complete a contract amendment between PEBP and AON Consulting; and a contract amendment between PEBP and Healthscope Benefits for Third Party Administration (TPA) services to amend the fee schedule through the contract term.

REPORT

AON CONSULTING

PEBP contracted with AON Consulting (AON) for Actuarial and General Consulting Services which began July 1, 2016. This will be the third amendment to the contract that is due to expire on June 30, 2022. This amendment revises the fee schedule to align with actual previous expenditures and remove specific grouping to allow flexibility in the utilization of the contract authority available for the remainder on the contract term.

HEALTHSCOPE BENEFITS THIRD PARTY ADMINISTRATION

PEBP contracted with Healthscope Benefits (Healthscope) for Third Party Administration Services which began July 1, 2016. This will be the sixth amendment to the contract that is due to expire on June 30, 2022. This amendment adds Physician Medical Reviews to the fee schedule to allow PEBP to accurately pay for Medical Reviews completed by Physicians.

RECOMMENDATION

PEBP recommends the Board authorize staff to complete a contract amendment for AON Consulting and Healthscope Benefits TPA contracts to amend the fee schedules.

10.

10. Health Claim Auditors, Inc. quarterly audit of HealthSCOPE Benefits for the timeframe January 1, 2020 – March 31, 2020: (1) Report from Health Claim Auditors; (2) HealthSCOPE Benefits response to audit report; and (3) for possible action to accept audit report findings and assess penalties, if applicable, in accordance with the performance guarantees included in the contract pursuant to the recommendation of Health Claim Auditors (Robert Carr, Health Claim Auditors) (**For Possible Action**)

Claims and System Audit Report

for

Nevada PUBLIC EMPLOYEES' BENEFITS PROGRAM

PEBP

Health Matters.

Audit Period: PEBP Plan Year 2020, Quarter Three
January, February and March 2020

Audited Vendor:

HealthSCOPE BENEFITS

Healthy People
Healthy Business
Healthy Futures

Submitted By:
Health Claim Auditors, Inc.
May 2020

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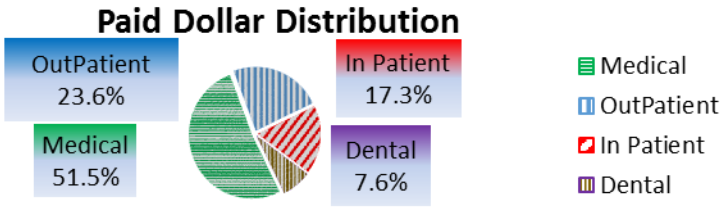
The following categories are reviewed each quarterly audit, however, because of their constant properties, the detail of each category will only be displayed within the first quarter audit of the PEBP fiscal year unless a change or defect is detected:

*HSB System	*HSB Policy/Procedure
*Eligibility	*Deductibles, Benefit Maximums
*Unbundling/Rebundling	*Concurrent Care
*Code Creeping	*Procedure, Diagnosis, Place of Service
*Experimental/Cosmetic Proc	*Medical Necessity Guidelines
*Patterns of Care	*Mandatory Outpatient/Inpatient Procedures
*Duplicate Claim Edits	*Adjusted Claims
*Hospital Discounts	*Hospital Bills and Audits
*Filing Limitation	*Unprocessed Claim Procedures
*R&C/Maximum Allowance	*Membership Procedures
*COBRA	*Provider Credentialing
*Coordination of Benefits	*Medicare
*Controlling Possible Fraud	*Security Access
*Quality Control/Internal Audit	*Internet Capabilities
*Communication, U/R and Claims Depts.	
*Claim Repricing	*Banking and Cash Flow
*Reporting Capabilities	*General System

EXECUTIVE SUMMARY

Audited Random Selection Data

Total number of claims: 500
Total Charge Value of random selection: $ 895,979.46
Total Paid Value of random selection: $ 271,303.34



Performance Guaranteed Metric Results

Metric	Guarantee Measurement	Actual	Pass/Fail
Payment Accuracy	≥ 98% of claims audited are to be paid accurately	98.2%	Pass
Financial Accuracy	≥ 99% of the dollars paid for the audited claims is to be paid accurately	99.7%	Pass
Claim Processing Turnaround Time	- 99% of all claims are to be processed within 30 days.	99.16%	Pass
Customer Service	-Telephone Response Time: ≤ 30 seconds. -Telephone Abandonment Rate: ≤ 2%. -First Call Resolution: ≥ 95%	21 sec. 1.6% 96.25%	Pass Pass Pass
Data Reporting	-100% of standard reports w/in 10 bus. days -Annual/Regulatory Documents w/in 10 business days of Plan Year end	No Exceptions Noted	Pass
Disclosure of Subcontractors	-Report access of PEBP data within 30 c. days -Removal of PEBP member PHI within 3 business days after knowledge	No Exceptions Noted	Pass

The following notations within the Executive Summary section are reported as follow up to previous findings and/or issues considered as an "outlier" of findings typically detected within the PEBP quarterly audits which require attention and/or acknowledgement for possible action(s).

Previous Recommendation(s)

HCA is pleased to report that all previous recommendations accepted by the PEBP Board of Directors has been implemented and/or in the process of application.

Trends/Issues

The audit revealed the following issues or trends detected from the random selection and bias selected claims. Please note: the reference numbers in **bold type** are claims from the random selection and are included within the statistical calculations. Reference numbers in normal type were identified as issues in bias claims as defined earlier and are not included within the statistical calculations of this audit. Specific information regarding supporting reference numbers can be found in the Audit Results Section in numerical sequence, which begins on page 14.

Incorrect allowable applied;
Supporting reference nos. 066, 104, 200, **295, 350** and 409

Incorrect rate due to network re-pricing;
Supporting reference nos. 167, 507, 510 and 513

Preventive claim/service paid as medical;
Supporting reference nos. 059 and **092**

Claim not reprocessed after requested information received;
Supporting reference nos. 196 and 272

Copay not applied; Supporting reference no. **050**

Medical claim/service paid as preventive; Supporting reference no. **112**

Claim paid after timely filing limitation; Supporting reference no. **122**

Incorrect copay applied; Supporting reference no. **123**

Claim missed when repricing returned; Supporting reference no. 203

Claim adjusted in error; Supporting reference no. 244

Duplicate paid; Supporting reference no. **246**

Incorrect benefit paid for provider; Supporting reference no. **418**

Charge/service paid in error; Supporting reference no. 422

The audit revealed the following issues, which appear to be administered properly by HSB but should be brought to client attention for proper notification or verification. Specific information regarding supporting reference numbers can be found in the Audit Results Section in numerical sequence, which begins on page 14.

System display issue causing incorrect fee schedule amounts to show in processing; Supporting reference nos. 075 and 250

VA claims no longer utilizing UCS pricing effective 01 October 2019:
Supporting reference no. 087

CLAIM PROCEDURES/SYSTEM CAPABILITIES/SUPPORT DATA

Introduction

In April 2020, Health Claim Auditors, Inc. (HCA) performed a Claims and System Audit of HealthSCOPE Benefits (HealthSCOPE) on behalf of The State of Nevada Public Employees' Benefits Program (PEBP).

This audit was performed by collecting information to assure that HealthSCOPE is doing an effective job of controlling claim costs while paying claims accurately within a reasonable period of time. This report was presented to HealthSCOPE for any additional comments and responses on 30 April 2020.

Breakdown of Claims Audited

The individual claims audited were randomly selected from PEBP's claims listings as supplied by HealthSCOPE. These claims had dates of service ranging from January 2019 to March 2020 and were processed by HealthSCOPE from 01 January 2020 through 31 March 2020 (PEBP's Third Quarter Plan Year 2020). These claims were stratified by dollar volume to assure that HCA audited all types of claims. The audit also includes large dollar paid amounts that are considered as bias* selected claims.

*Bias claims are not part of the random selection but were audited by HCA because of some "out of the ordinary" characteristic of the claim. There are multiple criteria to identify the "out of the ordinary" characteristics. Examples are duplicates, CPT up coding, exceeding benefit limits, etc.

The breakdown of the 500 random selected claims audited is as follows:

Type of Service	Charge Amount	Paid Amount	Paid Distribution	No. of Claims
Medical	$ 376,613.48	$ 139,706.94	51.5%	368
Outpt. Hospital	$ 317,294.40	$ 64,054.03	23.6%	43
Inpt. Hospital	$ 166,791.26	$ 46,802.79	17.3%	3
Dental	$ 35,280.32	$ 20,739.58	7.6%	86
TOTAL	**$ 895,979.46**	**$ 271,303.34**	**100%**	**500**

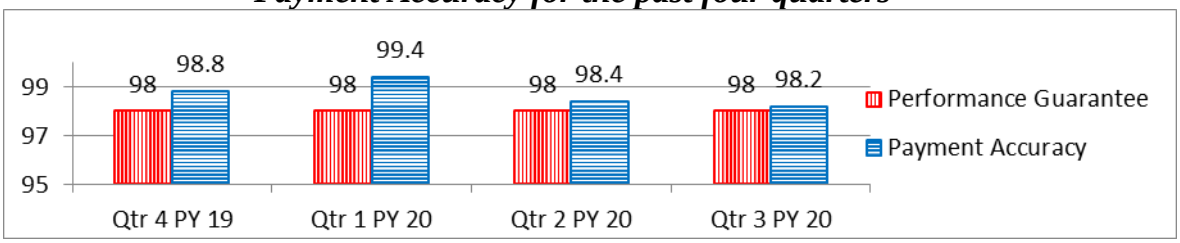
Payment Accuracy

Per PEBP, the Service Performance Standards and Financial Guarantees Agreement for the payment accuracy is to be 98% or above of claims adjudicated are to be paid correctly or a penalty of 2.5% of Quarterly Administration Fees for each percentage (%) point, or fraction thereof, below performance guarantee is to be applied. Payment Accuracy is calculated by dividing the total number of claims not containing payment errors in the audit period by the number of claims audited within the random selection.

The Payment Accuracy Percentage of the number of claims paid correctly from the HealthSCOPE random selection for this audited quarter is 98.2%.

Number of claims:	500
Number of claims paid incorrectly:	9
Percentage of claims paid incorrectly:	1.8%
Number of claims paid correctly:	491
Percentage of claims paid correctly:	98.2%

Payment Accuracy for the past four quarters



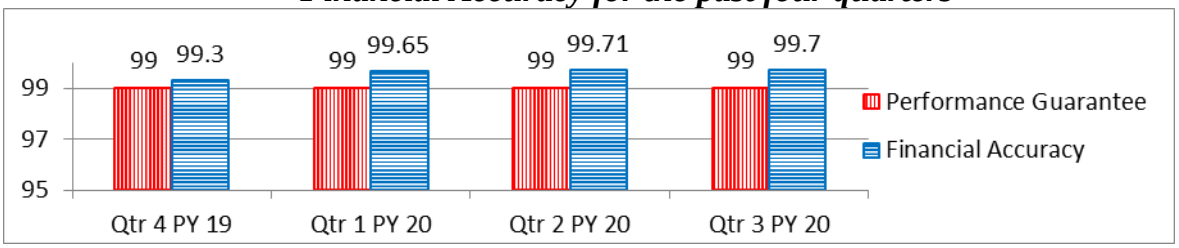
Financial Accuracy

Per PEBP, the Service Performance Standards and Financial Guarantees Agreement for the financial accuracy of the total dollars paid for claims adjudicated is to be paid correctly at 99% or above or a penalty of 2.5% of Quarterly Administration Fees for each percentage (%) point, or fraction thereof, below performance guarantee is to be applied. Financial Accuracy is calculated by dividing the total audited dollars paid correctly by the total audited dollars processed within the random selection.

The Financial Accuracy Percentage of paid dollars remitted correctly on the HealthSCOPE claims selected randomly for this audited quarter is 99.7%. This audit reflected fifty-six and six tenths percent (56.6%) of the audited errors within the valid random selection were overpayments.

Paid dollars audited	$ 271,303.34
Amount of paid dollars remitted incorrectly	$ 722.18
Percentage of Dollars paid incorrectly	0.3%
Paid Dollars of claims paid correctly	$ 270,581.16
Percentage of Dollars Paid correctly	99.7%

Financial Accuracy for the past four quarters



Historical Statistical Data of Performance Guarantees

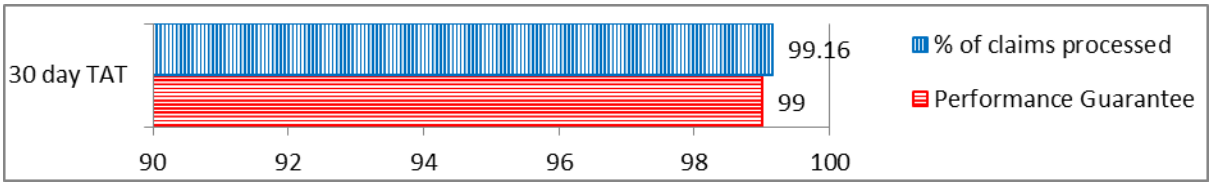
The following reflects the historical statistical data since the origin of PEBP medical claims administration by HealthSCOPE. The entries designated in **bold red type** are measurable categories with underperformance of the Service Performance Guarantees.

Period Audited	Payment Accuracy	Financial Accuracy	Turnaround Time	Telephone Response	Telephone Abandon Rate	First Call Resolution
1st Qtr PY 2012	95.7%	98.6%	7.6 days	:17	1.43%	N/A
2nd Qtr PY 2012	**93.3%**	**97.3%**	12.7 days	:12	1.16%	N/A
3rd Qtr PY 2012	**96.8%**	**98.6%**	3.7 days	:18	1.32%	N/A
4th Qtr PY 2012	**95.8%**	99.5%	11.4 days	:14	0.93%	N/A
1st Qtr PY 2013	97.2%	99.4%	10.4 days	:20	1.06%	N/A
2nd Qtr PY 2013	98.5%	99.3%	7.3 days	:11	0.87%	N/A
3rd Qtr PY 2013	98.0%	**95.7%**	6.4 days	:25	1.98%	N/A
4th Qtr PY 2013	98.4%	99.7%	6.2 days	:29	1.61%	N/A
1st Qtr PY 2014	98.8%	99.6%	5.4 days	:14	0.84%	N/A
2nd Qtr PY 2014	99.2%	99.2%	5.9 days	:29	1.96%	N/A
3rd Qtr PY 2014	98.0%	**98.5%**	5.2 days	**:30.5**	1.92%	N/A
4th Qtr PY 2014	99.0%	99.8%	4.4 days	:28	1.96%	N/A
1st Qtr PY 2015	98.8%	99.27%	4.9 days	:29.4	1.94%	N/A
2nd Qtr PY 2015	99.0%	99.35%	8.1 days	:22	1.18%	N/A
3rd Qtr PY 2015	98.6%	99.8%	5.9 days	:29.7	1.97%	N/A
4th Qtr PY 2015	99.6%	**95.6%**	4.9 days	:29.4	1.91%	N/A
1st Qtr PY 2016	99.0%	**98.9%**	4.8 days	:29.1	1.94%	N/A
2nd Qtr PY 2016	98.6%	99.7%	3.5 days	:24.0	1.14%	N/A
3rd Qtr PY 2016	98.8%	**98.53%**	5.3 days	:29.0	1.96%	N/A
4th Qtr PY 2016	99.0%	99.52%	6.3 days	:29.5	1.98%	N/A
1st Qtr PY 2017	99.0%	99.23%	6.6 days	:29.8	1.93%	N/A
2nd Qtr PY 2017	99.6%	99.78%	4.3 days	:29.3	1.96%	N/A
3rd Qtr PY 2017	98.2%	**93.83%**	3.7 days	:29.8	1.97%	N/A
4th Qtr PY 2017	99.0%	99.66%	4.6 days	:29.3	1.98%	N/A
1st Qtr PY 2018	99.2%	99.83%	4.4 days	:26.0	1.61%	98.79%
2nd Qtr PY 2018	99.6%	99.9%	4.3 days	:12.8	1.12%	98.28%
3rd Qtr PY 2018	98.6%	99.7%	3.5 days	:28.5	1.97%	98.65%
4th Qtr PY 2018	99.4%	99.5%	4.2 days	:21.0	1.50%	97.65%
1st Qtr PY 2019	98.8%	**98.2%**	5.4 days	:21.0	1.49%	97.85%
2nd Qtr PY 2019	99.6%	99.9%	5.6 days	:21.0	1.40%	97.18%
3rd Qtr PY 2019	98.4%	**98.31%**	5.8 days	:14.0	1.21%	95.89%
4th Qtr PY 2019	98.8%	99.30%	6.7 days	:14.0	1.09%	96.38%
1st Qtr PY 2020	99.4%	99.65%	7.1 days	:20.0	1.66%	95.03%
2nd Qtr PY 2020	98.4%	99.71%	5.0 days	:17.0	1.44%	95.89%
3rd Qtr PY 2020	**98.2%**	**99.7%**	**4.1 days**	**:21.0**	**1.60%**	**96.25%**

Turnaround Time

Per the Service Performance Standards and Financial Guarantees Agreement, the turnaround time for payments of claims is measured in calendar days from the date HealthSCOPE receives the claim until the date of process. Ninety nine percent (99%) of complete claims adjudicated are to be processed within thirty (30) calendar days, excluding federal holidays, or a penalty of two percent (2.0%) of Quarterly Administration fees for each two and a half percent (2.5%) of non-compliance complete claims is to be applied. HCA had requested the report that reflects the measurement of this issue. This report reflected that 99.16% of "complete" claims were processed within 30 calendar days, in compliance with the performance guarantee. This report also displayed the total turnaround process time for all claims at 4.1 days.

Turnaround Time Measurements



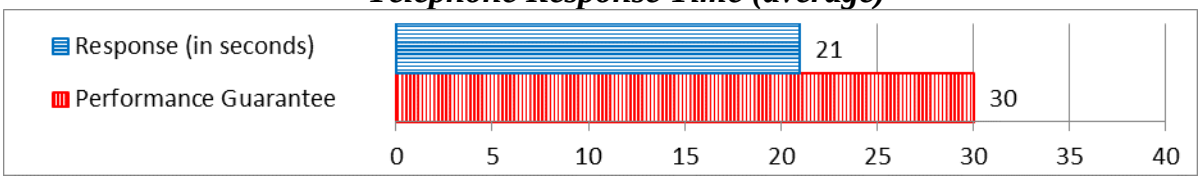
The turnaround time, measured only from the random selected claims, for Medical claims 10.0 calendar days, Out Patient Hospital claims was 9.5 calendar days, In Patient Hospital claims was 9.7 calendar days and Dental claims was 1.7 calendar days.

During the audit period of 01 January 2020 - 31 March 2020, HealthSCOPE had received 1,164 PEBP e-mail inquiries for information via the internet. The average turnaround time for these inquiries was calculated at approximately 6.5 hours.

Customer Service Satisfaction

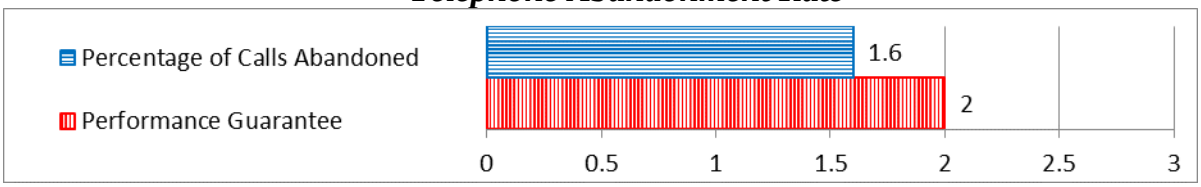
Per the Service Performance Standards and Financial Guarantees Agreement, the telephone response time reflects all calls must be answered within thirty (30) seconds or a penalty of one percent (1%) of Quarterly Administration fees for each second in non-compliance is to be applied. HCA has reviewed the appropriate report for the PEBP third fiscal quarter Plan Year 2020, which revealed the average incoming answer speed to be 21 seconds (0:21.0). The telephone response time was 37 seconds for January 2020, 17 seconds for February 2020 and 5 seconds for March 2020.

Telephone Response Time (average)



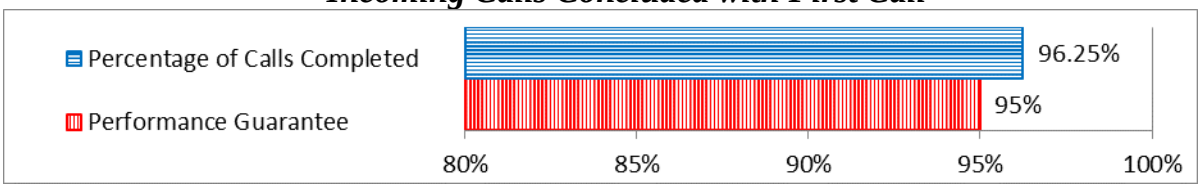
Per the Service Performance Standards and Financial Guarantees Agreement, the abandonment rate must be under two percent (2%) of total calls or a penalty of one percent (1%) of Quarterly Administration fees for each percentage point or fraction thereof in non-compliance is to be applied. HCA has reviewed the appropriate report for the PEBP third fiscal quarter Plan Year 2020, which revealed the abandoned calls ratio to be 1.6%. The telephone abandonment rate was 2.7% for Janaury 2020, 1.29% for February 2020 and 0.52% for March 2020.

Telephone Abandonment Rate



Per the Service Performance Standards and Financial Guarantees Agreement, ninety five percent (95%) of incoming PEBP member problems must be resolved to conclusion on the first call or a penalty of one percent (1%) of Quarterly Administration fees for non-compliance is to be applied. HCA has reviewed the appropriate report for the PEBP third fiscal quarter Plan Year 2020, which revealed that HealthSCOPE documented 96.25% of incoming calls were brought to completion on the first call.

Incoming Calls Concluded with First Call



HealthSCOPE has eighty plus (80+) Customer Service Reps (CSRs), of which, the majority are in the Little Rock office with an average of eight (8) years experience.

Health SCOPE currently has eighteen (18) CSRs dedicated to the PEBP plan.

HealthSCOPE stated that customer service hours of operation will be applied to PEBP direction for proper service levels.

Benefit data is supplied by electronic documentation so that the analyst may explain benefit information to clients, members and providers by HealthSCOPE.

HealthSCOPE stated that the customer service representatives will not have the ability to make system changes.

HealthSCOPE's telephone conversations are documented for future reference.

HealthSCOPE does have an audit process for Customer Service Representatives.

HealthSCOPE is able to monitor trends/errors found through Customer Service.

HealthSCOPE can conduct customer service satisfaction surveys to determine employee satisfaction of claims administration and service upon client request.

Soft Denied Claims

The audit identifies the volume of claims adjudicated and placed in a "soft denied" status. HCA recognizes and respects the need to place certain claims in a soft denied status such as claims that require additional information or special calculation of payment. It is important to include this data within this report to disclose the outstanding unpaid claims that could create an artificial debit/savings during the time that these claims were adjudicated. Note: The measurement of this data was provided as a "snapshot" report. The report reflected the "soft edit" amounts as they were reported on the specific day that the report was recorded. The report for the current claims placed in a "soft denied" status reflect a total of 4,521 claims representing $ 25,612,307.44.

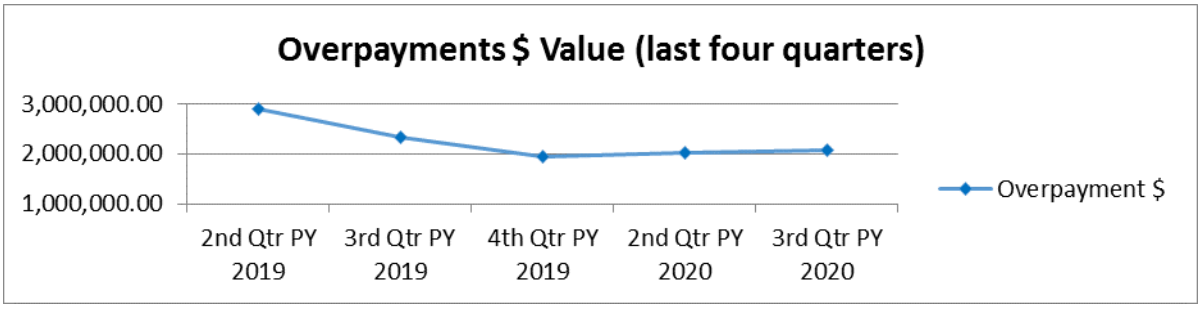
Audit Period	Total Number of Claims	Charge Amount Value of Soft Edits
1st Qtr PY 2012	2,607	$ 7,544,177.55
2nd Qtr PY 2012	4,068	$10,697,954.53
3rd Qtr PY 2012	1,536	$ 6,472,249.56
4th Qtr PY 2012	559	$ 2,205,318.16
1st Qtr PY 2013	1,053	$ 3,413,738.12
2nd Qtr PY 2013	1,107	$ 5,019,961.70
3rd Qtr PY 2013	1,023	$ 4,179,542.34
4th Qtr PY 2013	1,094	$ 3,049,481.74
1st Qtr PY 2014	1,389	$ 3,853,629.07
2nd Qtr PY 2014	1,157	$ 2,510,539.33
3rd Qtr PY 2014	1,621	$ 7,873,432.21
4th Qtr PY 2014	1.487	$ 4,665,197.77
1st Qtr PY 2015	1,404	$ 5,901,903.17
2nd Qtr PY 2015	1,668	$ 6,930,288.41
3rd Qtr PY 2015	2,897	$10,800,874.08
4th Qtr PY 2015	2,498	$10,685,255.24
1st Qtr PY 2016	3,071	$13,027,717.82
2nd Qtr PY 2016	2,543	$13,547,682.34
3rd Qtr PY 2016	2,871	$10,360,017.78
4th Qtr PY 2016	3,107	$15,262,995.27
1st Qtr PY 2017	2,580	$ 8,558,641.28
2nd Qtr PY 2017	3,876	$15,960,661.94
3rd Qtr PY 2017	3,696	$18,864,824.74
4th Qtr PY 2017	4,768	$20,217,736.28
1st Qtr PY 2018	3,926	$15,683,180.63
2nd Qtr PY 2018	4,073	$20,576,701.38
3rd Qtr PY 2018	4,144	$17,375,843.66
4th Qtr PY 2018	4,544	$21,591,987.11
1st Qtr PY 2019	4,624	$24,992,938.88
2nd Qtr PY 2019	5,558	$36,168,714.98
3rd Qtr PY 2019	5,476	$25,662,843.33
4th Qtr PY 2019	5,248	$24,848,496.79
1st Qtr PY 2020	4,992	$24,614,175.86
2nd Qtr PY 2020	4,275	$22,248,300.62
3rd Qtr PY 2020	**4,521**	**$25,612,307.44**

Overpayments

HCA requested an overpayment report that reflects the identified current outstanding overpayments incurred since the beginning of the contract period with HealthSCOPE. This report reflected a current total potential recovery value of $2,076,463.53 (an increase of $60,895.16). Detailed information regarding outstanding overpayments can be reviewed in a separate Supplemental Report, which for confidentiality purposes, is not included in this report but is made available to PEBP staff should they request it.

HSB's policy is to keep all identified overpayments active for potential recoupment(s The breakout of overpayments identified by the year paid are as follows:

Period	Due/Potential Recovery
- Fiscal Year 2012	$ 102,674.34
- Fiscal Year 2013	$ 142,307.51
- Fiscal Year 2014	$ 60,502.98
- Fiscal Year 2015	$ 146,549.50
- Fiscal Year 2016	$ 182,297.94
- Fiscal Year 2017	$ 102,762.67
- Fiscal Year 2018	$ 342,494.82
- Fiscal Year 2019	$ 174,131.05
- Fiscal Year 2020 (to date)	$ 822,742.72
TOTAL	$2,076,463.53



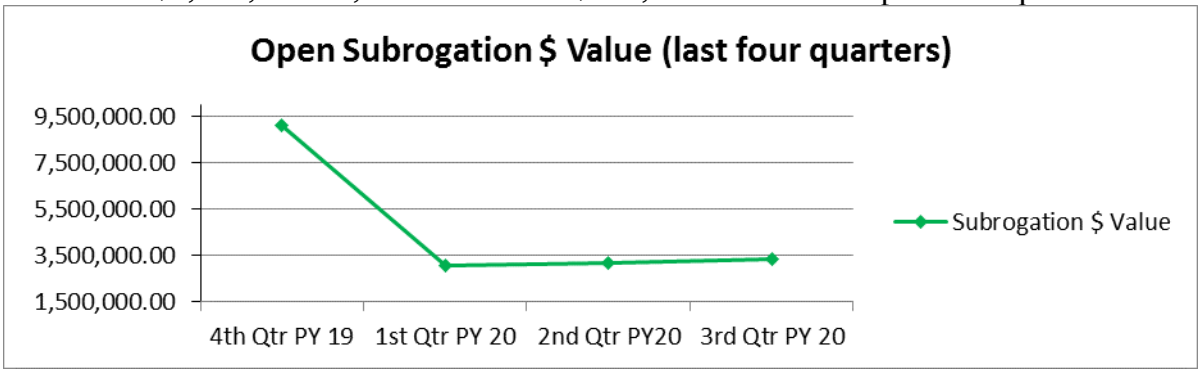
Of the 1,253 most current (Plan Year 2020) identified outstanding overpayments (HSB only), 55% were found to be caused by external sources that are not a cause of the HealthSCOPE adjudication processes. Breakout of the HealthSCOPE's most current overpayments (by claim count) are listed by reason as follows:

20.62%	Incorrect Rate Applied
18.55%	No COB on file
16.07%	Corrected HTH Network Pricing
12.07%	Provider caused, rebilled, charges billed in error, corrected EOB
11.35%	Incorrect Benefit Applied
4.72%	Retro termination
3.04%	Duplicate
2.72%	Paid NON PPO as PPO
2.32%	COB incorrectly calculated or not applied
1.36%	SHO Pricing Correction
1.36%	Previous Information Received
1.36%	Category error
0.64%	Service not covered
0.64%	Benefit Clarification
0.64%	Processed under the incorrect provider
0.40%	Adjusted after Medical Review
0.32%	Processed under incorrect patient
0.32%	Subrogation error
0.24%	Same Day Void
0.16%	Paid PPO provider as NON PPO
0.16%	Aetna network Pricing
0.16%	Workers Compensation Claim
0.08%	Stop Payment
0.08%	Entry Error
0.08%	Pharmacy Deductible Error
0.08%	Incorrect Assignment Applied
0.08%	Adjusted due to Appeal
0.08%	DME paid greater than Purchase Price
0.08%	Pre-Certification Error

Subrogation

HCA requested a subrogation report that can be reviewed in a separate Supplemental Report, which for confidentiality purposes is not included in this report. It is made available to PEBP staff should they request it.

This report reflects open subrogation claims representing a current potential recovery amount of $3,360,073.48; an increase of $171,203.20 from the previous quarter.



Reports received from HealthSCOPE reflect that subrogation recoveries for the audited period was $196,401.65. After contingency fees were paid, PEBP received $146,922.15.

HealthSCOPE system will apply a pursue and pay subrogation policy as directed by PEBP. Per HealthSCOPE, subrogation is determined and pursued on all claims where the total amount paid equals to or exceeds $1000 (one thousand).

HealthSCOPE does identify possible subrogation cases internally. HealthSCOPE utilizes a third party vendor for recovery of monies. Vendors are paid a contingency of which the administrator receives a portion of and disclosed within RFP 1983 for Third Party Claims Administration.

HealthSCOPE does not conduct auditing of outstanding subrogation cases sent to their vendors, but sends any cases not picked up by the main vendor to another vendor for review.

HealthSCOPE depends on the external vendors to conduct the appropriate International Classification of Diseases (ICD) sweep checks for subrogation detections. HealthSCOPE is currently utilizing the new ICD-10 conversions and the coding has been completed within their system.

Per HealthSCOPE, claims related to Worker's Compensation are denied.

Recoupment and payments for subrogation claims are assigned as directed by PEBP.

High Dollar Claimants

Per the request of PEBP staff, HCA has requested a report to identify the number of active, retiree or COBRA elected participants or dependents who have obtained a plan paid level of $750,000.00 or greater.

This report reflected forty-four (44) active members and thirty-one (31) dependents for a total of 75 active participants, who have obtained this level of plan payment participation representing an accrued dollar paid amount of $100,666,396.91.

Personnel

The audit included a review of the HealthSCOPE personnel dedicated or assigned to PEBP. The current Organization Chart for individuals assigned to the PEBP plan, is, with changes, as follows:

- State of Nevada Manager;
- Vice President – Quality Assurance;
- Sr. Vice President Operations Customer Care;
- Executive Account Manager;
- Client Relations Manager;
- Financial Operations Director;
- Provider Maintenance Specialist;
- Financial Analysts, 3 individuals;
- Funding Supervisor;
- Claims Administration Manager;
- Claims Administration Supervisor;
- Claims Analysts, 15 individuals;
- Eligibility Director;
- Eligibility Specialists; **CHANGED**, 2 individuals added and 2 removed for total of 2 individuals
- Customer Service Vice President;
- Customer Service Director;
- Customer Service Representatives, **CHANGED**, 3 individuals added and 3 removed for a total of 18 individuals;
- Scanning Services Manager;
- Recoveries Manager;
- Recoveries Specialists, 2 individuals;
- Vice President Data Services;
- Senior Data Analyst;
- Chief Information Officer;
- Data Architect
- Computer Domain Hosting (CDH) Services Manager;
- Sr. Vice President-Legal and Compliance;
- COBRA Service Manager;
- Customer Care Supervisor;
- Customer Care Representatives, 3 individuals.

HealthSCOPE POLICY/PROCEDURES/SYSTEM CAPABILITIES

This section details the HealthSCOPE adjudication system capabilities and operations as they pertain to the PEBP Health Plan. These operations typically do not change on a regular basis and remain redundant within subsequent audit reports, thereby, are only displayed within the first quarterly audit report for the fiscal year. The quarterly audit includes the review of the following operations, however, if any changes or defects are identified, they will be reported immediately within the audited period report:

- HealthSCOPE Policy/Procedures
- Eligibility
- Deductibles, Out-of-Pocket and Benefit Maximums
- Unbundling/Rebundling
- Concurrent Care
- Code Creeping
- Procedure, Diagnosis and Place of Service
- Experimental and Cosmetic Procedures
- Medical Necessity/Potential Abuse Guidelines and Procedures
- Patterns of Care and Treatment for Physicians
- Mandatory Outpatient/Inpatient Procedures
- Duplicate Claim Edits
- Adjusted Claims
- Hospital and Other Discounts
- Hospital Bills (UB-92) and Audits
- Filing Limitations
- Unprocessed Claims Procedures
- Reasonable/Customary and Maximum Allowances
- Membership Procedures
- COBRA Administration
- Provider Credentialing
- Coordination of Benefits
- Medicare
- Controlling Possible Fraudulent Claims and Security Access
- Quality Control and Internal Audit
- Internet Capabilities
- Communication between Utilization Review (UR) and Claims Department
- Claim Repricing Capabilities
- Banking and Cash Flow
- Reporting Capabilities
- General System
- Security

HCA CLAIM AUDIT PROCEDURES

HCA selects a valid random sampling of claims from the client's current detailed claims listings. The third party administrator is advised of the audit and requested to provide either limited system access or paper reproduction of the entire file associated with each random claim.

Each random claim and file is reviewed comparing eligibility and benefits to information provided by the client. Third party administrator personnel are questioned regarding any discrepancies. Entire files are reviewed to assure the client that deductibles, out-of-pockets benefit maximums and related claims are processed correctly. This allows HCA to verify all details of the client's benefit plan.

Audit statistics involve only those claims chosen in the random selection. If a randomly selected claim HealthSCOPE been recalculated or corrected prior to the release of the random selection for the audit, an error was not charged for the original miscalculation. HCA will, at its opinion, comment on any claim in the random claim history to illustrate situations it feels the client should be aware of or specific areas requiring definition.

A payment error is charged when an error identified in claim processing results in an under/ overpayment or a check being paid to the wrong party. Assignment errors are considered payment errors since the plan could be liable for payment to the correct party.

In situations where there is disagreement between HCA and the third party administrator as to what constitutes an error, both sides are presented in the report. Final determination of error rests with the client.

AUDIT RESULTS

Listed below are the errors or issues of discussion found by this audit while processing the claims for PEBP.

Ref. No. 050 Outpatient Hospital HSB claim no.

Overpayment - $75.00

REV 320	72050-TC	chg 295.00	allow 144.55			pd 144.55
612	72141-TC	890.00	436.10	copay 250		186.10

Per MPD "Non-Specialty Imaging & Diagnostic Testing (including x-rays & ultrasounds) – services provided in a hospital outpatient setting (except Specialty Imaging & Diagnostic testing as listed above) - $75 copay.

Should $75 copay have been applied to REV 320 (72050-TC)?

HSB response: Claim xxxxxx should have assessed an additional $75 copay. Examiner error.

Ref. No. 059 Outpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Originally processed under xxxxxx on 9/13/19 as:

REV 490	chg 953	allow 558.39	penalty 279.20	ded 279.19	pd 0.00
270	18	0.00			0.00
270	20	0.00			0.00

Claim penalized for lack of pre-cert & ded applied
Audited claim is adjustment to now pay as: Chg 991.00 allow/pd 558.39
Claim for routine colonoscopy paid as medical in error applying ded & pre-cert penalty
HSB response: Original claim xxxxxx processed incorrectly. During a routine audit the claim was identified. Claim corrected on 1/6/20 under xxxxxx to pay preventive.

Ref. No. 066 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Claim originally paid under xxxxxx on 11/27/19 as:
62322-59 chg 1150.00 allow 88.78 (x 80%) pd 71.02
Repriced amount from HTH on this claim shows 575.00
Audited claim is adjusted to now pay as:
62322-59 chg 1150.00 allow 575.00 88.80 x 80% = 71.04

486.20 x 100% =	486.20
	557.24
prev pd	71.02
	486.22

Why was only 88.78 allowed on original processing?
HSB response: Examiner error.

Ref. No. 75 Outpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.

REV 306	87081	chg 61.00	allow/pd 6.88
306	87150	325.00	36.63
			43.51

Per Renown Lab Fee Schedule 2018, shouldn't claim have pd as:

REV 306	87081	allow/pd 6.22
306	87150	37.29
		43.51

Please explain how allowables were calculated on this claim.
(Total allowable the same but allowed amounts for each service differ from schedule)
HSB response: Claim repriced correctly by HTH. There was a display issue in the PAID BY SERVICE field that was identified and correction completed on 4/9/20.

Ref. No. 087 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Provider – Reno VAMC
Audited claim paid as: 99283 chg/allow/pd 482.00
Claim xxxxxx DOS 8/29/19 same provider & service paid as:
99283 chg 482.00 allow/pd 53.02
Shouldn't audited claim have been cut back and paid as 53.02?
HSB response: Claim xxxxxx is for the facility ER fee. Claim xxxxxx is for physician charges for services provided during ER visit. The UCR for 99283 is $486, so claim allowed billed charges. Disagree, claim processed correctly.
Additional HSB response received 04 May 2020: PEBP stopped using UCS pricing as of 10/01/2019. This is the reason that the claim for DOS 12/01/2019 was processed correctly.

Ref. No. 092 Medical HSB claim no.

Underpayment - $84.00
Claim originally paid on 10/12/19 under claim xxxxxx as:
00811 chg 560.00 allow 420.00 ded 420.00 pd 0.00
Audited is adjusted claim to now pay as:
00811 chg 560.00 allow 420.00 (x80%) pd 336.00
Per Trans Msg category should have been changed to HM

Shouldn't adjustment have been paid as: 00811 chg 560 allow/pd 420.00
Appears underpaid 84.00
HSB response: Agree, adjusted claim should have paid at 100% of PPO allowed $420.00 Examiner error.

Ref. No. 104 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Provider: Reno VAMC
Originally paid on 10/28/19 under xxxxxx as:
REV 310 88302-TC allow/pd 38.54
Audited claim is adjustment to now pay as:
Allow/pd 50.17 – paying an additional 11.63
Appears incorrect allowed amount used on original processing?
HSB response: Yes original claim xxxxxx adjusted with updated pricing on 1/18/20 under claim xxxxxx. No error.

Ref. No. 112 Medical HSB claim no.

Overpayment – $44.53

80050	chg 193.50	allow/pd 30.51	
80061	104.50	15.82	
82306	294.50	40.68	
84153	116.50	16.95	(PSA test)
84402	201.50	36.73	
84403	171.50	33.90	
84439	143.50	8.48	
84481	236.50	24.30	
86376	112.43	18.08	
86800	109.57	14.13	

DX: R5383 – other fatigue, E785 hyperlipidemia, E559 Vit D deficiency, Z125 – encounter for screening malig neoplasm prostate

Shouldn't only 84153 have paid at 100% and the rest to ded & coins?

HSB response: Agree, only 84153 should have paid at 100% of the PPO allowed.

HCA Note: In calculating overpayment, HCA has assumed that the member has met their deductible. Claim therefore would have paid $16.95 x 100% plus $222.63 x 80% = $195.05 payable.

Ref. No. 122 Medical HSB claim no.

Overpayment - $27.01

COB w/Medicare

This is the first time this claim has been received. Claim submitted 15 months after DOS. Shouldn't the claim have been denied for timely filing? (Note – appears there may be others in history that were paid & should been denied for timely filing)

HSB response: Agree, claim should have denied timely filing.

Ref. No. 123 Medical HSB claim no.

Over/Underpayment - $0.00

Originally (audited) pd as: 99213 allow 88.16 copay 20 pd 68.16

Claim adjusted under xxxxxx on 4/17/20 as:

99213 allow 84.33 copay 40 pd 44.33

1) Per Trans Msg appears HTH corrected repricing?

2) Why is 40 copay now being applied on adjusted claim?

HSB response: 1) Audit claim xxxxxx was processed correctly with pricing by HTH at that time. 2) Examiner error assessing $40 copay on adjusted claim xxxxxx.

Ref. No. 167 Outpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Provider: Sunrise
HTH repriced claim at 4649.60 – appears claim repricing calculated as:
CPT 15275 ungrp = 3502.00
Rev 636 2869 x 40% = 1147.60
4649.60
Shouldn't allowable have been:
CPT 15275 ungrp = 3502.00
15004 grp 2 = 1580.00
Rev 636 2869 x40% = 1147.60
6229.60 x 80% = 4983.68
HSB response: Claim repriced incorrectly. Per HTH corrected pricing attached.
HCA Note: Per attached form HTH: "Surgery codes are both ungrouped allowable was updated 3502 for each surgery and Rev code 636". Total allowable now shows as $8,151.60.

Ref. No. 196 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Claim xxxxxx same DOS for surgeon's charges denied for accident details on 1/22/20. Per member messages info received 2/14/20.
Shouldn't this claim have been reprocessed & paid?
HSB response: Yes should have been corrected at the same time.

Ref. No. 200 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
OOP met
Claim xxxxxx same DOS from Mountain View for ER services charge $38,643.00. Claim paid as: allow/paid 13,370.48
HCA calculates as:
Rev 450 chg 32,641.00 x 49.75% = 16,238.90
636 6002.00 x 31.4% = 1,886.63
18,125.53
Please show how claim was calculated to allow 13,370.48.
HSB response: Agree with auditor, allowed should be $18,125.53.

Ref. No. 203 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Claim xxxxxx received 1/28/20 for facility fee has BE date of 2/11/20.
Why has this claim not been paid?
HSB response: Examiner oversight, missed when she was working reports when repricing returned.

Ref. No. 244 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Originally claim paid 1/3/20 under xxxxxx paid 553.84

99285	chg 989.00	allow 692.30	pd 553.84
93010	54.00	0.00	0.00
99053	74.00	0.00	0.00

Audited is adjusted due to corrected billing:

99053	chg 74.00	allow 51.80	pd 41.44
99285	1043.00	692.30	553.84

595.28
-553.84 prev pd
41.44 additional paid

Claim then adjusted under xxxxxx on 4/9/20 to take back payment on audited claim
Appears audited claim paid in error?
HSB response: During a routine audit performed claim xxxxxx was identified as being paid incorrectly. Claim was corrected on 4/9/20 prior to receipt of audit extract.

Ref. No. 246 Medical HSB claim no.

Overpayment - $8.53

Audited claim:	36415	chg 22.50	allow 0.00	pd 0.00
	85025	45.50	10.66	8.53

Claim xxxxxx same provider, DOS & services also paid 8.53 on 12/12/19
Appears audited claim is exact duplicate to claim xxxxxx and audited
Claim should have been denied.
HSB response: Paid twice in error. Analyst error.

Ref. No. 250 Outpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.

REV 300	36415	chg 23.00	allow/pd 2.62	
301	80053	98.00	11.82	
	80061	124.00	14.15	
	83036	90.00	10.27	
	84153	70.00	19.41	
			57.63	

Shouldn't claim have paid as:

36415	allow/pd 1.13	
80053		15.82
80061		15.82
83036		7.91
84153		16.95
		57.63

Total allowable the same but allowed amounts for each services differ from fee schedule. Why?

HSB response: Claim processed correctly with HTH allowed amount.

PAID BY SERVICE display issue was identified on 4/2/20 and corrected on 4/9/20.

Ref. No. 272 Outpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.

Claims xxxxxx same DOS for surgeon and xxxxxx same DOS were denied for accident info. Accident info received 2/26/20.

Shouldn't these claims have been reprocessed?

HSB response: Yes claim xxxxxx should be adjusted.

Ref. No. 295 Outpatient Hospital HSB claim no.

Underpayment - $229.60

Provider: Spring Valley

Claim paid as: Rev 278	allow 118.51	(x80%)	pd 94.81	
Rev 361 (52332)	944.00	"	755.20	
790 (50590)	472.00	"	377.60	
	1534.51		1227.61	

Shouldn't claim have paid as: allow 1821.51/ paid 1457.21?

Rev 278	allow 118.51	(x80%)	pd 94.81
361	944.00	"	755.20
790	759.00	"	607.20

(Rev 790 CPT 50590 ungrp = 1518.00 x 50% MSG = 759.00)

HSB response: Agree with auditor's calculation.

Ref. No. 350 Inpatient Hospital HSB claim no.

Overpayment -$214.31

Provider: Northern NV

Claim paid as: allow 14,547.48 coins 694.37 pd 13,853.11

Per SHO memo dated 11/18/19 new percent of billed charge amount effective 1/1/20 is now 32.8%

Appears claim calculated using 2019 percent of BC 33.4%

Shouldn't claim have paid as:

Rev 120, 1 day x 2618.00 = 2618.00

278 35,659 x 32.8% = 11692.87

636 68.00 x 32.8% = 22.30

14,333.17 allow

-694.37 coins

13,638.80 payable

Overpaid 214.31

HSB response: Agree with auditor's calculation.

Ref. No. 409 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.

Claim xxxxxx same DOS for Southern Hills allow 3575.02/paid 2859.98

Shouldn't claim have paid as:

Rev 360 (47562) allow 2433.00

636, 3922 x 31.4% 1231.50

3664.51

HSB response: Agree, auditor's calculation is correct.

Ref. No. 418 Medical HSB claim no.

Overpayment - $39.20

Provider: Doctor on Demand

99212-GT chg 49.00 allow 49.00 (x80%) pd 39.20

MPD says "In-Network: You pay after deductible $49 for primary care visit"

Should we have paid anything on this claim?

HSB response: Member had already met deductible but not maximum OOP. Since deductible met member pays $9.80 coinsurance and plan pays $39.20.

HCA Note: MPD states "Telemedicine (All other telemedicine providers except Doctor on Demand) – Plan pays 80% after Plan Year Deductible". Since this provider is Doctor on Demand member should have paid $49 as deductible was met and plan should have paid zero.

Ref. No. 422 Dental HSB claim no.

NOT charged in statistical calculation. Note to client for information only.

Claim paid as:

D0170	chg 90.00	allow 70.00	ded 70.00	pd 0.00
D1354	25.00	0.00	0.00	0.00
D1354	25.00	0.00	0.00	0.00

Service D1354 coded with service code FL

Previous claim xxxxxx DOS 2/24/20 same provider for service D1354 coded as SN and paid 18.75 at 100%

Shouldn't D1354 on audited claim have been coded SN and paid 18.75 for each at 100%?

HSB response: D1354 for silver diamine fluoride application which fluoride is a type of fluoride treatment. Member's max benefit was met with claims xxxxxx & xxxxxx. Claim xxxxxx was processed in error to allow D1354. Audited claim xxxxxx processed correctly.

Ref. No. 507 Inpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.

Provider – Mountain View

HTH allow 108,898.00 at 100%

Claim should have priced as:

Rev 128, 35 days x 3113.00 = 108,955.00

636, 41595.00 x 40% = 16,638.00

125,593.00

Appears incorrect allowed amount used in processing?

(Note: Trans Msg on claim dated 4/16/20 re: allowable)

HSB response: Per HTH priced incorrectly.

Ref. No. 510 Outpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.

Provider: Mountain View

Originally paid 7/19/19 claim xxxxxx as allow/pd 3113.00

Audited is adjusted claim to now allow: 252,986.00

- 1402.00 rev 636

251,584.00 x 53% = 133,339.52

133,339.52 – prev pd 3113.00 = 130,226.52 additional paid

Appears incorrect HTH pricing on original claim?

HSB response: Original claim xxxxxx HTH repriced the claim with an allowed of $3113.00. HTH then came back with a repriced/adjusted for a total allowed of $133,339.52.

Ref. No. 513 Inpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Provider: Renown
Claim adjusted multiple times:
Paid 65,974.20 claim xxxxxx on 12/2/19 (HTH repriced = 67,156.95)
Paid 64,693.45 claim xxxxxx on 2/14/20
Paid 67,156.95 claim xxxxxx on 3/4/20
Audited paid 67,156.95 on 3/12/20
Appears allow amount should have been total charge as allow calculated by HCA would be:

Rev 171	1 day x 624.00	=	624.00
172	17 days x 3703.00	=	62,951.00
173	2 days x 3703.00	=	7406.00
278	210.00 x 42%	=	88.20
636	117.26 x 42%	=	49.25
			71,118.45

Shouldn't we have paid full charge amount of 67,346.76?
HSB response: Original claim priced incorrectly by HTH. Pulled pricing from portal. Corrected pricing provided on 4/24/20 – copay attached.
Attached from HTH states: "We are in receipt of your request for review of the linked claim. The review has determined the claim was re-priced correctly. Hometown Health contract calculation is as follow:
Rev 171 – 624.00
Rev 172 – 3703.00 x 17 = 62951.00
Rev 173 – 3703.00 x 2 = 7406.00
Rev 278 – 210.00 x 42% = 88.20
Rev 636 – 117.26 x 42% = 49.25
Total allow 71118.45
Allowable is greater then billed charges, claim allowed billed charges on all lines of service except for Rev 278 and Rev 636 these lines allowed at the 42% bc rate.
HCA Note: Since total allowed amount is greater than billed charges, the billed charges of $67,346.76 would then be the allowable. The member has met OOP so plan would then pay 100% of allowable or $67,346.76. Claim is therefore underpaid $189.81

27 Corporate Hill
Little Rock, AR 72205

May 1, 2020

Public Employees' Benefits Program Board
State of Nevada
901 Stewart Street, Suite 1001
Carson City, NV 89701

Subject: Audit Results January 1, 2020 –March 31, 2020

Dear Public Employees' Benefits Program (PEBP) Board:

HealthSCOPE Benefits appreciates the opportunity to respond to the audit performed by Health Claim Auditors for the third quarter of Plan Year 2020. The audit included 500 claims with paid amounts totaling $271,303.34.

HealthSCOPE Benefits is extremely pleased to have met all performance guarantees for this audit period.

We strive to have the highest possible quality and we continue to review improvement opportunities within our organization and our vendor partners.

We are very pleased with cost containment measures we are able to provide on the PEBP account. We saved an additional $1M through non-network negotiations, subrogation, clinical edits and transplant savings in the third quarter of PY2020.

We appreciate the quarterly audit process and the interaction between Health Claims Auditors, PEBP, and HealthSCOPE Benefits as it provides for continuous improvement in our service.

Sincerely,

Mary Catherine Person
President

11.

11. Health Claim Auditors, Inc. yearly audit of Express Scripts, Inc. (ESI) for the timeframe July 1, 2018 – June 30, 2019 (Robert Carr, Health Claim Auditors) (**For Possible Action**)

REDACTED VERSION

COMPLIANCE WITH ESI AGREEMENT

Prescription Benefit Manager Audit Report

Nevada PUBLIC EMPLOYEES' BENEFITS PROGRAM

PEBP

Health Matters.

Plan Year 2019 (July 2018 – June 2019)

Conducted on

Express Scripts, Inc.

Submitted By:

Health Claim Auditors, Inc.

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INTRODUCTION

In September and October 2019, Health Claim Auditors, Inc. (HCA) performed a Prescription Drug Audit of Express Scripts, Inc. (ESI) on behalf of The State of Nevada Public Employees' Benefits Program (PEBP). ESI is a contracted vendor that provided administration of the PEBP's Benefit Plan for prescription drug claims as per terms within PEBP RFP 3220. Terms and guarantees were audited as per negotiated and signed Agreement Addendum No. 02 with effective date of 01 July 2018.

The audit was performed to assure PEBP that ESI is doing a proficient job of controlling prescription costs while paying claims accurately within a reasonable period of time and in compliance with the contract for services.

The prescription claims audited were processed by ESI from 01 July 2018 to 30 June 2019 (PEBP Plan Year 2019). HCA reviewed 100% of the prescription drug claims processed during this time period.

The preliminary report of audit results was electronically delivered to ESI representatives on 18 November 2019 for their review and comments. ESI comments and responses were requested with a return date within the xxxxx (xx) days allowed by agreement and will be inserted within this report displayed in ***Bold and Italicized type*** for easy detection. ESI responses and supporting documentation was received as displayed within this report electronically on 16 January 2020. ESI provided HCA the pricing guarantee reconciliation on 25 March 2020 (269 days from end of plan year). HCA requested additional definition/explanation for the ESI specialty drug claim identifiers within their year-end calculations on 26 March 2020. The ESI response was received on 09 April 2020 and the manufacturer true up report was received on 20 April 2020, of which, is reflected within this final report. Any differences from HCA findings are described within the Executive Summary/ Conclusions/Recommendations section of this report.

Please note*:* Certain contract discount data contained within this report is considered proprietary and thereby has been redacted in this report for confidentiality purposes to be in compliance with the ESI agreement. This version of the report is in compliance with all ESI requests for confidentiality redactions. The audit measured the actual values of specific negotiated rates for discounting, dispensing fees, rebates and all performance guarantees, however, are displayed within this version of the report as xx.x% or $xx.xx.

The detail claims data received for this audit reflected the Average Wholesale Pricing (AWP) for name brand and generic claims dispensed by retail and mail order pharmacies.

EXECUTIVE SUMMARY-

Summary of Findings for Contracted/Guaranteed Performance Measurements
Audit Period: PEBP Plan Year 2019 (01 July 2018 through 30 June 2019)

The table below provides an overview of the audit findings for contracted services with performance standards and financial guarantee indicators. Details of each category can be found within the Executive Summary and Report Details sections of this report.

Perf. Category	Detail Category	Under/Over Perform. Pass/Fail
Discounts	Retail Name Brand 1-83 days	*Over Performance
	Retail Name Brand 84-90 days	*Over Performance
	Retail Generic	*Under Performance
	Mail Order Name Brand	*Pass
	Mail Order Generic	*Under Performance
	ESI Pharmacy Specialty Drugs	*Under Performance
	Aggregate of all Categories	***Under Performance**
Dispensing Fees	Retail Name Brand 1-83 days	*Over Performance
	Retail Name Brand 84-90 days	*Under Performance
	Retail Generic 1-83 days	*Under Performance
	Retail Generic 84-90 days	*Pass
	Mail Order Name Brand	*Pass
	Mail Order Generic	*Pass
	Specialty Drugs	*Pass
	Aggregate of all Categories	***Over Performance**
Manuf. Rebates	$xx.xx Ret. NB 1-83 dys/$xxx.xx Ret NB 84-90 dys/$xxx.xx per MO NB/$xxx NB Specialty	***Over Performance**
	Timely remittance to PEBP	Pass to date
Admin. Fees	$x.xx per employee per month (PEPM)	Pass
Customer Service	Telephone Response within xx seconds	Pass
	Abandonment Rate less than x%	Pass
	Network Pharmacy xx% within x mi.	Pass
	xx% or greater First Call Resolution	Pass
	Mail clms shipped in x dys (no intrvntn)	Pass
	Mail clms shipped in x dys (w/intrvntn)	Pass
	Survey, xx% at "satisfactory" or better	Fail
Adjdctn Accuracy	xx% of Retail claims with no errors	Pass
	xx% of Mail Order claims with no errors	Pass
Reporting	Monthly, quarter and annual in xx days	Pass
Disclosures	All new subcontractors	No exceptions noted
	All movement of data storage	No exceptions noted
Claim Transfer	xx% daily data file transfer to TPA	Pass
Eligibility Data	xx% extracts available next bus. day	Pass

* Per Agreement, OTC, U&C, compounds, products subject to patent actions, member submitted claims, subrogation claims, vaccines, specialty products, biosimilar products, long term care pharmacy claims and products filled through in-house or 340b pharmacies were excluded from the performance guarantee calculations.

Summary of Findings for <u>NON Contracted/Guaranteed Performance Measurements</u>
Audit Period: PEBP Plan Year 2019 (01 July 2018 through 30 June 2019)

The table below provides an overview of the audit findings for services that do not include performance standards and financial guarantees. The data has been provided for informational purposes only. Details can be found within the Executive Summary and Report Details sections.

Category, Plan Year 2019	Detail Category	Note
Generic Distributions	Percentage of Generic claims to all claims	Exceeds industry
Specific Pricing	Zero Balance Pricing	Pass
Claim Adjudication	Days Supply Limits	Pass

Other findings

- PEBP should be congratulated for the xx% distribution of Generic Drug utilization of all Retail and Mail Order claims. This distribution is among the highest in the nation and drives an overall lower cost to PEBP participants and the PEBP plan;

- It is recommended that PEBP review the Possible Drug Exceptions for verification and confirmation with ESI for plan exclusion;

- The ESI adjudication system edits and DUR edits tested were found to follow proper protocol and practices in areas to include, but not limited to scheduled drugs, dosage limitations, days supply, step therapy, generic substitutions, etc.;

Executive Summary/Conclusions/Recommendations

ESI was found to provide and apply numerous services as PEBP's Prescription Benefit Manager that met and/or exceeded the contracted guarantees and vendor responses remitted within the processes for The State of Nevada Purchasing Division Request For Proposal (RFP) No. 3220.

HCA audited to the defined contents, exclusions, exceptions and negotiated terms of the Plan Year 2019 Agreement and Amendments. ESI was found to be in compliance with performance guaranteed metric measureable areas for customer services, dispensing fees, rebates, administration fees, eligibility and claim file transfers during the audited period.

The audit detected underperformance exceptions of the Agreement in the categories of the Aggregate Discount Rates (which included underperformances of Retail Generic, Mail Order Generic and ESI Specialty Drug categories). HCA and ESI calculations are similar for all categories with the exception of Retail Name Brand. In aggregate, ESI calculates the performance guarantees underperformance at $1,924,753. It is HCA's unbiased opinion that PEBP accept this amount for the discounting and dispensing fees guarantee underperformance of PEBP Plan Year 2019.

The Customer Satisfaction Survey results reported at xx% of participants being "satisfied" were below the xx% performance guarantee. It is HCA's unbiased opinion that the penalty as defined within the Plan Year 2019 Agreement for this underperformance be calculated and collected by PEBP.

ESI Comment: – ESI notes the 4th quarter rebate reports have been requested and will be provided upon receipt. Please also note the pricing guarantee reconciliation will be completed by March 01, 2020 (240 days from end of plan year) in accordance with the PBM Agreement. The guarantees will be requested and provided within two weeks of the completion date.

HCA UPDATE 09 April 2020:
ESI provided HCA their pricing guarantee reconciliation on 25 March 2020. This report reflects the data provided by ESI for their calculations of discounting and dispensing fee performance guarantees. HCA requested additional definition/explanation for the ESI specialty drug claim identifiers. The ESI response was received on 09 April 2020, of which, is reflected within this final report.

AUDIT SUMMARY

This report consists of HCA's findings and observations concerning the system edit capabilities, procedures, contract compliance and savings provided by Express Scripts, Inc. (ESI). Areas that have performance standards listed in the PEBP contract are listed first.

AUDIT CRITERIA

SELECTION PROCESS

One hundred percent (100%) of claims provided by ESI within the detailed claim report were audited for appropriate discount rates and compliance with PEBP's contract for services. The audit included, but was not limited to compliance with the following categories within the contract for services in force at the time of the adjudication:

1) Retail drug dispensing fee;
2) Mail order brand name and generic drug dispensing fees;
3) Manufacturer rebates;
4) Customer Service;
5) Drug Utilization Review (DUR) policies and procedures;
6) Claim processing and procedures;
7) Eligibility (both internal and compliance with PEBP's Medical Plan Administrator);
8) Accumulator data (both internal and compliance with PEBP's Plan Administrator);
9) Quality assurance and internal audits and training;
10) Security access;
11) Report capabilities;
12) Savings;
13) Administration Fees.

The individual prescription costs audited were calculated from the PEBP current detailed claims listings as supplied by ESI. Confidential data was collected and utilized to formulate this report.

AUDIT RESULTS– Period: 01 July 18 through 30 June 19, Performance Standards Apply

***Important Note:** Due to the issues experienced by PEBP with previous PBM services, the Average Wholesale Pricing (AWP) displayed within the detail claims report received from ESI for Name Brand drug claims was checked against a 2009 pre-class action lawsuit accounting format. It has been confirmed that the AWP supplied is in compliance with the current negotiated agreement between PEBP and ESI.

As per the Agreement, AWPs were audited and calculated utilizing the database supplied by Medi-Span for the allowables as of the date of service. Per Agreement, OTC, U&C, compounds, products subject to patent actions, member submitted claims, subrogation claims, vaccines, specialty products, biosimilar products, long term care pharmacy claims and products filled through in-house or 340b pharmacies were excluded from the performance guarantee calculations as displayed in each category results.

Transparency
Per Agreement, PEBP and ESI have negotiated metric measurements minimums for each category, i.e. xxxxxx, xxxxx, etc. PEBP and ESI have also entered into xxxxxxxxxx arrangements where PEBP pays ESI the xxxxx xxxxxx xxxxx and xxxxx xxxxx amount paid by ESI for a particular claim when the claim is adjudicated to the pharmacy.

HCA Findings: HCA has reviewed reconciliation reports to ensure ESI is providing PEBP the transparency portion of the Agreement as described above and concludes that ESI is in compliance with the Agreement.

Retail Claims Discount Rate

Retail Name Brand Claims

Per the agreement, the discount rate for Retail Pharmacy Name Brand Drugs is to be an aggregate of xx.xx% from 100% AWP (Average Wholesale Price) for 1-83 days supply.

HCA Findings: The aggregate discount rate for this category was calculated to be AWP – xx.xx% for the audited period and in compliance of the contract agreement. The aggregate paid by PEBP reflects an overperformance by an estimated $21,378 as compared with the performance guarantee.

Per the agreement, the discount rate for Retail Pharmacy Name Brand Drugs is to be an aggregate of xx.xx% from 100% AWP (Average Wholesale Price) for 84-90 days supply of standard claims and AWP – xx.xx% for Smart90 claims.

HCA Findings: The aggregate discount rate for this category was calculated to be an aggregate AWP – xx.xx% for the audited period and in compliance of the contract agreement. The aggregate paid by PEBP reflects an overperformance by an estimated $11,285 as compared with the performance guarantee.

Retail Generic Claims

Per the agreement, the discount rate for Retail Pharmacy Generic Drugs is to be an aggregate of xx.xx% from 100% AWP for standard claims and AWP – xx.xx% for S90 claims.

HCA Findings: The aggregate discount rate of this category for the entire audited period was found to be an aggregate AWP – xx.xx% for the audited period, below the contract agreement and not in compliance of the contract agreement. The aggregate paid by PEBP reflects an underperformance by an estimated $1,755,763 as compared with the performance guarantee.

Mail Order Claims Discount Rate

Mail Order Name Brand Claims

Per the agreement, the discount rate for the Mail Order Program Name Brand Drugs is to be xx.xx% from 100% AWP.

HCA Findings: Aggregate discount rate for this category was calculated to be AWP – xx.xx% for the audited period, within the agreement and in compliance of the contract agreement. The aggregate paid by PEBP reflects an equal value as compared with the performance guarantee.

Mail Order Generic Claims

The discount rate for Mail Order Generic Drugs is to be xx.xx% from 100% AWP.

HCA Findings: HCA found the AWP discount for Mail Order Generic claims to be AWP – xx.xx% for the audited period, in compliance with the contract. The aggregate paid by PEBP reflects an underperformance by an estimated $212,908 as compared with the performance guarantee.

Specialty Claims Discount Rate

Per Agreement (Performance Standards and Guarantees) a separate pricing category for Specialty Medications is to be applied.

Per agreement, the discount rate for Express Scripts Specialty Pharmacy Drugs, displayed in the agreement as "ESI Specialty Pharmacy Fills Only" is to be reimbursed as per the Exclusive Specialty Pharmacy Price List and guaranteed an aggregate discount of xx.xx% from 100% AWP.

HCA Findings: The aggregate discount rate of this category for the entire audited period was found to be AWP – xx.xx% for the audited period, below the contract agreement and not in compliance of the agreement. The aggregate paid by PEBP reflects an underperformance by an estimated $49,110.26 as compared with the performance guarantee.

HCA note: The detail claim report for claims within the performance guarantee for specialty drugs (GTY Key xxxxxx) provided from ESI displays an indicator (column s) that identifies the drug as "yes, retail claim, specialty" and "no, retail claim, not specialty". HCA's original calculations reflected an underperformance of $254,000 when only "yes, retail claim, specialty" claims were included. ESI data included column DP, which is an indicator for "non standard specialty indicator". When these claims are all included, HCA concurs with the ESI calculation of the $49,000 underperformance for this category. HCA requested an explanation of why an ESI "non specialty drug could be considered as a "specialty drug". HCA received the following response:

ESI response received on 09 April 2020: Prior to xxxx, specialty drugs were being identified using standard indicators (Spec_Flg) to include/exclude these drugs in pricing guarantees. This represented drugs considered specialty by ESI, but was not completely in line with the client's custom specialty listing. Starting in xxxx, ESI moved to only use 'Non_Standard_Specialty_Ind' as this would be in line with the client's custom specialty listing.

Aggregate Claims Discount Rate

Per the Agreement supplied, HCA did not recognize language regarding that overperformances may be used to offset discount rate underperformances, however, PEBP has stated that the intent was to combine the discount categories for an aggregate measurement.

HCA Findings:

Claim Type Category	Over/(Under) $ Performance
Retail Name Brand 1-83 days	$21,378
Retail Name Brand 84-90 days	$11,285
Retail Generics	($1,755,763)
Mail Order Name Brand	$0
Mail Order Generics	($212,908)
Specialty Drugs (ESI Pharmacy	($49,110)

ESI Comment: – ESI notes the pricing guarantee reconciliation has not yet been reconciled therefore ESI's self-reported performance cannot be provided at this time. The reconciliation will be completed by March 01, 2020 (240 days from end of plan year) in accordance with the PBM Agreement. The guarantees will be requested and provided within two weeks of the completion date.

HCA UPDATE 09 April 2020:
ESI provided HCA their pricing guarantee reconciliation on 25 March 2020 and additional explanations on 09 April 2020. ESI calculates the discount underperformance of the guarantee(s) at $1,902,399.91.

Retail Claims Dispensing Fees

Name Brand Claims

Per the Agreement, the dispensing fee during the audited period is to be an aggregate of $x.xx for 1-83 days supply of Retail Name Brand prescriptions.

HCA Findings: The dispensing fees ranged from $x.xx to $x.xx with an aggregate average dispensing fee of $x.xx, below the guaranteed level. The aggregate paid by PEBP reflects an overperformance by an estimated $15,825 as compared with the guarantee.

Per the Agreement, the dispensing fee during the audited period is to be an aggregate of $x.xx for 84-90 days supply of Retail Name Brand prescriptions.

HCA Findings: The dispensing fees ranged from $x.xx to $x.xx with an aggregate average dispensing fee of $x.xx, above the guaranteed level. The aggregate paid by PEBP reflects an underperformance by an estimated $691 as compared with the guarantee.

Generic Brand Claims

Per the Agreement, the dispensing fee for the audited period is to be an aggregate of $x.xx for 1-83 days supply of Retail Generic prescriptions.

HCA Findings: The dispensing fees ranged from $x.xx to $x.xx with an aggregate average dispensing fee of $x.xx, above the guaranteed level. The aggregate paid by PEBP reflects an underperformance by an estimated $8,166 as compared with the guarantee.

Per the Agreement, the dispensing fee for the audited period is to be an aggregate of $x.xx for 84-90 days supply of Retail Generic prescriptions.

HCA Findings: The dispensing had an aggregate average dispensing fee of $x.xx, within the agreement guarantee.

Mail Order Brand Name Dispensing Fees

Name Brand and Generic Claims

The dispensing fee for Mail Order Name Brand and Generic prescriptions is to be $x.xx.

HCA Findings: The average dispensing fee was found to be $x.xx in compliance with the agreement.

Specialty Drug Dispensing Fees

The dispensing fee for all Specialty Drug claims is to $x.xx.

HCA Findings: The average dispensing fee was found to be $x.xx in compliance with the agreement.

Aggregate Claims Dispensing Fees

Per Agreement, all dispensing fee guarantees will be reconciled annually against actual results. Overperformance may be used to offset discount rate underperformance.

HCA finds the actual aggregate dispensing fee paid by PEBP for all categories is $6,968 less than the aggregate guaranteed rate.

ESI Comment: – ESI notes the pricing guarantee reconciliation has not yet been reconciled therefore ESI's self-reported totals cannot be provided at this time. The reconciliation will be completed by March 01, 2020 (240 days from end of plan year) in accordance with the PBM Agreement. The guarantees will be requested and provided within two weeks of the completion date.

HCA UPDATE 09 April 2020:
ESI provided HCA their pricing guarantee reconciliation on 25 March 2020 and additional explanations on 09 April 2020. ESI calculates the discount underperformance of the guarantee(s) at $22,353.94.

Processing Accuracy

Per agreement, xx% of all claims (Retail and Mail Order) are to be paid with no errors. Errors are displayed as the incorrect drug, form, strength or wrong patient.

HCA Findings: Reports for this issue was reviewed by HCA and found to be xx% for retail and xx% for mail order claims during the audited period.

Mail Order Processing Time

Per agreement, clean claims (without intervention) are to be shipped within x business days of receipt and claims requiring intervention are to be shipped within x business days for each quarter year period.

HCA Findings: All claims paid within this audited period were in compliance with this portion of the agreement with claims without intervention being shipped in an average of x.x days and claims with intervention shipped in an average of x.x days.

Manufacturer Rebates

The contract for services with PEBP is to collect, report and pay manufacturer rebates on a xxxxxx basis and payments will be made within xx calendar days after the last calendar day of the xxxxx in which such rebates are received. As per Agreement, ESI agreed to provide PEBP the greater of a flat guarantee of $xx.x per net 1-83 day supply retail name brand paid claim, $xxx.xx per net 84-90 day supply retail name brand paid claim, $xxx.xx per net mail order name brand paid claim, $xxx.xx per specialty drug claim dispensed through participating pharmacies and $xxx.xx per specialty drug claim dispensed exclusively through ESI Specialty Pharmacy or the yield of manufacturer rebates collected for PEBP claims by ESI.

There are typically multiple types of payments pertinent to manufacturer rebates; (access, administration cost, base and market share). PEBP is paid an estimation of rebates by quarter and the actual amount is calculated as the rebates are received.

Reports received from ESI reflected the manufacturer rebate reimbursement payments made to PEBP in the following amounts and require PEBP verification of receipt:

Quarter	Period	Retail	Mail Order	Total
1	01 Jul - 30 Sep 18	$x,xxx,xxx.xx	$x,xxx,xxx.xx	$x,xxx,xxx.xx
2	01 Oct - 23 Dec 18	$x,xxx,xxx.xx	$x,xxx,xxx.xx	$x,xxx,xxx.xx
3	01 Jan - 31 Mar 19	$x,xxx,xxx.xx	$x,xxx,xxx.xx	$x,xxx,xxx.xx
4	01 Apr - 30 Jun 10	$x,xxx,xxx.xx	$x,xxx,xxx.xx	$x,xxx,xxx.xx
	TOTALS	$x,xxx,xxx.xx	$x,xxx,xxx.xx	$xx,xxx,xxx.xx

HCA findings: HCA requested the appropriate reports regarding the calculations and payments to PEBP for PEBP's Plan Year 2019. HCA received the ESI reports on 20 April 2020 for the audited quarters. The total reported as PEBP's paid share is $xx,xxx,xxx.xx, an overperformance of the guarantee for this category. HCA requests that PEBP verify that this amount was received by PEBP for Plan Year 2019 manufacturer rebates.

ESI Comment: – ESI notes the rebate report will be available once the true up is completed. The true up will be completed by March 01, 2020 (240 days from end of plan year) in accordance with the PBM Agreement. The report will be requested and provided within two weeks of the completion date.
HCA Update: The rebate true up was received on 20 April 2020.

Customer Service

A. Per the contract for services, the telephone response time is to be an average of xxxxx seconds (x:xx) or less.

HCA Findings: HCA obtained the data for this issue and found the telephone response time range per quarter to have a range of x.x seconds (x:xx.x) to xx.x seconds (x:xx.x) for an aggregate average of xx.x seconds (x:xx.x) over-performing the benchmark level guaranteed within the agreement.

B. Per the contract for services, the telephone abandonment rate is to be less than xxxx percent (x%) of all calls.

HCA Findings: HCA obtained the data for this issue and finds that the abandonment telephone rate ranged from x.x% to x.x% for each quarter year measurement, within the guarantee level.

C. Per the contract for services, xx% or greater of the incoming telephone calls from participants are to be resolved within the first call received.

HCA Findings: HCA obtained the data for this issue and finds that the first call resolution equaled xx% for the year measurement, within the guarantee level.

D. Per the contract for services, xx% of PEBP PPO Plan Participants must have a network pharmacy within xxxx (x) miles of their residence.

HCA Findings: HCA requested a report that reflects the percentage of this issue. The report reflected that xx% of PEBP participants had at least one (1) Network Pharmacy within x miles of their residence for each of the quarter year periods.

E. Per Agreement, an annual Program Satisfaction Survey is to be conducted of PEBP plan participants who have used the pharmacy benefit. xxxxx percent (xx%) or more of participants must provide a "satisfactory" level of services they received or a penalty can be assessed.

HCA Findings: Per the Customer Satisfaction Survey results, ESI underperformed the guaranteed metric measurement of xx% with xx% satisfied members surveyed.

ESI comment: – ESI agrees with HCA's findings. ESI estimates the penalty payment to be $6,301. The final amount will be provided upon finalization of the audit in accordance with the PBM agreement.

Subcontractor Disclosures

Per Agreement supplied to HCA, is requesting that ESI supply a statement confirming if there are any exceptions of ESI notifying PEBP and receive approval a minimum of xx days prior to any subcontractor commencing work utilizing PEBP information or data.
ESI comment: ESI initially provided Nevada PEBP with a list of approved subcontractors, which Nevada PEBP approved. The ESI Account Team sends all changes occurring throughout the year to Nevada PEBP.

Data Storage Change Disclosures

Per Agreement, ESI must disclose to PEBP all physical locations of PEBP data storage. HCA is requesting that ESI supply a statement confirming if there are any exceptions of ESI notifying PEBP for movement of any data storage xxxx (xx) days prior to a subcontractor vendor of ESI.

ESI comment: ESI initially provided Nevada PEBP with a list of approved data storage facilities which Nevada PEBP approved. The ESI Account Team sends all changes occurring throughout the year to Nevada PEBP.

Eligibility Accumulators/Data Transfer delivered to PEBP Third Party Administrator

Per Agreement, ESI must make available xx% of full electronic claim accumulator extracts by xx:xx xxx on the next business day.

HCA Findings: Report received and reviewed for this category reflect that ESI met the guarantee for each quarter and is in compliance with the guarantee.

Per Agreement, a daily operational data file must be transferred, retrieved and processed by the predetermined time with no incorrect content.

HCA Findings: Report received and reviewed for this category reflect that ESI met the guarantee for each quarter and is in compliance with the guarantee.

AUDIT RESULTS – Period of 01 July 2018 through 30 June 2019
Performance standards do not apply

1. **Distributions**

Based on audit results, calculations for the distribution of Name Brand versus Generics and Retail versus Mail Order were measured for the audited period. Please note that Specialty Drugs and Compound Drug claims are not included within the number of claims and ingredient cost of claim distributions.

Number of Claims

Retail - Brand, xx.x% of total retail claims; Generic, xx.x% of total retail claims; Total, xx.x% of all claims.
Mail Order - Brand, xx.x%; Generic, xx.x% of mail order claims; Total, xx.x% of all claims.
Name Brand Prescriptions, xx.x% of all claims.
Generic Prescriptions, xx.x% of all claims.

Ingredient Cost of Claims

Retail - Brand, xx.x% of total retail claims; Generic, xx.x% of total retail claims; Total, xx.x% of all claims.
Mail Order - Brand, xx.x% of m.o. claims; Generic, xx.x% of mail order claims; Total, xx.x% of all claims.
Name Brand Prescriptions, xx.x% of all claims.
Generic Prescriptions, xx.x% of all claims.

Specialty Drugs

Distribution by claims number volume, xx.x% of all claims;
Distribution by Ingredient Cost, xx.x% of all claims.

2. Days Supply

The audited period was reviewed for claims that exceed the Day Supply maximum levels as per the PEBP PPO benefit plan. The claim detail reports were audited for retail claims that exceeded xx day supply and mail order claims that exceeded xx day supply that did not reflect a Prior Authorization or a maintenance drug prescription.

HCA Findings: The audit detected no exceptions within all categories.

3. Administration Fees

The audit reviewed the administration fees billed to PEBP for claim processing services during the audited period as compared with the PEBP Agreement. Per Agreement, PEBP will pay an administrative fee of $x.xx per employee per month (PEPM) for the period of PEBP's Plan Year 2019.

HCA Findings: Calculations for each month reflect that the correct method of "each employee" was applied at the agreed to PEPM value. PEBP paid a total of $xxx,xxx with an average of xx,xxx member fees per month.

The audit reviewed the fees billed to PEBP for appeal services during the audited period as compared with the PEBP Agreement. Per Agreement, PEBP will pay a fee of $xx.xx for Administrative level two appeals.

HCA Findings: x,xxx level two appeal services were provided to PEBP for a total fee of $xx,xxx for the audited period. HCA determined that these charges are in compliance with the Agreement.

The audit reviewed the fees billed to PEBP for AUM services during the audited period as compared with the PEBP Agreement.

HCA Findings: The audit reflects that PEBP paid a fee of $x.xx PEPM for the PEBP month of July 2018 and $x.xx for the remaining months of Plan Year 2019 for a total fee paid of $xxx,xxx.

4. Drug Utilization Review

This audit and previous audits have detected claims with extensive utilization (dispensing in every month of the audited period or excessive multiple prescriptions within the same time period) with scheduled drugs. HCA was supplied protocols and cases with said drugs where case management and the appropriate interventions were found to be applied and utilized.

HCA also previously requested documentation regarding sample cases in which the patients are utilizing drugs in which step therapy or alternate over the counter drugs should be used before prescriptions of said drugs are to be charged to the RX plan. Review of these reports reflects that ESI was found to have the correct system edits in place and properly reviewed each case for Drug Utilization Review and possible case management.

5. Possible Drug Benefit Exceptions

The audit revealed drugs paid within claims of the audited period, which could be considered exclusions of the PEBP PPO benefit plan. These possible drug exclusions should be verified by PEBP. Drugs audited for exclusions included but were not limited to: Fertility Agents (injectable and oral), sexual dysfunction (quantity greater than allowed), self injectables, diagnostic/biologicals, blood products, growth hormones without PA, hemophiliac factors, immunization, OTC, nutritional supplements, anorexiants, cosmetic, hair growth/replacement, infertility, and investigational drugs. ESI provided a report reflecting the following drugs dispensed through the PEBP benefit plan as permitted, however, they should be presented to PEBP for verification of possible exceptions that could be considered outside the PEBP benefits:

-xxxxxx, over age 26 to age 50 without Prior Authorization, (cosmetic);
ESI Response: x
X
X
X
X
X
X

-xxxxxx, over age 26 to age 64 without Prior Authorization, (cosmetic);
ESI Response: x
X
X
X
X
X
X

-xxxxxx, without a Prior Authorization, (xxxx);
ESI Response: x
X
X
X

HCA supplied a file containing samples of possible drug benefit exception claims for each of the drug as described above for ESI research and response. These sample claims and ESI responses can be found within file upon request from PEBP officials: St.NV.PEBP.RX.Possible Drug Exceptions.PY2019.ENCRYPTED.

REPORT DETAILS

I. SYSTEM CAPABILITIES

A. Drug Utilization Review (DUR)

ESI has the capability for the pharmacist to utilize a screen indicating specific patient information regarding known allergies and/or possible drug reactions. ESI Clinical Personnel will conduct a retroactive DUR review if necessary.

ESI does generate reports to determine prescribing and dispensing patterns for patients and pharmacies. ESI currently does not provide Current DUR Savings or Retrospective DUR reports monthly for PEBP; however, the ESI clinical pharmacist does provide physicians with reporting to encourage increased generic and formulary prescribing.

B. Diagnosis Sensitive Prescription Drugs.

The ESI system does not currently have the capability to edit specific prescriptions by comparing the diagnosis with other clinical data to determine appropriate dispensing.

C. Adverse/Potential Chemical Reaction.

The ESI system will edit if the prescriptions being dispensed would have an adverse reaction or potential chemical reaction when taken together.

D. Duplicate Claim Submissions.

The system edits for duplicate claims submitted either on-line or by paper. Three types of duplicate edits exist on the ESI system. These edits are for a True Ingredient Duplicate, which is when both claims have the exact same NDC number, a Therapeutic Duplicate and a "Refill Too Soon" Duplicate.

The ESI system will edit when multiple drugs are prescribed which would have the same therapeutic effect and if similar prescriptions are received from multiple providers concurrently.

E. Frequency/Dosage.

The ESI system will edit if a prescription is purchased prior to the time the original drug dispensed will be depleted (refill too soon). This edit is client specific. For PEBP participants, this edit will not allow the refill until xxxx xxxx percent (xx%) of the retail prescription and xxxx xxxx percent (xx%) of the dispensed mail order prescription usage time has expired.

The system is capable to edit if a prescription being dispensed indicates long term usage for a drug that is normally prescribed on a short term basis. The system is capable and will edit for failure to refill a prescription at the appropriate time.

F. Federal Legend Drug Requirement.

The system will edit to assure that the Federal Legend Drug Requirement is met utilizing the NDC (National Drug Code) number.

G. Appropriate Drugs.

The ESI system does contain edits to assure that drugs prescribed are appropriate for a patient's age or gender.

The ESI system does edit for prescriptions that may cause harm during pregnancy or lactation.

Drugs with possible uses for possible cosmetic or experimental conditions which are not allowed under the PEBP PPO benefit plan are flagged and denied or researched before payment is made.

H. Correct Pricing.

ESI utilizes automated pricing to assure that the charge is appropriate for the drug being billed.

I. Formulary Alternatives and Generic Substitution.

Currently, the ESI system does edit at the time of sale to show a formulary alternative or a generic substitution.

J. Ineligible Prescriptions.

ESI systematically denies specific types of drugs that the client advises them are ineligible by utilizing NDC and GPI, third party exception codes and Route of Administration.

K. Suspended Physician.

The ESI system has the capability for denial of a claim when a drug is prescribed by a physician with a suspended or restricted license.

L. Case Management and Subrogation.

ESI does have the ability to edit or identify prescriptions that may require Third Party Liability (Subrogation). These edits will be used only if the TPA contacts ESI to advise them of a subrogation situation.

ESI edits all prescriptions to identify drugs utilized for potential Case Management intervention. This information is communicated during a monthly meeting with Case Management personnel.

ESI was found to have the correct system edits in place and properly reviewed each case for Drug Utilization Review and possible case management.

II. CLAIM PROCESSING AND PROCEDURES

A. Electronic Claims Submission.

ESI currently does have a program which has the capability to receive electronic requests for prescriptions from physicians. ESI relies mostly on communications by, e-prescribing, forms, fax and sometimes E-Mail currently.

B. Overpayment Procedures.

If an overpayment is detected, ESI will subtract overpayments from future payments and credit the client when utilizing the retail and mail order programs.

C. Turnaround Time for Client Billing.

ESI remits payment to pharmacies on a xxx xxxxx basis. ESI will provide PEBP with invoices for retail and home delivery drugs on a xxx xxxx time basis.

D. Pended Claim Procedures.

Claims are not pended for additional information; claims are denied and processed when complete information is obtained.

E. Compound Drug Reimbursement.

ESI stated reimbursement for compound drugs is calculated using submitted price of the main ingredient for the compound. Compound drugs over xxxx xxxxx dollars filled at retail and xxxx xxxxx dollars filled through the mail order program require prior authorization.

F. Paper Claim Reimbursement.

Per ESI each client has the option of how paper claims are reimbursed. Under the PEBP agreement, employees are reimbursed at the contracted amount less applicable copayments and/or coinsurance for in network paper claims submitted.

The PEBP plan is currently set-up to reimburse participants at the contracted amount less applicable copayments and/or coinsurance for in network and out of network paper claims.

Per agreement, ESI charges $x.xx for each paper claim processed.

G. Mail Order Program.

The mail order program is integrated with the retail drug program. The system does not have the capability to pay the difference between the retail and mail order pricing when the mail order program is not utilized. This is pertinent for those plans which require subsequent refilled prescriptions be filled through the mail order program.

H. Filing Limitation.

The ESI system utilizes a filing limitation of xxx months for paper claims and xxxx (xx) days for pharmacies to resubmit a claim.

I. Specialty Drugs/Home Infusion

Many home infusion billings are adjudicated through the medical claims paying system. ESI has wholly owned subsidiaries, Accredo and CuraScript SP Pharmacy which are utilized for specialty drugs. These companies provide specialty pharmacy and related services for patients with certain complex and chronic health conditions. The focus of the specialty pharmacy is on infused, injectable, and oral drugs that:

- Are used recurrently to treat chronic and life-threatening diseases
- Are expensive
- Are difficult to administer
- May cause adverse reactions
- Require temperature control or other specialized handling
- May have restrictions as determined by the FDA

Accredo locations have been continuously accredited by The Joint Commission Home Care Accreditation Program since 2003. Beginning in 2011, Accredo pursued and received URAC Specialty Pharmacy Accreditation. The major Accredo locations in Warrendale PA, Corona CA, Greensboro NC, Orlando FL, Indianapolis IN, Memphis and Nashville TN are currently accredited by URAC.

III. ELIGIBILITY

Eligibility files are maintained on-line at ESI. Communication of eligibility for PEBP participants to ESI is determined by the eligibility listing received daily from PEBP. This includes changes, additions, terminations, dependent eligibility, and disabled dependent status. Eligibility information is loaded onto the ESI system within xxx hours of receipt. PEBP does have the option to have access to ESI's system so that manual eligibility can be entered; however, ESI stated that they have declined this option.

The ESI system has the ability to handle multiple eligibility periods for its members. Claims are processed by date of service to assure accurate processing without regard of benefit or eligibility changes. A pharmacist cannot add or change eligibility information.

The ID card is currently issued by PEBP's third party administrator, HealthSCOPE Benefits.

ESI relies on the information from PEBP to edit for an overage dependent. The ESI system shows dependents as either covered or not covered. ESI can provide claims data for participants who have terminated retrospectively.

ESI does have the capability for card to card COB determination through the RX system. ESI stated that currently PEBP is not using this feature.

ESI will deny any claim for Subrogation if they are notified of such by the TPA.
ESI is not specifically notified of PEBP participants who elect benefits under COBRA rulings under the eligibility file from the TPA. These elected participants are included as active within the regular eligibility listing.

IV. CUSTOMER SERVICE

A. Customer Service Availability

ESI Customer Service Representatives are available xxxx (x) days a week. In addition, an ESI Registered Pharmacist is available for questions xxx xxxx (xx) hours a day, xxxx (x) days a week. The telephone number for ESI is included on all prescription cards issued to the employees.

Benefit and specific client information is documented on-line. Telephone conversations are recorded. Customer Services Representatives are not able to make claim adjustments. Representatives are audited by phone monitoring and quality control.

Per the contract for services, the telephone response time is to be an average of xxxxx seconds (x:xx) or less. HCA obtained the data for this issue and found the aggregate average telephone response time to be in compliance with the guarantee for PEBP plan year 2019.

Per the contract for services, the telephone abandonment rate is to be less than xxxx percent (x%) of all calls. HCA obtained the data for this issue and finds that the abandonment telephone rate ranged from x.x% to x.x% for each quarter year measurement and found to be within the annual guarantee level.

B. Network Pharmacy Availability

Per the contract for services, xx% of PEBP PPO Plan Participants must have a network pharmacy within xxx (x) miles of their residence. HCA requested a report that reflects this issue percentage and in response, received the Accessibility Summary Report from ESI. This report reflected that xx% of PEBP participants had at least xxxx (x) Network Pharmacy within x miles of their residence.

C. Customer Satisfaction Report

Per Agreement, an annual Program Satisfaction Survey is to be conducted of PEBP plan participants who have used the pharmacy benefit. xxxxx percent (xx%) or more of participants must provide a "satisfactory" level of services received or a penalty can be assessed.

Per the Customer Satisfaction Survey results received from ESI, ESI did not meet the guaranteed metric measurement of xx% satisfied members surveyed. ESI supplied a report that displayed the results of the survey scorecard experienced by PEBP members to be at xx% for overall satisfaction during the audited period.

V. QUALITY ASSURANCE AND INTERNAL AUDITS/TRAINING

A. Quality Assurance Programs

Quality Assurance Programs exist for Benefit Administration, Eligibility and Pharmacy Services. Each department has its own procedures, checks and standards.

B. Internal Audit for Fraudulent/Abuse Claims

ESI does conduct internal audits for possible fraudulent drug abuse related claims. ESI issues monthly reports which display potential risk claims and presents them to a committee of Registered Nurses and Doctors for determination of possible action.

C. On-site/ Internal Desk Audit of Vendors.

ESI does perform on-site auditing of vendors. ESI audited xx.xx% of the pharmacies that submitted at least xxx claims, onsite and desk, for the time period 7/1/18-6/30/19.

D. Appropriate Care.

The ESI claims system edits for appropriate diagnosis, age and gender as well as edits on quantity and dollar limits. If ESI receives a complaint from a participant regarding the quality of service provided by a pharmacy, the ESI Provider Relations Department will contact the pharmacy/pharmacist for immediate resolution.

E. Employee Self-Audit.

ESI does not send EOB letters with a listing of prescriptions to PEBP participants in order to perform a self-audit. PEBP participants are able to view their EOB through the ESI website for self-audits.

F. Preapproval Programs.

ESI offers a preapproval program to predetermine appropriateness and medical necessity of specific prescription drugs.

G. Disease Management Programs.

ESI does offer Patient Care Management Programs to patients, physicians and pharmacists in the areas of Diabetic, etc.

H. Physician Assistance.

Pre-certification is generally provided by ESI Clinical Pharmacists. ESI's Medical Director is also available to assist as necessary.

ESI does have educational programs for physicians and pharmacists for potential drug substitutions.

I. Participant Assistance.

ESI does offer educational materials to PEBP participants with chronic diagnosis(es) through the Disease Management program. ESI stated that PEBP groups allow them to disseminate information regarding the Diabetes Sense program but does not have any mandatory programs in place.

ESI does notify associates when a mail order prescription is shipped and filled with a name brand drug that a generic drug is available.

J. Internal Audit/Training.

ESI does have an Internal Audit Department. Newly hired ESI employees are required to complete a formal training program. The duration of the training varies by the department employing the new hire. Additional/continued training needs are identified by internal audits, Quality Assurance or a customer/client complaint.

VI. SECURITY ACCESS

Security logs are created and monitored by ESI. Passwords are utilized by ESI employees and client personnel and must be updated. Client can access online eligibility via internet.

VII. REPORT CAPABILITIES

A. Possible Fraud and Drug Abuse.

ESI does have the capability to provide possible fraud and drug abuse reports by pharmacy and physician.

B. Percentage of Generic Drugs Dispensed.

ESI provides monthly reports to PEBP groups that will allow them to monitor the percentage of generic drugs dispensed.

C. Formulary Alternatives.

ESI has the capability to produce detailed reports regarding the percentage of brand name prescriptions filled with a formulary alternative. ESI stated that they currently provide Formulary Utilization Reports for PEBP groups at no additional cost.

D. Stop-Loss Accumulators.

ESI can communicate information to the TPA of stop-loss (if or when it may be appropriate) on a monthly basis. Since PEBP does not include stop-loss coverage this process is not required.

E. Prescribing Patterns of Individual Physicians.

ESI does have the capability to produce reports detailing prescribing patterns of physicians.

F. Large Numbers of Prescriptions per Patient.

ESI does have the capability to provide information to PEBP regarding participants who incur a large number of prescription claims.

G. Current and Retrospective Drug Utilization Review.

ESI does not generate reports to determine prescribing and dispensing patterns for patients and pharmacies. ESI currently does not provide Current DUR Savings or Retrospective DUR reports monthly for PEBP groups.

ESI's clinical pharmacist meets with the top prescribing physicians to provide benchmarking and encourages increased generic dispensing as well as use of OTC products.

ESI does provide retrospective DUR services. These services include:

- Therapeutic Duplication Review of same therapeutic class used concomitantly.
- Drug-Drug Interactions Review of drugs including any new drug interactions identified through review of clinical trials or warnings released by the FDA.
- High Prescription Utilization Review of all covered individuals.
- ESI reviews claims that are over a set dollar amount dispensed through retail and mail pharmacies.
- Narcotic/Controlled Substance Overutilization/Abuse Review of covered individuals who are utilizing multiple controlled substances and multiple physicians/pharmacies.
- Concurrent evaluations of medications with a potential for overuse.

H. Benefit Description Report

ESI has a summary plan description for each individual client. PEBP's summary plan description is utilized to adjudicate claims per the PEBP PPO benefit plan.

VIII. SAVINGS

A. Average savings from Average Wholesale Price (AWP).

A contract was obtained between ESI and PEBP as sponsor which reflects the discount available to PEBP groups when using the Prescription Benefit Manager (PBM) program for name brand and generic drugs dispensed at retail and the discount available when utilizing the mail order program. The agreement relevant to the name brand discounting for this audited period was to be calculated and reported in post lawsuit effect Average Wholesale Pricing (AWP) values. HCA's audit conformed that name brand prescriptions, both retail and mail order are in compliance with terms negotiated within the agreement.

Savings percentages were calculated excluding the dispensing fee and any administrative cost.

The discount rates were audited against the following criteria for PEBP as described within the Prescription Drug Program Services Agreement Attachment Addendum No. 02 (Negotiated Items) and supplied to HCA:

Drug Type	Discount	Disp. Fee
Retail Name Brand 1-83 days	AWP–xx.xx%	$x.xx
Retail Name Brand 84-90 days	AWP – xx.xx%	$x.xx
Retail Generics	AWP – xx.xx%	$x.xx 1 – 83 days $x.xx 84 – 90 days
Mail Order Name Brand	AWP-xx.xx%	$x.xx
Mail Order Generics	AWP-xx.xx%	$x.xx
ESI Pharmacy Specialty Drugs	AWP – xx.xx%	$x.xx

B. Usual/Reasonable versus Discount Price.

Pharmacies enter the Usual/Reasonable amount and the discounted price for each prescription into their computer database. These amounts are systematically compared, and the lower amount is paid. To assure ESI that their clients will pay the lowest cost available, the retail amounts submitted by the pharmacies are audited for accuracy.

C. Generic Pricing and Carrier Ability to Encourage Generic Prescriptions.

Typically, the copayments contained in a benefit plan encourage participants to utilize generic drugs. The application of these copayments (when applicable) is systematic. ESI does have the capability to entice the retailer to fill prescriptions with a generic drug by contracting reimbursement of higher dispensing fees. Retail pharmacists will receive an edit if a generic equivalent is available.

ESI does have capability to charge the member the difference between the cost of the brand and generic drug if a prescription is filled with a brand name drug solely at the patient's request (DAW 2).

In other words, if a generic equivalent for a prescribed brand name drug is available (multisource) but the patient requests the brand name drug, the member pays the difference of the generic allowable and the brand name allowable rate.

ESI will reimburse the retailer the cost of the generic equivalent when a prescription is filled with the brand name drug due to the pharmacists choosing to dispense the brand name drug (DAW3). Provider contract does dictate reimbursement utilized for a DAW 3; however, ESI will reimburse the pharmacy at the generic pricing.

ESI will reimburse the retailer the cost of the generic equivalent when a prescription is filled with the brand name drug if a pharmacy is utilizing a (DAW 4) generic not in stock. The pharmacy is reimbursed at the generic pricing in this situation.

When the mail order program is utilized, the prescription is always filled with the generic equivalent unless prohibited by law.

ESI offers educational programs for physicians, pharmacists and patients for potential substitution of brand name with generic drugs.

Formulary Alternative

This section is for review of the ESI formulary program. When a generic drug is not available, there may be more than one (1) brand name drug to treat a condition.

Formulary programs provide a list of recommended brand name drugs for physicians and pharmacists to utilize when prescribing and dispensing medications. It is an alternative tool for controlling rising drug costs while maintaining patient care.

The brand name drugs listed are a preferred list of drugs that have been selected based on their ability to meet a patient's needs at a lower cost. The Formulary maintained by ESI contains xx% of generic drugs and xxx single source brand drugs. Lists of these drugs are printed and distributed yearly and are available for review via the internet.

The Formulary Committee is composed of clinical pharmacists and a Clinical Director and the Review Committee is composed of physicians and Pharm Ds. Formulary medications are selected based on safety, efficiency, therapeutic merit, current standard of practice and cost. Changes are made as deemed necessary to remain responsive to the needs of patients and clients. Formulary educational materials are sent to physicians, pharmacies and patients.

ESI does have the capability to apply an employee rebate program for those employees who switch and utilize alternate drugs.

IX. COPAYMENTS

A. Copayments

HCA was supplied Benefit Summary for PEBP. The following copayments were - reflected in these summaries. The annual medical deductible does apply to dispensed prescription drug claims and is coordinated with the PEBP Medical Third Party Administrator.

Consumer Driven Health Plan (CDHP)

- In-network Retail:
  Name Brand and Generic – 20% Co-Insurance after Deductible
  Brand Non-Preferred –Not covered - 100% Copay

- Mail Order
  Name Brand and Generic – 20% Co-Insurance after Deductible
  Brand Non-Preferred –Not covered - 100% Copay
  Out-of-network Provider – Not covered

- Specialty Medications
  Name Brand and Generic – 20% Co-Insurance after Deductible
  Out-of-network Provider – Not covered

Exclusive Provider Organization (EPO) Premier Plan

- In-network Retail:
  Name Brand - $40.00 Copayment
  Generic – $7.00 Copayment
  Brand Non-Preferred – $75.00 Copayment

- Specialty Medications
  Name Brand and Generic – 30% Co-Insurance after Deductible
  Out-of-network Provider – Not covered

The audit detected no copayment exceptions within the categories of Retail Name Brand, Retail Generics, Mail Order Name Brand and Mail Order Generics.

ESI Comment:

Express Scripts has completed the research for the findings presented above and is available to discuss plan benefit set-up directly with Nevada PEBP should any questions remain.

12.

12. Public Comment

13.

13. Adjournment