Master

TAB I

Part I A – Technical Proposal	
RFP Title:	Utilization Management and Large Case Management
RFP:	3084
Vendor Name:	***Quantum Health, Inc.***
Address:	***7450 Huntington Park Dr, Suite 100 Columbus, Ohio 43235-5740***
Proposal Opening Date:	December 3, 2013
Proposal Opening Time:	2:00 PM

TAB II - Table of Contents

TAB I – TITLE PAGE 1
TAB II – TABLE OF CONTENTS 2
TAB III – VENDOR INFORMATION SHEET 3
TAB IV– STATE DOCUMENTS 4
TAB V – ATTACHMENT B – Technical Proposal Certification of Compliance 24
TAB VI – SECTION 3 – Scope of Work 25
TAB VII – SECTION 4 – Company Background and References 55
TAB VIII – ATTACHMENT G – Proposed Staff Resumes 64
TAB IX - Other Informational Material 66

TAB III - VENDOR INFORMATION SHEET FOR RFP 3084

Vendor Must:

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

B) Type or print responses; and

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

V1	Company Name	***Quantum Health, Inc.***
V2	Street Address	***7450 Huntington Park Drive, Suite 100 Columbus***
V3	City, State, ZIP	***Columbus, Ohio 43235***

V4	Telephone Number		
	Area Code: ***614***	Number: ***395-5952***	Extension: ***N/A***

V5	Facsimile Number		
	Area Code: ***866***	Number: ***849-8912***	Extension: ***N/A***

V6	Toll Free Number		
	Area Code: ***800***	Number: ***257-2038***	Extension: ***1145***

V7	***Contact Person for Questions / Contract Negotiations, including address if different than above***
	Name: ***John Bradford***
	Title: ***Vice President of Account Services***
	Address: ***7450 Huntington Park Drive, Suite 100 Columbus, Ohio 43235-5740***
	Email Address: ***John.Bradford@Quantum-Health.com***

V8	Telephone Number for Contact Person		
	Area Code: ***614***	Number: ***395-5952***	Extension: ***N/A***

V9	Facsimile Number for Contact Person		
	Area Code: ***866***	Number: ***849-8912***	Extension: ***N/A***

V10	***Name of Individual Authorized to Bind the Organization***	
	Name: ***John Bradford***	Title: ***Vice President of Account Services***

V11	Signature ***(Individual must be legally authorized to bind the vendor per NRS 333.337)***	
	Signature:	Date: ***11/27/13***

Tab IV – State Documents

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

Brian Sandoval
Governor

Greg Smith
Administrator

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

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

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

3084 RFP TIMELINE

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

ALL ELSE REMAINS THE SAME FOR RFP 3084.

Vendor must sign and return this amendment with proposal submitted.

Vendor Name: ***Quantum Health, Inc.***

Authorized Signature:

Title: ***Vice President of Account Services*** Date: ***11/27/13***

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

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

Brian Sandoval
Governor

Greg Smith
Administrator

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

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

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

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

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

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

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

   See the response to question #2.

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

   See the response to question #2.

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

5. additional attachments, specifically attachments A through J. Can you please tell me where I can find attachment A through J?

Those attachments were intentionally omitted from the RFP. These attachments refer to administrative functions that are related to PEBP and its business operations and would not affect any vendor who would bid on this RFP.

6. What are the names of the organizations that submitted questions?

This information is not available.

7. Section 3.7, page 11: Are bidders required to be fully accredited by URAC in utilization management and/or case management?

PEBP prefers that URAC accreditation be in place at the start date of the contract, July 1, 2014. If a vendor is in the process of accreditation and if the date of accreditation is within a reasonable timeframe of the start date of the contract, PEBP may be willing to make accreditation a negotiated item of the contract.

8. Section 3.9.4, page 13: In this section, there is a statement that, "your organization's ability to provide these services with these requirements." Please describe what these services are. In particular, please explain what is meant by a "Letter of Agreement" which is mentioned in this section.

A Letter of Agreement (LOA) is a document facilitated by the UM/CM vendor that is typically exchanged between the facility, PEBP as the payer, and HealthSCOPE, the third party administrator, stating that a certain plan exception is being made in the case of a specific plan participant. The exception may be a negotiated case rate, allowing a facility that is not in the network to be considered in-network for the purposes of treating that participant in exchange for a discounted rate, or extending a stay in a facility beyond what PEBP's Master Plan Document states when, based on certain clinical criteria, a participant's condition warrants the exception.

9. Section 3.9.5, page 13: Does PEBP pay for the health plan auditor, or is this contractor expected to pay for the health plan auditor? Please explain.

PEBP is responsible for paying its health plan auditor.

10. Section 3.11.1.2, page 13: Does PEBP have a mandatory or preferred location for the nurse case managers assigned to this contract? If so, please explain.

PEBP requires that the case manager nurses servicing this contract be licensed appropriately for the states in which they provide services.

11. Section 3.11.4 and Section 3.11.1.5, pages 13 and 14: Both of these sections request descriptions for criteria for case management services. Please explain the difference in these two questions. Please explain the difference between general case management and large case management.

Section 3.11.1.5 lists some of the additional conditions/complications that separate general case management from large case management.

12. Section 3.11.2.13, page 17: Is PEBP willing to accept recommendations from this contractor regarding which services should require pre-certification?

PEBP works in partnership with all its vendors and accepts recommendations from its vendors; however, PEBP has the final say in what changes to the plan are made.

13. Section 3.19, page 22: Does the current contractor have performance standards and/or performance guarantees? If so, has PEBP collected any performance guarantee financial penalties? Please describe.

All PEBP contracts have performance standards and guarantees. The current vendor has not had any financial penalties assessed.

14. Section 5.2, page 29: Are plan participants the primary participant only, or does plan participant include the primary participant and the covered dependents? Please explain.

The PPPM listed is Per Participant Per Month, meaning <u>primary participant</u> only. Vendors are encouraged to price their services accordingly.

15. Contract for Services of Independent Contractor, Section 14, p. 4: Will the State agree that the contractor will not be liable to indemnify the State for claims to the extent that those claims arose from the negligence or willful acts or omissions of the State or its employees or agents?

The Contractor's obligation to indemnify the State under this section shall not require indemnification for the State's own fault or negligence. However, if a loss is caused by the Contractor's negligence or fault, the existence of some concurrent, contributory, or joint negligence on the part of the State would not relieve the Contractor of its obligation to indemnify to the full extent of the loss caused by the Contractor.

16. Contract for Services of Independent Contractor: Is the State willing to include a section in the contract regarding the confidentiality of peer review deliberations clause such as: a. To preserve the integrity of independent review, Contractor will keep, and is entitled to keep, confidential and will not disclose to the State, a Covered Person, or any other interested party the full identity of any clinical reviewer and/or Qualis Health physician reviewer who provides services under this Agreement except where such identities must be disclosed pursuant to U.S. Department of Labor regulations, 29 C.F.R. section 2560.503-1 (the "DOL Regulations"), the American Accreditation of Health Care Commission ("URAC") standards, or as may otherwise be required by law or by a court of competent jurisdiction. Qualis Health will also keep confidential and will not disclose to the State, a Covered Person, or any other interested party the discussions, communications, review notes, minutes of meetings and any other records of discussion and judgments involving the Utilization Management Services, except where such disclosure is required by the DOL Regulations, URAC standards, or as otherwise required by law or by a court of competent jurisdiction. The parties mutually agree that 42 C.F.R. section 480.139(b) (Reasons for Quality Improvement Organization Decisions) is hereby incorporated by reference into this Agreement and will apply with respect to the UM Services rendered by Qualis Health. For purposes of applying such regulations to this Agreement, the reference therein to "those who have access to Quality Improvement Organization information" will be

interpreted to refer to the State and its applicable employees and agents; and the State will comply with the provisions

This is something that PEBP will submit to the agency Deputy Attorney General for review if needed for negotiation if this vendor is chosen.

17. Contract for Services of Independent Contract: Please clarify if the Contractor's UM and CM decisions are advisory only to the State, so that the State is not bound by the UM and CM decisions by this contractor.

PEBP accepts the clinical decisions made by the UN/CM vendor as advisory only.

18. Business Associate Agreement: Is the state be willing to negotiate some of the terms of the Business Associate Agreement so that both parties may be in compliance with current HIPAA requirements?

PEBP's Business Associates Agreement is revised on a regular basis based on the results of its biennial legal compliance review. PEBP may be open to suggestions from the vendor as long as the suggestions are minimal and do not change the intent of the agreement.

19. Section 3.9.1 – How many individuals from PEBP's TPA will need to access the contractor's Utilization Management/Case Management IT system.

This would be determined through negotiations with the winning vendor, PEBP's TPA, and PEBP's Chief Information Officer.

20. Section 3.9.3 – How many PEBP staff members/other vendors will participate in the bimonthly calls?

In addition to PEBP staff, PEBP's third party administrator, pharmacy benefit manager, representative from the statewide PPO network, and other vendors when requested will join the bimonthly calls.

21. Section 3.10 – Please provide the following Utilization Management and Case Management Data for the latest 12 month period: o Case Management Cases Opened o Case Management Cases Closed o Case Management Cases Open at End of the Period o Inpatient Authorizations by Specialty (Medical, Surgical, MH Acute, CD Acute/Residential and MH Residential o Inpatient Denials by Specialty (Medical, Surgical, MH Acute, CD Acute/Residential and MH Residential o Outpatient Authorizations o Outpatient Denials

The data available is provided in this embedded document.

PEBP SFY 2013
Annual Report.pdf

22. Please confirm that the implementation fee provided on the cost schedule should be in the format of a fixed fee and not a PPPM rate. *(Attachment I)*

The implementation fee may be in the form of a fixed fee in the cost scheduled provided in Attachment I.

23. Are there any reimbursable (pass through) costs like postage that should not be included in the cost proposal? *(Attachment I)*

    All costs that the vendor anticipates in the execution of this contract should be reflected Attachment I. This would include postage, marketing, travel, etc. PEBP will not reimburse for any costs other than what is proposed in Attachment I.

24. Please detail how payments for implementation services prior to July 1, 2014 will be paid and on what schedule. *(Attachment I)*

    There will be no payments made to any vendor for work done prior to the start date of July 1, 2014. If there are implementation costs they should be listed in the cost table provided in Attachment I.

25. When is the contract expected to be signed given that the vendor must be working to have implementation completed by July 1, 2014? *(Section I, page 4)*

    There will be no payments made to any vendor for work done prior to the start date of July 1, 2014. If there are implementation costs they should be listed in the cost table provided in Attachment I. The contract is expected to be presented at the April 2014 Board of Examiners meeting.

26. Please confirm the contractor has six months for implementation after BOE approval. *(Section I, page 4)*

    The contract is anticipated to be presented to the Board of Examiners in April 2014. The contract has the anticipated start date of July 1, 2014.

27. Will the State please confirm that answers to questions will be incorporated into the RFP by an amendment or addendum? *(Section 7.1, page 29)*

    The State will release an amendment that includes all questions with all answers. This amendment will be appended to the contract as an attachment.

28. Is the current pricing listed in 5.2 applied to all participants in the graphic "Current Plan Census?" *(Section 3.1 [page 8] and Section 5.2 [page29])*

    The pricing that is provided in Section 5.2 is what the current vendor is paid per month on a per-participant basis. The headcount can vary month to month based on plan census reports.

29. The requirements states that Healthscope have access to the UM/CM IT system. How many viewers will they require? *(Section 3.9.1, page 12)*

    This would be determined through negotiations with the winning vendor, PEBP's TPA, and PEBP's Chief Information Officer.

30. Is all travel relating to the administration of the proposed requirements billable to PEBP or are there specific functions designated for travel reimbursement. *(Section 11.3.2, page 46)*

All costs associated with this contract should be reflected in the table provided in Attachment I. PEBP will not reimburse vendors for travel that is not listed in the cost table provided in Attachment I. All costs that a vendor anticipates in the execution of this contract should be included. The line item for "Other" can be used for travel expenses if needed.

31. Section 3.10 refers the bidder to Attachment L for current vendor volumes for the 7/1/12 to 6/3013 time period. The document in Attachment L does not contain time frames and the tables are blank. The Executive Summary contains several service counts. Are these counts to be used for volume estimation? If so, what is the time frame? If not, can you please provide volumes for the last 12 months broken out by the pricing categories outlined in Attachment I, Cost Schedule? *(Section 3.10 [page 13]) and Attachment L)*

See the response top Question #21.

32. What is the anticipated earliest date PEBP may request services to be initiated? *(Section 1, page 4)*

PEBP does not anticipate the start date of this contract being prior to July 1, 2014.

33. Does the State anticipate any significant increase or decrease in the total number of eligibles prior to contract start date? And if so, by what anticipated amount/percentage? *(Section 3.2, page 9)*

While the total number of participants enrolled in the PEBP plan can vary from month to month, there are typically no great variations in the number from month to month. PEBP does not foresee a great increase or decrease in the total number of eligible plan participants.

34. The CDHP is one benefit option to employees. Please confirm that participants have access to local HMOs and a retiree health insurance exchange. Please confirm that services under this RFP are for those that choose the CDHP only? Are there any strategic initiatives that would decrease enrollment in the CDHP? *(Section 3.2, page 9)*

Confirmed. Eligible PEBP retirees must enroll in a Medicare Exchange. Other participants, including active employees and retirees not yet Medicare-eligible, must choose between the CDHP and the HMO plans. There are no planned initiatives that would decrease enrollment in the CDHP. The CDHP is PEBP's default plan.

35. What is the approximate number of PEBP staff that will need access to the reporting tools? *(Section 3.4.2, page 11)*

There are approximately four (4) staff members needing access.

36. What is the anticipated annual volume and types of ad hoc reports that may be requested by PEBP? *(Section 3.4.3, page 11)*

This information is unknown at this time.

37. Does the State require that only Registered Nurses provide the Utilization Management services or would the State be open to a combination of Registered Nurses and Licensed Practical Nurses? *(Section 3.5.2, page 11)*

PEBP requires that registered nurses provide case management and large case management services. For utilization management, registered nurses and/ or licensed practical nurses would be acceptable.

38. What is the approximate number of individuals, with HealthSCOPE benefits? *(Section 3.9.1, page 12)*

This would be determined through negotiations with the winning vendor, PEBP's TPA, and PEBP's Chief Information Officer.

39. Who will require access to the UM/CM vendor's system? *(Section 3.9.1, page 12)*

See the answer to question #38.

40. Please provide a list of the states in which PEBP participants reside. *(Section 3.11.1.19, page 16)*

Currently, PEBP has participants residing in all 50 states.

41. Please provide the number of participants per state. *(Section 3.11.1.19, page 16)*

Requested information is provided in this embedded document.

Participants by State.xlsx

42. The Service Performance Standard references both Quarterly and Annual management reports. However, the method of measurement only references Quarterly reports. Please confirm that both Quarterly and Annual reports will be provided by the vendor and the associated timing of delivery for each. *(Section 3.19, page 22)*

The last quarterly report due from the vendor typically has the quarterly data, as well as an annual performance summary included. It serves as the annual report as well as the quarterly report. The schedule for the reports due from vendors is based on the PEBP Board meeting schedule and is subject to change. The schedule for the Plan Year 15 reporting schedule has not been determined.

43. Section 3.5 Vendor Staffing (p. 11) makes reference to an Account Manager, Registered Nurses and Technicians, but doesn't include the phrase – key personnel. Does the State have any requirements specific to key personnel or is this at the discretion of the vendor? If the former, please elaborate. *(Section 4.4, page 28)*

PEBP trusts that the vendor will staff the contract with the best staff available to meet the needs of PEBP and its participants.

44. Please provide the scoring associated with each of the evaluation criteria. *(Section 10.1, page 41)*

The criteria weights are confidential at this time.

45. Is a web portal available currently for internet submission of pre-certification requests? If so, please elaborate on the number of users, number of requests, how users are authenticated/validated? And what type of functionality is available, i.e., submission only, reporting, auto-auth determinations. *(Section 3.11.2.6, page 16)*

Currently a web portal is not available. PEBP exchanges all information with the current vendor via a secure email hosted by the vendor.

46. The RFP does not specifically talk about transition activities from the existing vendor. Please provide a high level description of what data, processes, and activities will be transitioned from the existing vendor as part of the implementation effort? *(General Question)*

All data associated with case management, utilization management, pre-authorizations, and all other related duties associated with the contract will be transferred to the new vendor. The data exchange requirements will be exchanged with the new vendor and PEBP's current vendors. Historical data will be transferred. Data is able to be exchanged once the contract is signed by the Board of Examiners, anticipated to be to April 2014.

47. Will historical data, authorization, and case management information be made available or will vendor start with a "clean slate"? If the date is made available, will the State expect us to import the data? *(General Question)*

See the response to question #46.

48. Does the State expect: (1) a complete, formal disaster recovery plan, (2) a detailed description of the proposed disaster recovery plan addressing each of the four scenarios listed, or (3) a sample/template of a disaster recovery plan? *(Section 3.16, page 20)*

Proposal response should include the prospective vendor's current production systems' disaster recovery plan for the systems that will support PEBP in the execution of this contract.

49. Section 3.3, page 10. Please provide review volumes for all CDHP services pre-authorized for the last full contract year per PEBP's Master Plan Document. What are the anticipated preauthorization review volumes during the coming year?

See the response to question #21.

50. 3.4.4, page 1. Please provide the type and volume of ad hoc reports requested during the last contract year.

During the last year there were no reports requested from the vendor outside of the vendor reports in the required vendor report format provided.

51. Section 3.11.2.13, page 17. Please state the frequency of updates to the PEBP Master Plan Document. What has been the historic review volume percentage increase associated with expanding the list of services requiring preauthorization on the PEBP's Master Plan Document; including the resultant increased volume for concurrent and retrospective reviews, if any?

PEBP's Master Plan Document is updated every plan year or as conditions warrant. Typically, updating the MPD does not cause a measurable increase in concurrent or retrospective reviews.

52. Section 3.11.3, page 17. What has been the volume of concurrent review during the last contract year?

See the response to question #21.

53. Section 3.11.4, page 17. What has been the volume of retrospective review during the last contract year?

See the response to question #21.

54. Can we please receive 2 years' worth of claims, pharmacy, and eligibility data to better customize our programs and refine our pricing?

The data provided for Question 21 is the data that will be provided for this RFP.

55. Will the PEBP provide regularly updated membership files including benefit plan enrollment and effective date spans?

Each PEBP vendor receives a monthly eligibility file. The vendor may contact PEBP with questions regarding the participants' eligibility or the participants' dependents eligibility should a potential discrepancy be identified.

56. Section 3.5.1 Does the account management need to be a full time employee dedicated to this contract?

PEBP expects the vendor to staff this contract appropriately; as such, PEBP expects its account manager to be available any time there is an issue with the contract, or when there is an issue with a participant which requires escalation or immediate resolution.

57. Section 3.5.2 Do the registered nurses need to be full time employees dedicated to this contract? OR Can a pool of nurses be used?

PEBP expects the vendor to staff this contract appropriately; however, PEBP would prefer that the nurses the vendor proposes using for this contract are staffed for the purposes of serving the PEBP population.

58. Section 3.9.2 What technologies are utilized for the electronic interface with HealthSCOPE Benefits? Secure File Transfer Protocol (sFTP)?

FTP is the method in which PEBP allows data to be exchanged between vendors.

59. Section 3.9.3 Is bimonthly meant as twice a month or every other month?

"Bimonthly" means twice per month.

60. Section 3.9.3.2 Does PEBP support the use Transport Layer Security (TLS) for email encryption between entities?

PEBP can support the use of TLS for email. Use of this technology would require specific configuration and testing with the approved entity.

61. Section 3.9.4 Will the Letter of Agreement (LOA) be required before the Utilization Management and Large Case Management Vendor can authorize services?

In cases where an LOA is required it must be approved by PEBP before services can be authorized.

62. Section 3.9.4 Will the Letter of Agreement require approval by PEBP before it can be finalized?

Yes.

63. Section 3.9.5 Will these audits be on-site at the vendor's location and include an "electronic" audit or will the vendor be required to submit reports, records, etc. via hard copy to the auditor?

The audits will be conducted on site at the vendor's location(s). The vendor will be required to submit certain reports and data to the auditor prior to the auditor's arrival, and at the request of the auditor when validated by PEBP.

64. Section 3.9.5 What is the frequency of the routine security audits?

The audits are scheduled to be conducted every other year.

65. Section 3.9.5 What is the notice period given prior to the Vendor prior to the audit occurring?

Typically, the UM/CM vendor is given 3-6 months' notice prior to PEBP's auditor arriving on site.

66. Section 3.9.5 What is the timeframe allocated for the audit?

PEBP's health plan auditor is typically on site for 2-4 days, depending on findings and the level of follow-up required to finalize the report. The audits are able to be finished timely when the vendor has all staff necessary for the audit on-site and ready to participate.

67. Section 3.10 The RFP references volumes in Attachment L. However, there are no volumes in Attachment L. Can those historical volumes please be provided?

See the response to question #21.

68. Section 3.11.1.9 Is it a correct assumption that requests for transplant will come through the Utilization Management and Large Case Management vendor, and if authorized as medically necessary, the vendor will then contact the third party administrator to coordinator with the Center of Excellence?

Typically, yes.

69. Section 3.11.1.9 Is the third party administrator responsible for coordinating/communicating with the Centers of Excellence contracts signed and the member to get the COE contract and agreement signed?

Yes.

70. Section 3.11.2.8 This denial rate should only include PPO plans, no other organizations or would PEBP care to see over denial rate for all pre-certification cases?

For this question, the denial rate should only apply to PPO Plans (CDHP).

71. Section 3.11.2.13 Does the PEBP plan to increase the pre-certification services in the future? If so, when?

PEBP cannot anticipate what plan design changes will be made in the future.

72. Section 3.11.2.13 Would the anticipated volume increase exceed 10% of the total volume?

See the response to question #71.

73. Section 3.11.4.2 Please define onsite. Onsite at the providers office or onsite in the UMCM vendors local office?

Onsite would be at providers' offices, facilities or other inpatient/outpatient locations.

74. Section 3.11.4.2 Will other methods be considered?

PEBP is open to whatever methods vendors propose to best meet the needs of the State and the participants of the plan.

75. Section 3.14.2 "PEBP requires vendors to assign a dedicated account manager..." Does this mean a full time employee?

PEBP requires the vendor to staff this contract appropriately.

76. Section 3.18.1 Will PEBP require the use of the HIPAA EDI X12 transactions to effect data interchanges with the Vendor for this scope of work? If yes, please identify the transaction (sets) that will be used.

All data exchanges (EDI processes) transmitting information to/from PEBP or between PEBP vendors will be reviewed and approved in advance by PEBP's CIO. EDI process requirements will be evaluated on an individual basis and configured as best suited for the purpose and systems in use.

77. Section 3.19 Does a "single claim or treatment plan" include continuation of services? (As an example, the member's initial reason for admission is not expected to exceed $100,000. However, complications occur which will then result in a claim of >$100,000.)

Yes.

78. Section 3.19 Is it a correct assumption that the "odd year audits" will include two years' worth of cases? Which means that penalties, if they exist, will be paid only every other year but incorporate penalties that may have occurred in the year before?

Yes.

79. Section 11.3.2 Is the travel indicated in this provision travel related to the execution and operationalization of this contract? OR Does it only apply to potential travel not directly related to this contract?

PEBP does not reimburse for travel. Any travel must be included in the cost proposal in Attachment I. Travel costs may be included as line item "Other." PEBP will not consider any expenses that are not a part of the cost proposal.

80. Attachment D (Contract Form) Can the State clarify the term for cross-liability coverage?

The State is looking for assurance that the insurance policy does not exclude coverage if one insured is liable to another insured.

81. Attachment E (Insurance Schedule) Can the State clarify the need for automobile insurance and to be named as an additional insured?

The State requires all contracted vendors to maintain this coverage naming the State as an additional insured on the policy when the vendor has the possibility of coming on to State property for any reason while performing the duties of the contract.

82. Attachment M (Privacy Security Policies and Procedures) Please provide these two documents: Attachment I - HIPAA/HITECH Notice Requirements and Attachment J - New Breach Determinations effective September 23, 2013.

See the response to question #5.

83. Attachment N (Business Associate Agreement) Can the State clarify the means by which business associate is expected to communicate notifications/approvals and to whom they should be made?

All notifications will be made to PEBP. All approvals will come from PEBP. Notifications must be made in accordance with the terms of the contract.

84. With regard to requirement 3.5 VENDOR STAFFING (3.5.3), what are the desired qualifications of "Technical Staff." Could LPNs serve in this role?

See the response to question #37.

85. With regard to requirement 3.13 Facility Channeling -What is the requirement related to communicating in network and out of network reviews to members, facilities and providers. -How many networks are available? -Is there capability to provide the provider file for the providers within network?

The lists of participating providers (in Nevada and outside of Nevada) are located on the PEBP website at www.pebp.state.nv.us.

86. With regard to requirement 3.11.1.8, -What Transplant Networks does the State of Nevada currently contract with? -Who is HealthSCOPES transplant network for Center of Excellence?

HealthSCOPE Benefits contracts with several Center of Excellence networks for transplants. Cigna and Lifesource are two examples.

87. With regard to requirement 3.11.1.3, the State mentions on-site case management. -Can you please provide a list of possible locations and caseloads where on-site would be needed? -Can you please provide a number of how many cases have required on-site case management? -Is on-site CM part of the State's current program? If so, are there specific case scenarios that trigger on-site engagement?

PEBP relies on the vendor to propose the best possible options to meet the needs of the state and the participants of the program. Onsite case management has not been a requirement previously.

88. With regard to requirement 11.3.2, Are travel expenses reimbursable?

See the response to question #30.

89. With regard to section 5. Cost: Would the State consider a Per Employee Per Month or Per Member Per Month fee structure?

With the exception of implementation costs and travel costs, which can be listed as flat dollar amounts, all other costs associated with this contract need to be listed in a PPPM (per participant per month) format.

90. How does the State define a "participant" for Per Participant Per Month pricing? For example, if one employee has an event that requires multiple pre-authorizations for that single event, is that employee considered one Participant?

See the "Definitions" section of the RFP. A participant refers to the primary insured (active employee or retired employee).

91. Can the State provide volume counts for 2012 "participants? -Can the State provide hospital census data? -Can the State provide hospital census data by primary diagnosis?

See the response to question #21.

92. Can the State provide the number by type of out-patient pre-authorizations, or just the aggregate number of out-patient pre-authorizations?

See the response to question #21.

93. How many large case management cases does the State refer directly to the vendor on a monthly average?

See the response to question #21.

94. How many large cases were managed by the State's current vendor in 2011 and 2012?

See the response to question #21.

95. Does the State have a fixed budget based on last year's volume and current vendor pricing?

The State does not have a fixed budget.

96. Regarding requirement 4.4, Vendor Staff Resumes, a. Please provide examples on who the State considers "key personnel" b. Is it your intention that the "relevant professional experience" represents current clients under service with the vendor? c. Are the references at the bottom of the form the same three from the relevant professional experience section above on the form?

PEBP expects that the vendor will propose qualified staff that can best meet the needs of the State and participants of the plan.

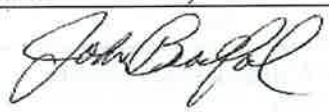
97. With regard to requirement 3.5 VENDOR STAFFING (3.5.3), what are the desired qualifications of staff in the UM decision making process - to meet the needs of PEBP participants, and PEBP providers?

See the response to question #37.

ALL ELSE REMAINS THE SAME FOR RFP 3084.

Vendor must sign and return this amendment with proposal submitted.

Vendor Name: ***Quantum Health, Inc.***

Authorized Signature: 

Title: ***Vice President of Account Services*** Date: ***11/27/13***

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

ATTACHMENT A – CONFIDENTIALITY AND CERTIFICATION OF INDEMNIFICATION

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

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

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

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

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

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

Part I B – Confidential Technical Information			
YES		NO	JB
Justification for Confidential Status			
N/A			

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

Part III – Confidential Financial Information			
YES	JB	NO	
Justification for Confidential Status			
N/A			

Quantum Health, Inc.
Company Name

Signature

John Bradford, VP of Account Services ***11/27/13***
Print Name Date

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

ATTACHMENT C – VENDOR CERTIFICATIONS

Vendor agrees and will comply with the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

Quantum Health, Inc.

Vendor Company Name

Vendor Signature

John Bradford, VP of Account Services ***11/27/13***

Print Name Date

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

Copies of any vendor licensing agreements and/or hardware and software maintenance agreements.

This is not applicable, as Quantum Health does not lease any hardware or software to perform our health management services.

Certificate Number: U100062R - 1164

Certificate of Full Accreditation

is awarded to

Quantum Health, Inc
7450 Huntington Park Drive Suite 100
Columbus, OH 43235

for compliance with

Health Utilization Management Accreditation Program

pursuant to the

Health Utilization Management , Version 6.0

Effective from the Wednesday 1st of June of 2011 through the Sunday 1st of June of 2014

William Vandervennet
Chief Operating Officer

Susan DeMarino
Vice President of Accreditation Services

ACCREDITED
HEALTH UTILIZATION MANAGEMENT

URAC accreditation is assigned to the organization and address named in this certificate and is not transferable to subcontractors or other affiliated entities not accredited by URAC.

URAC accreditation is subject to the representations contained in the organization's application for accreditation. URAC must be advised of any changes made after the granting of accreditation. Failure to report changes can affect accreditation status.

This certificate is the property of URAC and shall be returned upon request.

Certificate Number: M112127R - 1164

urac

Certificate of Full Accreditation

is awarded to

Quantum Health, Inc
7450 Huntington Park Drive Suite 100
Columbus, OH 43235

for compliance with

Case Management Accreditation Program

pursuant to the

Case Management, Version 4.0

Effective from the Sunday 1st of April of 2012 through the Tuesday 1st of April of 2014

William Vandervennet
Chief Operating Officer

Susan DeMarino
Vice President of Accreditation Services

URAC

ACCREDITED
CASE MANAGEMENT

URAC accreditation is assigned to the organization and address named in this certificate and is not transferable to subcontractors or other affiliated entities not accredited by URAC.

URAC accreditation is subject to the representations contained in the organization's application for accreditation. URAC must be advised of any changes made after the granting of accreditation. Failure to report changes can affect accreditation status.

This certificate is the property of URAC and shall be returned upon request.

SECRETARY OF STATE

STATE OF NEVADA

NEVADA STATE BUSINESS LICENSE

COORDINATED CARE PROGRAMS, LLC

Nevada Business Identification # NV20111056639

Expiration Date: January 31, 2014

In accordance with Title 7 of Nevada Revised Statutes, pursuant to proper application duly filed and payment of appropriate prescribed fees, the above named is hereby granted a Nevada State Business License for business activities conducted within the State of Nevada.

This license shall be considered valid until the expiration date listed above unless suspended or revoked in accordance with Title 7 of Nevada Revised Statutes.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the Great Seal of State, at my office on November 14, 2012

ROSS MILLER
Secretary of State

This document is not transferable and is not issued in lieu of any locally-required business license, permit or registration.

Please Post in a Conspicuous Location

You may verify this Nevada State Business License online at www.nvsos.gov under the Nevada Business Search.

Copies of applicable certifications and/or licenses.

Please find included in this section copies of our URAC Accreditation for Health Utilization Management and Case Management, along with our State of Nevada Business License.

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

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

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

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

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

Quantum Health, Inc.

Company Name

Signature

John Bradford, VP of Account Services ***11/27/13***

Print Name Date

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

EXCEPTION SUMMARY FORM

EXCEPTION #	RFP SECTION NUMBER	RFP PAGE NUMBER	EXCEPTION (Complete detail regarding exceptions must be identified)
1	*Contract for Services of Independent Contractor*	N/A	*Please refer to our comments and exceptions in the attached copy of the State's "Contract for Services of Independent Contractor" form*

ASSUMPTION SUMMARY FORM

ASSUMPTION #	RFP SECTION NUMBER	RFP PAGE NUMBER	ASSUMPTION (Complete detail regarding assumptions must be identified)

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

SCOPE OF WORK

UTILIZATION MANAGEMENT, CASE MANAGEMENT, AND PRE-CERTIFICATION

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

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

Case management and large case management;

Confirmed

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

Confirmed

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

Confirmed

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

Confirmed

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

Confirmed

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

Confirmed

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

Confirmed

Carpal tunnel surgery;

Confirmed

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

Confirmed

Weight-loss surgery;

Confirmed

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

Confirmed

Dialysis- Inpatient and Outpatient;

Confirmed

Cardiac Pace Makers;

Confirmed

Illnesses requiring chemotherapy;

Confirmed

Any procedure that might be deemed to be experimental and/or investigational; And Durable medical equipment when the cost is expected to exceed $1,000.00.

Confirmed

MANAGEMENT REPORTING

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

This is confirmed. In addition, PEBP will have access to on-demand reports that are available on our secure website in real-time. Your benefit team will have the ability to select what data they want to see on their dashboard, select reports they can run on a regular basis and create ad hoc reports. Each individual team member can select different information and reports to display on their dashboard.

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

This is confirmed. PEBP will have access to on-demand reports that are available on our secure website in real-time.

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

Confirmed. PEBP will have the ability to create and access ad hoc reports via their secure website which will be generated in real-time.

VENDOR STAFFING

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

An account manager, whose primary responsibility is PEBP;

Confirmed.

Registered nurses, whose primary responsibility is PEBP; and

Confirmed.

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

Confirmed.

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

Confirmed.

QUALITY ASSURANCE

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

Confirmed.

UTILIZATION REVIEW AND PRE-CERTIFICATION APPEAL RESOLUTION

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

Confirmed.

NOTIFICATION OF SUB-CONTRACTORS

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

Confirmed.

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

Confirmed.

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

Confirmed.

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

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

COLLABORATION WITH PEBP AND PEBP VENDORS

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

Confirmed. Quantum Health will provide PEBP with a Gateway that may be accessed to perform this action. The PEBP staff will be able to see data and access certain pieces of information via the Gateway.

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

Confirmed. To successfully operate, our program requires close integration with the client's vendors (e.g. claim administrators, PBM, etc). Additionally, we regularly integrate with any additional internal client initiatives (e.g. wellness) or vendors (EAP, Behavioral Health), and actively refer patients to them depending on their situation.

Quantum Health integrates all patient-facing functions of healthcare -- customer service, referrals, pre-certifications, utilization review, case and disease management, and wellness activities -- into an integrated process that dramatically increases the opportunity for us to interact with members of interest, and to promote wellness events and services.

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

As the host, the UM/CM vendor agrees to provide a toll-free number and passcodes for PEBP approved vendors to access the bimonthly calls. These calls will allow for PEBP and

its vendors to collaborate on the direction of care and provide solutions to any issues that may be identified.

We respect the underlying issues this requested process addresses and the importance of this practice in traditional programs. The Quantum Health approach is different and we believe obviates the need for this process. However, we are open to discussion in regards to this request. Quantum Health integrates deeply with both the TPA and PBM with nightly feeds going both ways, and with Quantum Health providing the customer service for both as well. Because we handle all the calls, we are in position to prevent the problems you address on the proposed calls or solve them quickly.

We typically have a nurse working with 97% of members with over $10,000 in claims and because we are in continuous contact with members using healthcare, we intercept them 96% of time before the first claim is paid. This means we are involved as the case evolves and decisions are made. We are in the position to coordinate care avoiding unnecessary services, while making sure the member is getting the most out of their benefits.

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

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

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

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

PEBP, your TPA, and PBM will have a dashboard where you will have real time access to all stats, reporting and key information that you specify during implementation. Those you designate to be involved in benefit exception decisions will be immediately notified when an exception is recommended. We will work with you to use technology and optimal processes to create appropriate, efficient, and regular interface including routine phone meetings with your Account Team.

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

This is confirmed and agreed to.

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

through the audit process. Please indicate that your organization would agree to this condition.

This is confirmed and agreed to.

REVIEWED CASES

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

Reviewed and confirmed.

CARE COORDINATION

Case Management and Large Case Management

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

Confirmed.

How long has your organization provided case management services?

Case Management services are integrated in the Quantum Health Care Coordination model. Quantum Health's case management model has been in use since 1999.

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

The PEBP account will be serviced and managed at the Quantum Health headquarters in Columbus, Ohio. PEBP will be provided with a dedicated 800 number for both employees and employers. We also provide a member website and an employer website, which PEBP can use to access claims, plan information, health information, etc.

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

Case management services will be provided telephonically by Quantum Health's Care Coordinators.

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

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

G. Meeting durable medical equipment needs;

H. Planning for hospital discharges;

I. Coordinating home health care needs;

J. Coordinating hospice care; and

K. Coordinating community based services.

Confirmed. A detailed description of our criteria for general case management services is attached. Please refer to the attached "Case Management Overview" included with our response.

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

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

M. Potentially large-dollar claims;

N. Chronic or progressive disease;

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

P. Multiple diagnoses;

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

R. IV therapy or parenteral nutrition;

S. Severe injuries; and

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

Please refer to the attached "Case Management Overview" included with our response.

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

Yes, we allow members to self-refer to the case management program and encourage PEBP to refer covered individuals as well. This is included in our standard costs and fees.

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

OUR CASE MANAGEMENT GOALS:
The goal of Case Management is to reduce fragmentation of health care delivery during a complex time in a person's life. Nurses are specially trained to work with patients, families, physicians and facilities in an effort to coordinate all care. Through Case Management Care Coordination:

- ***The patient has an opportunity to improve quality of life and reduce out-of-pocket expenses.***
- ***The plan has an opportunity to realize savings since there are great efforts to educate the managing physicians on the use of in-network providers and facilities, as well as how the benefit plan works.***
- ***The Care Coordinators have an opportunity to help patients gain knowledge and understanding about how to care for themselves.***

OUR CASE MANAGEMENT APPROACH:
Our unique model reorganizes an employer's benefits delivery to make the most of each member interaction while minimizing confusion. To make that happen, we perform all customer service and care management allowing opportunities to intercept members in real-time—just as members are making their healthcare decisions. Our Care Coordinators intercept patients at all touch points in the healthcare process, including customer service, referrals, precerts, and reviewing claims data which results in increased engagement in Case Management.

This unique model produces different results compared to competitors:

- ***Highest engagements in the industry -- Our Care Coordinators have phone contact (not e-mails or passive mailings) with 85% of households and 62% of members.***
- ***Dramatic impact on utilization -- By intercepting members on a real-time basis and holding their hand through a complex healthcare system, we're able to make a dramatic impact on utilization—particularly in higher cost categories. Results include a 4% decrease in emergency room use, 22% fewer re-admissions, 7% decrease in in-patient length of stay, 11-16% decrease in-patient days, and a 5% less cases that average $50,000 or more.***
- ***98% of all patients who have claims over $10,000 are working with a Care Coordinator and reduces the cost of patients with >$50,000 in claims by 15%.***
- ***Significant savings in year one and beyond -- First-year clients net per employee per month savings ranges from $134 to $976. Clients, on average, experience 3.9%***

compound average trend over three years (versus the 10%+ industry average over the past decade).

• 100% guarantee on performance -- We put up to 100% of our fee at risk based on mutually agreed upon targets.

IDENTIFICATION:

In addition to reviewing historical medical claims for identification, members are identified through "intercept" throughout course of care. Identifying sources include: Health Needs Assessment, Customer Service, Employer referral, Disease Management referral, pre-certification information, Utilization Review, Post-discharge follow-up and medical/Rx claims. The logic behind PIVIT will trigger an automatic referral to Case Management for patients with identified diagnoses. Medical claim data is loaded nightly from the Claims Administrator and Rx data weekly from the PBM, so on a nightly basis, additional logic is run triggering alerts that are acted upon by case managers the next business day.

INTERCEPT:

Real time intercept occurs in the following manner:

1. *Provider request for treatment or services*
2. *Member calls requesting information*
3. *HR requests*
4. *Self-reported data (example HRA or Health profile)*
5. *Finally claims activity*

CONDITIONS MANAGED:

The Quantum Health Case Management program manages the following conditions:

- *Cancer*
- *Neurological conditions that are not under control (e.g., newly diagnosed MS)*
- *Post trauma (e.g., motor vehicle accidents or burns)*
- *Transplants*
- *Dialysis or End Stage Renal Disease*
- *Premature Infants*
- *Sickle Cell Anemia that is not under control*
- *HIV/AIDS*

CASE MANAGEMENT PROCESS:

Throughout the Case Management process the following conditions are assessed and action is taken:

- *Condition becomes exacerbated or acute*
- *There is a change in the psychosocial functions (example the member has loss of function due to progression of condition)*
- *Safety is compromised*
- *Over utilization of services or use of multiple providers*
- *Lack of an established treatment plan or ineffective treatment plan*
- *Underutilization of services*
- *Premature or delayed discharge from appropriate level of care*
- *Non-adherence to treatment or medication*
- *Lack of education related to condition, prognosis, or plan of care*

Our program also has a number of highly innovative processes:

- *The nurse becomes a patient advocate and contacts the physician and other*

members of the health care team making sure they are aware of benefits and services available.

- ***The Case Management process is initiated before the claim is incurred. Case managers are alerted to the case at the time of service or when treatment is requested.***
- ***Since Quantum is a partner with PEBP, there are also referrals made to the case manger through the HR team***
- ***Case managers are involved throughout the continuum of care. This is possible since the provider and member have a single point of contact for all health care events***
- ***Case managers have the opportunity to have access to data from claims, pharmacy, utilization review, and clinical notes in real time vs. having to request this information from other vendors or facilities***
- ***Case Management services are integrated in Quantum Health's Care Coordination model. Case managers are located in Pods designated to specific clients which allow them to meet Case Management criteria in "real time".***

PATIENT CONTACT:

The number of times a person is contacted by Case Management Care Coordinators varies with the individual. It is based on his/her needs and the needs of his/her caregiver. However, people in active management are contacted at least once a month. Frequent calls with providers occur during the course of the case. At a minimum, physicians and all provider members of the patient medical team are contacted whenever the patient has a change, anticipates procedures, or falls off the evidenced care path.

Case managers also assess and manage non-catastrophic high cost conditions. An example of this would be any diagnosis requiring growth hormone.

COMPLETION:

Individuals with cancer remain in management until active treatment is completed. For all other conditions, individuals remain in management until the condition is under control. The average length of time a person is in management is six months. After Case Management is curtailed, people who have a chronic condition, such as diabetes or heart disease, are referred to Disease Management for ongoing follow-up. In other situations, they are discharged from Case Management and readmitted only if their condition changes.

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

Please refer to the attachment titled "Transplant Overview" included with our response.

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

Yes, Quantum transplant Case Managers coordinate with the transplant coordinators at the COE and the plans transplant network coordinator, including donor evaluation service. Quantum agrees to work with PEBP's TPA when assisting members who require care at Centers of Excellence.

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

It has been our experience that 2-5% of the population will meet criteria and warrant intervention from case managers.

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

Since all clinical services are integrated at Quantum Health, the UR nurse is able to refer the member to case management, allowing for immediate contact with patient and/or family, and all healthcare providers that will be involved in post hospitalization.

We support members and their family while the member is in the hospital in a number of ways, including:

- ***When we are aware of a planned in-member stay, we call to review instructions, answer questions, and remind members we are available to help them and their family before, during and after hospitalization. It is common practice to speak with a spouse or caregiver and offer to be available for them during the stay.***
- ***During hospitalizations we receive calls from family members with questions about what is being done, concerns about recovery, and what to expect while their loved one is an in-member.***
- ***When a member is in Case Management or Disease Management, the Clinical Care Coordinator may call a designated spouse/care giver to check in with them, ask how the member is doing, and offer support.***

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

If, in the course of working with participants or providers in case management issues arise that warrant active participation of or action from either party, our cases managers will reach out to designated individuals to seek assistance on behalf of the participant. Quantum Health will provide regular reporting about the number and type of participants that are managed in case management.

There are a number of situations that occur in the course of working with an individual in case management that may require outreach and coordination with the client, or an associated business partner such as the TPA or PBM. Some common examples include:

- ***Clarification of coverage policy or SPD language when addressing an issue specific to an individual member's clinical circumstances***
- ***Questions related to a network configuration issue, such as whether a particular provider or practitioner is active in the network***
- ***Questions about how a claim has been processed***
- ***Unusual clinical circumstances that may warrant client engagement in order to make the most appropriate coverage determination for a given individual***

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

We require the following qualifications for our case managers:

- ***RN***
- ***Three years of experience in a clinical specialty area***
- ***Yearly continuing education credits in an area of clinical specialty***
- ***Case management certification within two years of hire***

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

Please see below for our staffing ratios:

- ***Customer Service - 1 per 4,000 members***
- ***UR - 1 per 40,000 members***
- ***Case Management - 1 per 18,000 members***
- ***Disease Management - 1 per 20,000 members***

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

We will begin discharge planning even prior to the admission, if needed. During the admission, our nurses are working with the UR and discharge planning staff at the hospital to ensure a smooth transition. Post discharge calls are made within 5 days of discharge and there are multiple attempts to contact. When we are made aware of a member going for an elective surgery; such as a total joint or back surgery, a nurse will make a preadmission contact. The purpose of the call is to assist the member with decision support in the following areas: obtaining in network services, how to discuss expectations with the surgeon, what to expect in the hospital and questions to ask before being discharged, safety issues (who will be there to assist upon discharge), etc. Once the member is discharged from the hospital, a post discharge call is made assessing the member/caregiver understanding of instructions, reviewing post discharge medication, assuring appointments are arranged, coordinating with other healthcare providers such as DME or home health, and if necessary, referring to case or disease management for continue follow up.

A post discharge call is made on all non-elective admissions with the exception of non-high risk normal delivery where mom and baby are discharged the same day. The nurse will conduct a full assessment based on the circumstances of the admission and make all necessary outreach calls to assure member has appropriate follow up to prevent readmission.

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

Generally, Quantum Health's clients determine the success of the program based on the ability to maintain claims below pre-set targets for basic medical (default), complex medical (defined by ICD-9 codes), Rx claims, changes in utilization patterns, member

and provider satisfaction, intercept rates overall within the subset of cases >$10K and chronic disease patients, and improvements in compliance with care pathways.

The effectiveness of the Quantum Health program is measured in the cost savings reduced from total spend.

- ***94% of clients have a better trend than in the prior 3 years***
- ***Average trend year one for all clients is 1.7% and the typical year one net savings is $605 PEPY***
- ***59% of Y1 clients have lowered their costs in year one vs. the prior year***
- ***Average CAGR at year three net of our fees is 3.9%.***

Such outcomes are able to be objectively determined based on claims data and data maintained within PIVIT. Reports are provided quarterly with additional drill-down reports as needed. Reducing claims cost is measured on a total claim spend basis - actual claims against a pre-set target. This is supported by book-of-business and individual client statistics demonstrating plausibility through changes in utilization.

This model and savings measurement has been confirmed by independent actuary Michael Taggart, F.S.A., MAAA, and examined and endorsed by the Disease Management Purchasing Consortium (DMPC), the most stringent outcomes measurement standards in the industry (See attached documentation with our response).

Is your organization's case management service for behavioral health and substance abuse managed by a separate subcontracted vendor and/or provided at a different location from the location indicated in ***section 3.10.1.2***? If yes, is the case management protocol different from other general case management services? Please describe the differences, if any.

Quantum Health provides Behavioral Health services as part of the integrated care coordination team. Care Coordinators are well-versed in your benefit design and help members understand what Behavioral Health (BH) benefits are available to them and when to use them or refer to your EAP. Whether to refer to BH or EAP varies by client. Your Quantum Health team will be trained in the agreed upon protocols and the PIVIT system reminds them of what they are. In addition, we also have a licensed social worker who manages Utilization Review for inpatient and outpatient mental health cases.

The following services specific to BH are included:
--Assessment and referral to EAP or BH network consistent with client protocols
--Review and explanation of members' benefits, network providers, and other available resources
--Utilization review of all inpatient, residential and intensive outpatient services
--Work with members and members' providers to find the member what they need within their coverage and network
--Co-management of co-morbid cases because BH issues often come with other health issues, the Care Coordinators work closely with BH care managers to coordinate all care for that member and always look for appropriate, non-crisis situations to help these members improve their health and well being
--Integration of DM

Not included:
--Network. We work with the client's select network of BH providers.
--Non-intensive BH outpatient utilization review/case management

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

Please refer to our answer directly above regarding our protocol regarding behavioral health and substance abuse.

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

We agree to conform to licensing requirements in each state where cases are managed.

3.11.2 Pre-certification

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

This has been reviewed.

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

Quantum Health always wants to be available whenever members are interacting with the health care system. There are a number of ways that we support people while they are in the hospital including:

1. Once we have received the request, we call the patient to go over their instructions, answer any questions, and remind them we are available to help them and their family before, during, and after their hospitalization. It is common to speak with a spouse or caregiver and offer to be available for them during the stay.

2. During hospitalizations, family members call with questions about what's being done, concerns about recovery, and what to expect while their loved one is in the hospital. We also offer to reach out to them during the inpatient stay.

3. Following an inpatient stay the member is contacted by a nurse to assess understanding of discharge instructions, medications, symptom management, and follow up appointments. Should the member be in case or disease management, either prior to the admission or eligible as a result of the admission, a call will be made by the nurse who is assigned to either case or disease management.

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

The average length of time to pre-certify an inpatient admission is usually performed within the same day of receiving the notification.

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

Utilization of services is addressed in all areas of the Quantum Health program. We request that providers pre-cert more services than are typically requested. Pre-certs allow us to evaluate potentially unnecessary or duplicative care as well as over-utilization. Through our program, 3-5% of pre-cert requests end up being withdrawn by the requesting provider. It is also why we have been successful at consistently increasing primary care and preventive care utilization (+5%) and significantly decreasing specialist use (-7%), ER use (-6%), outpatient diagnostic utilization (-1%), outpatient surgery (-1%) and inpatient utilization (-22%). Thus, we ask providers to submit a much broader set of pre-certs, which, in addition to the above, include, but are not limited to:
(1) Referral notices from primary care physicians when they are referring a patient to a specialist
(2) MRIs/MRAs
(3) Outpatient surgery
(4) Therapies (physical, occupational, speech, behavioral)
(5) DME over $500 and all rentals
(6) Dialysis
(7) Home health
(8) Hospice
(9) Transplants
(10) Sleep studies
(11) Oncology services (chemotherapy and radiation)
(12) Hospitalizations to include acute care, skilled nursing, skilled rehabilitation, and behavioral health/substance abuse

We use outpatient surgery requests as an opportunity to identify clinical coordination needs. For example, if we discover the patient is diabetic, we will refer them to Disease Management to begin the process of managing their condition. We also look to see if there are opportunities to intervene and provide more appropriate clinical care, services, treatments, etc, that they are not receiving.

Quantum Health's UR includes not just the standard UR process of reviewing services for appropriateness under the medical criteria and benefit terms under the plan, the information obtained through the UR process is also used to activate further coordination of care. With PIVIT, care management coordinators can see not only the outpatient surgery being proposed, but they can also see the patient's benefits, network providers, all the other services the patient is receiving, determine whether a proposed service is duplicative, and activate case and health management based on the member's diagnosis.

Quantum Health's UR team also contacts patients if care is proposed out of network or at a lower benefit tier, educates the patients on their benefits, and gives the member in-network or higher tier options. Additionally, the UR team also contacts the provider office to inform the provider of the patient's benefits and will facilitate transition of care to in-network providers, doing the work for the provider office. In the event that proposed care is duplicate, unnecessary, or can be provided in a lower cost care setting (such as outpatient rather than

inpatient), the Quantum Health UR team will facilitate the transition of care and set-up all such services once approved by the physician.

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

The average length of time to pre-certify an outpatient surgery admission is performed 95% of the time within the same day of receiving the notification.

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

Yes. Quantum Health uses InterQual clinical criteria guidelines when requests for treatment or service require assessment against clinical criteria.

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

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

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

Yes, please refer to the sample letter templates that we send regarding pre-certification confirmation.

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

Please find below the requested data for each time period for PPO plans only:

July 2011 – June 2012: 40 out of 2269 inpatient authorizations were non-certs, or about 1.8%

July 2012 – June 2013: 96 out of 3892 inpatient authorizations were non-certs, or about 2.5%

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

We require the following credentials and qualifications for our pre-certification nurses:

- ***RN***
- ***Three years of experience in a clinical specialty area***
- ***Yearly continuing education credits in an area of clinical specialty***

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

Quantum Health handles level-one appeals that are in regards to the medical management decisions. Response time to routine appeals is <30 days, unless there are two levels of appeal, in which case, response to each level is within 15 days. Urgent appeals would be responded to within 72 hours. All appeals are reviewed de novo, by an MD with the same area of specialty as the rendering provider. Quantum Health contracts with an external review firm to conduct these reviews. The Director of Quality Assurance reviews appeals each week to monitor turnaround time and reviews each appeal letter to ensure it contains the necessary components such as reason for denial.

All other appeals would be handled by the claims administrators.

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

All inpatient admissions require precertification. For elective admissions, such as weight loss surgeries, the request for service/treatment is assessed against the Summary Plan Document to assure requested treatment/service is coverable under the Plan, and then against clinical criteria sets to assure treatment and setting meet standards of care. In addition to assessing against the SPD and clinical criteria, Quantum Health Care Coordinators seek opportunities for interventions assisting members and providers in understanding health plan benefits, in network opportunities, and health management opportunities such as case management or nurse coaching.

Quantum Health works with centers of excellence for transplant, burn units, and gastric surgeries and will consult the plan's PPO network. The member and physician are made aware of the centers at the time request for service is made. For all other services/treatment we rely on the managing physician to direct their patient to the most appropriate provider.

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

This is confirmed. In addition to PEBPs pre-certification requirements, we require the additional services below to be pre-certified. Utilization of services is addressed in all areas of the Quantum Health program. Pre-certs allow us to evaluate potentially unnecessary or duplicative care as well as over-utilization. Through our program, 3-5% of pre-cert requests end up being withdrawn by the requesting provider. We have been successful at consistently increasing

primary care and preventive care utilization (+5%) and significantly decreasing specialist use (-7%), ER use (-6%), outpatient diagnostic utilization (-1%), outpatient surgery (-1%) and inpatient utilization (-22%). We accomplish this because we ask providers to submit a much broader set of pre-certs, which, in addition to the above, include:

(1) Referral notices from primary care physicians when they are referring a patient to a specialist (note: these are notification to give us early understanding of what's going on, but not a gate keeper model. The referrals are not precerts, but rather prenotifications).
(2) MRIs/MRAs
(3) Outpatient surgery
(4) Chemotherapy, physical therapy, etc.
(5) DME over $500 and all rentals
(6) Dialysis
(7) Home health
(8) Hospice
(9) Transplants
(10) Sleep studies

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

This is confirmed.

3.11.3 Concurrent Review

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

The Quantum Health Utilization Review nurse will begin concurrent review the 1st day and unlike the traditional model of UR, will not pre-assign days. Instead, the nurse will review the case against criteria, and work with the hospital UR staff to assure the member is being cared for in the most appropriate setting based on severity of illness and intensity of service. Also unlike traditional UR, the hospital staff has only one point of contact to arrange services post inpatient care, this can include but is not limited to ambulance transport, transition to lower level of care such as rehab, arranging home health care, or arranging home infusions and DME. Since all clinical services are integrated at Quantum Health, the UR nurse is also able to refer the member to disease or case management, allowing for immediate contact with patient and/or family and all healthcare providers that will be involved in post hospitalization.

All conditions are reviewed while inpatient and all patients discharged are contacted with exception of normal deliveries of non-high risk mothers when mother and baby are discharged together.

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

When a member is hospitalized, our Nurse Care Coordinators have daily contact with the hospital, review clinical information and assist discharge planners with arranging in-network post-discharge services.

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

In contrast to traditional UR protocols, we do not assign length of stays up-front. We perform concurrent review and coordination to ensure patients continue to meet medical criteria and "most appropriate care setting" standards every day. As a result of this process, our average length of stay is 7% lower than the expected for our book of business.

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

Please refer to the attachment with our response titled "Medical Necessity Guidelines Overview".

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

Please refer to the attachment with our response titled "Medical Necessity Guidelines Overview".

3.11.4 Retrospective Review

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

Please refer to the attachment regarding our Utilization Management Overview, which includes our retrospective review procedures.

We perform retrospective reviews as needed, however, 97% of the time a Care Coordinator is actively managing care as it is happening—before any claims are submitted.

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

We perform retrospective reviews telephonically, and they are performed by our Care Coordinators.

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

We require the following credentials and qualifications for our staff that is responsible for retrospective reviews:

- ***RN***
- ***Three years of experience in a clinical specialty area***
- ***Yearly continuing education credits in an area of clinical specialty***

How is the need for retrospective review determined?

If the claims payer receives a claim for a service and there is no prior authorization on file, they will either pay it with a no-precertification penalty, or they will send a request to Quantum Health to review, depending on the benefit design of the client. If a case is reviewed retrospectively, Quantum Health contacts the physician's office and/or patient to obtain any necessary information and InterQual criteria are utilized.

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

When an inpatient hospital review is performed, a letter is provided when requested. All other communication is performed telephonically.

MANAGEMENT REPORTING

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

Quantum Health provides clients with a detailed quarterly analysis of all activity, metrics, trends and patterns. The goal of this analysis is to understand how members are using health and care services, where opportunities exist strategically for improvement, and to measure performance and effectiveness. The report includes measurement of standard utilization metrics and financial analysis. We have also included samples of our standard reports with our response.

The below reports are included:

	Variable is currently measured	Will provide Client-Specific Reporting		Reporting – If Yes, How Often?		
		Yes	No	Monthly	Quarterly	Annually
Actual claims trend vs. industry and historic trends	Yes	X			X	
Number of people with a primary doctor	Yes	X			X	
Physician utilization	Yes	X			X	
Specialist utilization	Yes	X			X	
Preventive care use overall and by population segment	Yes	X			X	

Number of cases that involved episodic care coordination	Yes	X			X	
Number of members requiring specialty care or procedures	Yes	X			X	
Utilization trends (in-patient, out-patient, ER, etc.)	Yes	X			X	
Members assessed for a potential trigger condition	Yes	X			X	
Impact of high cost cases on overall claims, origin of case, and type of case relative to ability to	Yes	X			X	
Summary of high cost cases and on-going impact (both paid and potential)	Yes	X			X	
Number of members with chronic conditions assessed for DM	Yes	X			X	
Number of members with risk factors for chronic conditions	Yes	X			X	
Members based on DM	Yes	X			X	
	Variable is currently measured	Will provide Client-Specific Reporting		Reporting – If Yes, How Often?		
		Yes	No	Monthly	Quarterly	Annually
stratification						
Average cost/member/disease and stratification level	Yes	X			X	
Transition of members within levels of stratification	Yes	X			X	
DM compliance rates	Yes	X			X	
Prevalence rates of key conditions	Yes	X			X	
Demographic trends (age/sex) and projected impact on claims	Yes	X			X	
Member transition/turnover in	Yes	X			X	

Member advocacy	*Yes*	*X*			*X*	
Distribution of issues from member advocacy contacts	*Yes*	*X*			*X*	

Are your reports available via the web?

Yes, in addition to the above, PEBP will be able to run various health plan reports via HR Dashboard on a real-time basis. To see an HR Dashboard demo, contact John Bradford, VP of Account Service at John.Bradford@quantum-health.com

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

PEBP will have the ability to create and access ad hoc reports any time. Quantum Health provides a client portal called the HR Dashboard, which allows clients to review standard reports and create ad hoc reports using real-time data. This site can be accessed by anyone the client designates, including consultants and their stop loss carrier. Each user can create a unique view and access can be restricted as to who can see what. The dashboard also facilitates secure, real-time interactions between the client's team and their Quantum Health account team.

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

Report	**Provided**
Outcome Management	*X* Yes ☐ No
Patterns of Care	*X* Yes ☐ No
Inpatient utilization	*X* Yes ☐ No
Utilization by diagnosis	*X* Yes ☐ No
Case specific detail	*X* Yes ☐ No
Activity and days reduced	*X* Yes ☐ No
Savings summary	*X* Yes ☐ No

FACILITY CHANNELING

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

Although we do not impose restrictions on benefits, our Care Coordinators are keenly focused on helping members get the most out of their benefits and their in-network health care dollar. Members highly value our services and recommend us to their coworkers, because we are the gateway to all benefits-related questions, advocacy, claims problems, consumerism guidance, and support for members with health challenges, e.g. chronic conditions, and episodes of acute care.

Quantum Health's UR team contacts patients if care is proposed out of network or at a lower benefit tier, educates the patients on their benefits, and gives the member in-network or higher tier options.

The UR team also contacts the provider office to inform the provider of the patient's benefits and will facilitate transition of care to in-network providers, doing the work for the provider office. In the event that proposed care is duplicate, unnecessary, or can be provided in a lower cost care setting (such as outpatient rather than inpatient), the Quantum Health UR team will facilitate the transition of care and set-up all such services once approved by the physician.

Additionally, the goal of Case Management is to reduce fragmentation of health care delivery during a complex time in a person's life. Nurses are specially trained to work with patients, families, physicians, and facilities in an effort to coordinate all care.

Through Case Management Care Coordination:

- ***The patient has an opportunity to improve quality of life and reduce out-of-pocket expenses.***
- ***The plan has an opportunity to realize savings since there are great efforts to educate the managing physicians on the use of in-network providers and facilities, as well as how the benefit plan works.***
- ***The Care Coordinators have an opportunity to help patients gain knowledge and understanding about how to care for themselves.***

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

It has been our experience that client preferences vary on how they wish us to address network limitation issues. As part of our routine implementation practices, Quantum Health will discuss and plan for these issues with PEBP.

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

Actual negotiations will be performed by the TPA.

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

Actual negotiations will be performed by the TPA.

ACCOUNT SERVICE

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

For PEBP staff?
For PEBP participants?
For providers?

Our Care Coordinators are available to PEBS's staff, participants and providers from 8:30am to 10:00pm ET on weekdays. All Care Coordinators have direct phone numbers and confidential voicemail, and all calls are returned the next business day. Members can also send confidential emails directly to their Care Coordinator via their member website on a 24/7 basis. The member website also has benefit plan, health, and decision support information. After hours, members can leave private and confidential voicemails or emails which are returned the next business day.

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

Confirmed. PEBP will have a dedicated Client Executive & Strategist who will be responsible for the overall relationship with PEBP and other servicing partners (claims administrator, PBM, etc.), and ensuring that the appropriate resources of Quantum Health are brought to the relationship. In addition, the CE will lead the analysis of PEBP's data and Plan performance, the development of strategy based on PEBP's goals and insights indicated by the data and Plan performance, and execution through Quantum Health of strategy decisions.

From what location will the account manager be servicing PEBP?

The Client Executive servicing PEBP will be located at our headquarters in Columbus, Ohio or at our location in Denver, Colorado. This will be determined once Quantum Health has been selected as a finialist.

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

Confirmed, Quantum Health has a preferred format to receive electronic enrollment and eligibility data. However, we are flexible and can (and do) accept many different formats.

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

Yes, our Medical Director, Dr. Benita Jackson, joined Quantum Health in 2013. With more than 25 years of medical experience specializing in internal medicine, public health, and preventative medicine, Dr. Jackson provides guidance in the review and assessment of cases that do not meet clinical criteria.

She is a diplomat certified healthcare quality manager (CHCQM) with the American Board of Quality Assurance and Utilization Review Physicians (ABQAURP), as well as a fellow in the American College of Preventive Medicine, and a member of the American

College of Physician Executives. Dr. Jackson received her AB in Biochemistry from Mount Holyoke College, and her medical degree from Howard University. She completed her residency training in Internal Medicine in Washington D.C., and a second training program in Public Health/Preventive Medicine at Morehouse College's School of Medicine in Atlanta. Dr. Jackson earned her master's in public health (MPH) from Emory University's Rollins School of Public Health, with a concentration in health management and policy.

IMPLEMENTATION SERVICES

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

At Quantum Health we are especially proud of our implementation process and we have a highly-experienced team that will help guide PEBP through a successful implementation. An implementation manager is assigned to your account and will work in close collaboration with PEBP to ensure a smooth, expedient implementation. Of note, a detailed timeline has been included as an attachment.

While each client's situation is unique, we start with a standardized implementation process that helps ensure a seamless transition from a client's current vendors to Quantum Health. The implementation process consists of the following:

- ***Internal transition meeting handing-off from sales to other work groups***
- ***Initial Implementation Kickoff meeting***
- ***Communications plan and timeline developed***
- ***Weekly ongoing implementation calls with client, TPA & other vendors (extend 30 days beyond effective date)***
- ***Client onsite at Quantum Health for culture training with pod members***
- ***Plan benefits training for pod members***

Implementation begins with an initial combined organizational meeting that includes the Quantum Health Implementation Team, plus representatives from the client, claims payer, and consultant. During this meeting, the following items are reviewed:

- ***Quantum Health Plan Setup Guide, which includes contact and eligibility information, network structure, enrollment details, enhanced benefits guidelines, pre-certification services, etc.***
- ***Enrollment Materials, the Enrollment Presentation, and Enrollment Meetings, member communications (please see our proposal for details).***
- ***Compliance documents, including a PHI Roster, Business Associate Agreement, etc.***
- ***Next Steps (including working with a PEBP representative to train our Care Coordinators in the finer points of your culture).***

Please refer to the sample implementation plan included with our response.

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

Yes, an implementation manager, along with an implementation team, is assigned to your account and will work in close collaboration with PEBP to ensure a smooth, expedient implementation.

Describe the most frequent problems your organization has encountered during previous transitions for plans of this size. How were these resolved?
Because we go to every effort to make a smooth transition (such as opening the phones as much as 30-60 days in advance of the effective date), we really do not have transition problems.

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

This is confirmed. Please refer to the pricing section for associated costs.

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

This varies according to the client's needs, but it typically ranges from 30-90 days.

DISASTER RECOVERY PLAN

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

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

Confirmed. Please refer to our URAC approved Disaster Recovery Plan which has been included with our response.

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

If there was a catastrophic event that interrupted the redundant on-site servers, we can restore operation through the off-site location within 2-4 hours. If the Columbus Care Coordination center became unusable, the Business Continuity plan provides for transfer of the data, servers, and Care Coordinators to an off-site location that is equipped and ready to operate in Akron, Ohio. Service restoration is planned for 12-24 hours. For a long-term interruption, there is also a contingency that provides for mobile call center units to be set up in Columbus with service restoration in 36-72 hours. Our communications vendors can re-route all inbound calls "in the cloud" within about two hours, to either the payer-partner serving each client or any other location that we designate.

Further, we are in the planning stages for another service center site within 12 months which will allow us further flexibility.

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

For Business Continuity Program planning, we completed a formal Business Impact Analysis (BIA) at the end of calendar year 2011. The BIA is the foundation for the Business Continuity Plan which outlines the critical business processes and functions.

Periodic Disaster Recovery tests for failover and recovery of critical systems are initiated from our Primary Data Center and our Disaster Recovery site is part of our maintenance process.

Our Business Continuity and Disaster Recovery Plan is a multi-tiered plan designed to handle varying levels of interruption. Although in the last 12 years, we have experienced no events triggering our plan we test the plan components quarterly.

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

Our Disaster Recovery Plan has been reviewed and approved by URAC, which should meet all qualifications and needs of PEBP.

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

All data in our system is backed up to a mirror server array in real time, so we can recover from a server malfunction in literally minutes. Servers are also virtualized to provide real time redundancy. Off-site data backup is a dual system. A full data set backup is also created daily and taken off-site to a secure, environmentally controlled facility. Operational data (all data related to patient records, health plans and care coordination) is backed up through a network connection every four hours. In addition, we maintain a server array that mirrors our Columbus on-site configuration in Cincinnati, Ohio, approximately two hours away.

PRIVACY AND SECURITY

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

Yes, we encrypt our backups and data is transmitted via an encrypted connection. We use SSL 128-bit encryption for all information transmitted over the Internet.

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

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

Yes, we comply.

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

Yes, we comply.

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

Yes, we comply.

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

Yes.

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

Confirmed and agreed.

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

Confirmed. Once Quantum Health has been selected as the vendor, the Business Associate Agreement will be signed and agreed upon.

ELECTRONIC DATA INTERCHANGE (EDI)

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

Confirmed and agreed.

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

Confirmed and agreed.

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

Confirmed and agreed.

PERFORMANCE STANDARDS, GUARANTEES, PENALTIES

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

Confirmed and agreed.

July 1, 2014- June 30, 2019

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

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

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

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

Confirmed and agreed.

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

Confirmed and agreed. Please refer to our comments regarding the "Contract for

Services of Independent Contractor" in Attachment B.

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

Confirmed. Please refer to the additional information provided in Tab IX – Other Information Material, in our response.

2. Tab VII – Section 4 - COMPANY BACKGROUND AND REFERENCES

VENDOR INFORMATION

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

Question	Response
Company name:	***Quantum Health, Inc.***
Ownership (sole proprietor, partnership, etc.):	***Corporation***
State of incorporation:	***Delaware***
Date of incorporation:	***1999***
# of years in business:	***14 years***
List of top officers:	***Kara Trott is CEO and Founder***
Location of company headquarters:	***Columbus, Ohio***
Location(s) of the company offices:	***Columbus, Ohio***
Location(s) of the office that will provide the services described in this RFP:	***Columbus, Ohio***
Number of employees locally with the expertise to support the requirements identified in this RFP:	***350***
Number of employees nationally with the expertise to support the requirements in this RFP:	***350***
Location(s) from which employees will be assigned for this project:	***Columbus, Ohio***

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

Confirmed.

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

Question	Response
Nevada Business License Number:	***NV20111056639***
Legal Entity Name:	***Coordinated Care Programs, LLC.***

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

Yes	*X*	No	

If "No", provide explanation.

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

Confirmed

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

Yes		No	*X*

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

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

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

Yes		No	*X*

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

N/A

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

N/A

Disclosure of any significant prior or ongoing contract failures, contract breaches, civil or criminal litigation in which the vendor has been alleged to be liable or held liable in a matter involving a contract with the State of Nevada or any other governmental entity. Any pending claim or litigation occurring within the past six (6) years which may adversely affect the vendor's ability to perform or fulfill its obligations if a contract is awarded as a result of this RFP must also be disclosed.

N/A

Does any of the above apply to your company?

Yes		No	*X*

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

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

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

Yes	*X*	No	

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

Confirmed.

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

Confirmed.

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

Please refer to our company overview which has been included as an attachment with our response.

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

Headquartered in Columbus, Ohio, Quantum Health was founded in 1999 by CEO Kara Trott to develop and operate a different health management system that provides better coordination of care. Earlier in her career, Trott worked with Fortune 100 consumer products firms as well as healthcare organizations. She observed that challenges in healthcare were related to patient confusion when accessing a fragmented system, which showed little collaboration and information-sharing among providers, as well as disjointed, separate, and isolated interactions. The result was mis-utilization and unnecessary costs.

Based on this experience and in-depth research, Trott identified the typical healthcare process, key points of disconnect, quantified the excess cost, and then developed insights into how to connect patients and providers at critical points. The company created a different model that assisted patients, families, and physicians as they navigate healthcare and saved money. After six years of testing and development, Quantum Health launched its program nationally to employers, and their employee benefit brokers and/or consultants.

After more than 14 years of learning and significant growth, Quantum Health now has more than 300 employees. We are fortunate to be recognized as a "great place to work" by our employees – it's something for which we strive yearly. In the 2010 Great Place to Work® Rankings of the Best Small & Medium Workplaces presented by Entrepreneur® magazine, Quantum Health ranked 23rd among the "50 Best" companies nationally. In addition, we earned 2nd place in the small companies category of Columbus's Business First 2010 "Best Places To Work" competition —one spot higher than our 2009 3rd place finish. Most recently, the company was recognized as a 2011 Top Small Company Workplaces Winner by Inc. magazine and Winning Workplaces.

SUBCONTRACTOR INFORMATION

Does this proposal include the use of subcontractors?

Yes		No	*X*

If "Yes", vendor must:

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

N/A

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

Describe the relevant contractual arrangements;

N/A

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

N/A

Describe your previous experience with subcontractor(s).

N/A

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

Selecting and qualifying appropriate subcontractors for the project/contract;

N/A

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

N/A

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

N/A

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

N/A

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

N/A

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

N/A

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

N/A

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

Agreed and confirmed.

BUSINESS REFERENCES

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

Agreed and confirmed.

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

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

Reference #: *1*			
Company Name:	*City of Savannah*		
Identify role company will have for this RFP project (Check appropriate role below):			
X	*CLIENT*		*SUBCONTRACTOR*
Project Name:	*Medical Management*		
Primary Contact Information			
Name:		*Beth Robinson*	
Street Address:		*132 E Broughton St 5th Floor*	
City, State, Zip		*Savannah, GA 31401*	
Phone, including area code:		*912-651-6925*	
Facsimile, including area code:		*912-651-6706*	
Email address:		*BRobinson@Savannahga.Gov*	
Alternate Contact Information			
Name:		*N/A*	
Street Address:		*Please see above information.*	
City, State, Zip			
Phone, including area code:			
Facsimile, including area code:			
Email address:			
Project Information			
Brief description of the project/contract and description of services performed, including technical environment (i.e., software applications, data communications, etc.) if applicable:		***Quantum Health exists to take unnecessary cost and confusion out a member's healthcare event. To do this, we've created a unique, comprehensive program that combines all member claims and eligibility services, patient advocacy, pre-certification, utilization review, case management, disease management and ongoing care coordination into a single, cohesive relationship-based place to call for help and encouragement.***	
Original Project/Contract Start Date:		*1/1/2007*	
Original Project/Contract End Date:		*N/A*	
Original Project/Contract Value:		*N/A*	
Final Project/Contract Date:		*Current client*	
Was project/contract completed in time originally allotted, and if not, why not?		***City of Savannah is a current client.***	

Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	***City of Savannah is a current client.***

Reference #: *2*			
Company Name:	***HCR Manorcare***		
Identify role company will have for this RFP project (Check appropriate role below):			
X	***CLIENT***		***SUBCONTRACTOR***
Project Name:	***Medical Management***		
Primary Contact Information			
Name:	***Nicole Ausmus***		
Street Address:	***333 N. Summit St.***		
City, State, Zip	***Toledo, Ohio 43604***		
Phone, including area code:	***419-254-7846***		
Facsimile, including area code:	***N/A***		
Email address:	***nausmus@hcr-manorcare.com***		
Alternate Contact Information			
Name:	***N/A***		
Street Address:	***Please see above information.***		
City, State, Zip			
Phone, including area code:			
Facsimile, including area code:			
Email address:			
Project Information			
Brief description of the project/contract and description of services performed, including technical environment (i.e., software applications, data communications, etc.) if applicable:	***Quantum Health exists to take unnecessary cost and confusion out a member's healthcare event. To do this, we've created a unique, comprehensive program that combines all member claims and eligibility services, patient advocacy, pre-certification, utilization review, case management, disease management and ongoing care coordination into a single, cohesive relationship-based place to call for help and encouragement.***		
Original Project/Contract Start Date:	***1/1/2013***		
Original Project/Contract End Date:	***N/A***		
Original Project/Contract Value:	***N/A***		
Final Project/Contract Date:	***Current client***		
Was project/contract completed in time originally allotted, and if not, why not?	***HCR Manorcare is a current client.***		
Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	***HCR Manorcare is a current client.***		

Reference #: 3			
Company Name:	***State-Wide Schools Cooperative Health Plan (SWSCHP)***		
Identify role company will have for this RFP project (Check appropriate role below):			
X	***CLIENT***		***SUBCONTRACTOR***
Project Name:	***Medical Management***		

Primary Contact Information	
Name:	***Norm Freimark***
Street Address:	***SWSCHP*** ***c/o WRM*** ***12 Metro Park Road Suite 208***
City, State, Zip	***Colonie, NY 12205***
Phone, including area code:	***914-617-9398***
Facsimile, including area code:	***N/A***
Email address:	***nfswschp@hotmail.com***
Alternate Contact Information	
Name:	***N/A***
Street Address:	***Please see above information***
City, State, Zip	
Phone, including area code:	
Facsimile, including area code:	
Email address:	
Project Information	
Brief description of the project/contract and description of services performed, including technical environment (i.e., software applications, data communications, etc.) if applicable:	***Quantum Health exists to take unnecessary cost and confusion out a member's healthcare event. To do this, we've created a unique, comprehensive program that combines all member claims and eligibility services, patient advocacy, pre-certification, utilization review, case management, disease management and ongoing care coordination into a single, cohesive relationship-based place to call for help and encouragement.***
Original Project/Contract Start Date:	***7/1/2010***
Original Project/Contract End Date:	***N/A***
Original Project/Contract Value:	***N/A***
Final Project/Contract Date:	***Current client***
Was project/contract completed in time originally allotted, and if not, why not?	***SWSCHP is a current client.***
Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	***SWSCHP is a current client.***

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

Confirmed.

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

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

Confirmed.

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

Confirmed.

TAB VIII – Attachment G – Proposed Staff Resumes

PROPOSED STAFF RESUME

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

COMPANY NAME:	***Quantum Health, Inc.***		
Contractor		***N/A***	
Name:	***Quantum Health staff members***	**X Key Personnel**	
Classification:	***Full-time employees***	**# of Years in Classification:**	***Varies***
Brief Summary: of Experience:	***Quantum Health has been helping our clients achieve significant reductions in utilization and overall claims spend without reducing benefits.***		
# of Years with Firm:	***Over 14 years***		

RELEVANT PROFESSIONAL EXPERIENCE	
Required Information: ***MMYYYY to Present:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	***Account Executive assignments will be made once Quantum Health is notified it is a finalist for the PEBP account. Specific team leads for other roles will be assigned once the PEBP account is awarded. PEBP will be provided resumes and an opportunity to meet the team members prior to the effective date.*** ***Contractors or subcontractors will not be used to service the PEBP account.***
Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	***Account Executive assignments will be made once Quantum Health is notified it is a finalist for the PEBP account. Specific team leads for other roles will be assigned once the PEBP account is awarded. PEBP will be provided resumes and an opportunity to meet the team members prior to the effective date.*** ***Contractors or subcontractors will not be used to service the PEBP account.***
Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	***Account Executive assignments will be made once Quantum Health is notified it is a finalist for the PEBP account. Specific team leads for other roles will be assigned once the PEBP account is awarded. PEBP will be provided resumes and an opportunity to meet the team members prior to the effective date.*** ***Contractors or subcontractors will not be used to service the PEBP account.***

EDUCATION	
Institution Name: ***City:*** ***State:*** ***Degree/Achievement:*** ***Certifications:***	***N/A***

REFERENCES	
Minimum of three (3) required, including name, title, organization, phone number, fax number and email address	***Please refer to the references in Section "4.3 BUSINESS REFERENCES"***

TAB IX – Other Information Material

Please find the following materials in this section for PEBP's consideration:

- ***Quantum Health's Utilization Management Overview***
- ***Quantum Health's Pre-certification Overview***
- ***Quantum health's Concurrent Review Overview***
- ***Quantum Health's Case Management Overview***
- ***Quantum Health's Transplant Overview***
- ***Quantum Health's Medical Necessity Guideline's Overview***
- ***Quantum Health Case Study***
- ***Taggart Letter***
- ***Comments and Exceptions regarding the "Contract for Services of Independent Contractor" form***
- ***Quantum Health Program Summary Overview***
- ***Sample Pre-certification Letters***
- ***Sample of Reporting Package***
- ***Sample Implementation Plan***
- ***Copy of Disaster Recovery Plan***

Quantum Health's Utilization Management Overview

Everything regarding Utilization Management is performed in house.

Utilization of services is addressed in all areas of the Quantum Health program. We request that providers pre-certify more services than are typically requested. Pre-certs allow us to evaluate potentially unnecessary or duplicative care as well as over-utilization. Through our program, 3-5% of pre-cert requests end up being withdrawn by the requesting provider. We have been successful at consistently increasing primary care and preventive care utilization (+5%) and significantly decreasing specialist use (-7%), ER use (-6%), outpatient diagnostic utilization (-1%), outpatient surgery (-1%) and inpatient utilization (-22%). We accomplish this because we ask providers to submit a much broader set of pre-certs, which, in addition to the above, include:
(1) Referral notices from primary care physicians when they are referring a patient to a specialist (note: these are notification to give us early understanding of what's going on, but not a gate keeper model. The referrals are not precerts, but rather prenotifications).
(2) MRIs/MRAs
(3) Outpatient surgery
(4) Chemotherapy, physical therapy, etc.
(5) DME over $500 and all rentals
(6) Dialysis
(7) Home health
(8) Hospice
(9) Transplants
(10) Sleep studies

Quantum Health's Utilization Management includes not just the standard UR process of reviewing services for appropriateness under the medical criteria and benefit terms under the plan, but the information obtained through our proprietary system, PIVIVT, assists Care Coordinators to activate further coordination of care and provide the member with helpful information. With PIVIT, care management coordinators can see not only what is being proposed, but can see the patient's benefits, claims information, network providers, all the other services the patient is receiving, determine whether a proposed service is duplicative, if the service is being ordered by a physician as part of a referral, we will verify the receiving physician needs the service, and activate case and health management based on the member's diagnosis. Quantum Health's UR team also contacts patients if care is proposed out of network or at a lower benefit tier, educates the patients on their benefits, and gives the member in-network or higher tier options. Additionally, the UR team also contacts the provider office to inform the provider of the patient's benefits and will facilitate transition of care to in-network providers, doing the work for the provider office. In the event that proposed care is duplicate, unnecessary, or can be provided in a lower cost care setting (such as outpatient rather than inpatient), the Quantum Health UR team will facilitate the transition of care and set-up all such services once approved by the physician.

Although pre-certification is the primary alert, members are identified through "intercept" during course of care. Identifying sources include: Health Needs Assessment, Customer Service, Employer referral, Disease Management referral, pre-certification information, Utilization Review, Post-discharge follow-up and medical/Rx claims. PSRs also have the ability to immediately transfer any patient who is having health care issues to a nurse irrespective of whether the patient meets technical "case management" criteria. The logic behind PIVIT will trigger an automatic referral to case management for patients with identified diagnoses. By "automatic" we literally mean immediate - i.e., a pre-cert for an MRI for a diagnosis of cancer will trigger an automatic alert immediately to a case manager. Medical claim data is loaded nightly from the claims administrator and Rx data weekly from the PBM. So, on a nightly basis additional logic is run, triggering alerts that are acted on by case managers the next business day.

Concurrent inpatient review (including frequency of contact with the hospital and if you contact members during an inpatient stay): Daily and interaction with member or member designated contact

while the member is inpatient as needed or desired by patient/care giver.

When a member is hospitalized, our Nurse Care Coordinators have daily contact with the hospital, review clinical information and assist discharge planners with arranging in-network post-discharge services. In contrast to traditional UR protocols, we do not assign length of stays up-front. We perform concurrent review and coordination to ensure patients continue to meet medical criteria and "most appropriate care setting" standards every day. As a result of this process, our average length of stay is 7% lower than the expected for our book of business.

Retrospective reviews: As needed, although 97% of the time a Care Coordinator is actively managing care as it's happening—before any claims are submitted.
If the claims payer receives a claim for a service and there is no prior authorization on file they will either pay it with a no-precertification penalty or they will send a request to Quantum Health to review depending on the benefit design of the client. If a case is reviewed retrospectively, Quantum Health contacts the physician's office and/or patient to obtain any necessary information and Interqual criteria is utilized

Discharge planning/coordination of services and post discharge follow up: These services begin before the member is hospitalized as part of case management. Quantum Health begins discharge planning prior to the admission, if needed. During the admission our nurses are working with the UR and discharge planning staff at the hospital to ensure a smooth transition. Post discharge calls are made to patients within 5 days of discharge. And, we are successful 78% of the time!

Quantum Health's Pre-Certification Program Overview

Pre-Certification Program/Goals:

Quantum Health's pre-certification process is designed to identify the early intervention of cases that may benefit from care coordination, case management and/or redirection. It also assesses the frequency of requested services, the potential for inappropriate use of requested service and determination of medical necessity and plan specific coverage.

This is accomplished by the implementation of an extensive pre-certification list, that in conjunction with the client specific SPD, national criteria guidelines and a team of medical reviewers working collaboratively with the POD structure creates a seamless process for the above identified interceptions.

Quantum Health's Standard Pre-Cert list is a follows:

•Inpatient Admissions

•Skilled Nursing Facility admission

•Outpatient surgeries

•MRIs/MRAs/ PET Scans

•Oncology care and services (chemotherapy, radiation therapy etc.)

•Home Health Care and Services

•DME all rentals and purchases over $500

•Hospice Care

•Organ and Bone Marrow Transplants

•Speech, Physical and Occupational Therapies

•Dialysis

The pre-certification list is further comprised of two categories, a clinical review list and a no clinical review list. The 'no review' list encompasses a wide range of services consisting of certain diagnostic procedures, initial therapy requests, to specific outpatient surgeries that act as points of intercept. The 'no clinical review' list allows for early identification of referrals for CM and DM without the need for clinical review. For example, a request for a biopsy to diagnosis cancer requires pre-cert and is an opportunity to refer the case to CM but will not be reviewed against Interqual criteria. The remainder of the pre-cert list will be reviewed against nationally established criteria (see Clinical Review Process document) medical review and if applicable involve onsite medical directors or contracted peer like specialty reviewers.

During the course of the medical review process, the nurse will assess for duplication of services, opportunities to redirect the member to a par provider as well as reviewing the services against established national criteria/policy and the SPD. In the event of an adverse benefit determination the nurse will make outbound calls to the member and the provider to discuss the rationale of the determination, alternative treatment options and next steps, i.e. peer review.

Pre-admission calls are assigned upon authorization of total joint replacements and back surgeries. During the call, the nurse will assess the members knowledge of pre-admission instructions from the ordering MD, identify potential needs for assistance before, during and after the surgery including caregiver availability, home environment, discussion of pre-planned post hospital needs (home health, SNF, therapies, DME, injectable medications, etc.) and if applicable will initiate and complete the pre-certifications. Any information resulting from the pre-admission call will be communicated to the UR nurse, assisting in a smooth transition from hospital to home, potentially eliminating delays in discharge.

Quantum Health's Concurrent Review Overview

Quantum Health's Utilization Review includes not just the standard UR processes, but we utilize an inpatient concurrent review process. In concurrent review, our UR nurses will not pre-assign days, but instead will review the case against criteria and work with the hospital UR staff to assure the member is being cared for in the most appropriate setting based on severity of illness and intensity of service.

Also unlike traditional UR, the hospital staff has only one point of contact to arrange services post inpatient care, this can include but is not limited to ambulance transport, transition to lower level of care such as rehab, arranging home health care, or arranging home infusions and DME. Since all clinical services are integrated at Quantum Health, the UR nurse is also able to refer to disease or case management, allowing for immediate contact with patient and/or family and all healthcare providers that will be involved in post hospitalization.

All conditions are reviewed while inpatient and all patients discharged are contacted, with exception of normal deliveries of non-high risk mothers when mother and baby are discharged together.

Our PIVIT system gives us the ability to provide the inpatient UR staff with everything they need in one place, therefore improving efficiency of care and smooth transitions in care. The UR staff greatly appreciates our integration as it saves them time and increases their productivity, and ability to help their patient.

The other success is the post discharge contact. By calling the member/family within 5 days of discharge we are able to assess their knowledge of post discharge instruction, facilitate physician office visits when symptoms are not controlled, recognize potential for readmission. We work with the healthcare providers and the physician in order to initiate quality cost effective home or outpatient care, and be a resource for the patient regarding how claims will be paid, and benefits available to assist in recovery and wellness.

Quantum Health's model of UR has reduced inpatient day's 17-25%, reduced inpatient length of stay 15-20%, and reduced readmission by 24%. 78% post discharge contact and 60% of the targeted elective admissions are contacted.

In addition, the information obtained through the UR process is used to activate further coordination of care. With PIVIT, our proprietary system, care management coordinators can see not only what is being proposed, but can see the patient's benefits, network providers, all the other services the patient is receiving, determine whether a proposed service is duplicative, if the service is being ordered by a physician as part of a referral, and activate case and health management based on the member's diagnosis.

Quantum Health's UR team also contacts patients if care is proposed out of network or at a lower benefit tier, educates the patients on their benefits, and gives the member in-network or higher tier options.

Additionally, the UR team contacts the provider office to inform the provider of the patient's benefits and will facilitate transition of care to in-network providers, doing the work for the provider office. In the event that proposed care is duplicate, unnecessary, or can be provided in a lower cost care setting (such as outpatient rather than inpatient), the Quantum Health UR team will facilitate the transition of care and set-up all such services once approved by the physician.

Quantum Health's Case Management Overview

The goal of Case Management is to reduce fragmentation of health care delivery during a complex time in a person's life. Nurses are specially trained to work with patients, families, physicians, and facilities in an effort to coordinate all care. Through Case Management Care Coordination:

- The patient has an opportunity to improve quality of life and reduce out-of-pocket expenses.
- The plan has an opportunity to realize savings since there are great efforts to educate the managing physicians on the use of in-network providers and facilities, as well as how the benefit plan works.
- The Care Coordinators have an opportunity to help patients gain knowledge and understanding about how to care for themselves.

The critical difference between Quantum Health's Case Management from other programs is the integration of our service with the entire care process, the early activation of Case Management, the rich stream of information that triggers Case Management, and the fact that the Case Managers will work with patients and providers not just on the clinical aspects of their care, but also on their benefits and claims issues.

Our unique model reorganizes an employer's benefits delivery to make the most of each member interaction while minimizing confusion. To make that happen, we perform all customer service and care management allowing opportunities to intercept members in real-time—just as members are making their healthcare decisions. Our Care Coordinators intercept patients at all touch points in the healthcare process, including customer service, referrals, precerts, and reviewing claims data which results in increased engagement in Case Management.

This unique model produces different results compared to competitors:

- Highest engagements in the industry -- Our Care Coordinators have phone contact (not e-mails or passive mailings) with 85% of households and 62% of members.
- Dramatic impact on utilization -- By intercepting members on a real-time basis and holding their hand through a complex healthcare system, we're able to make a dramatic impact on utilization—particularly in higher cost categories. Results include a 4% decrease in emergency room use, 22% fewer re-admissions, 7% decrease in in-patient length of stay, 11-16% decrease in-patient days, and a 5% less cases that average $50,000 or more.
- 98% of all patients who have claims over $10,000 are working with a Care Coordinator and reduces the cost of patients with >$50,000 in claims by 15%.
- Significant savings in year one and beyond -- First-year clients net per employee per month savings ranges from $134 to $976. Clients, on average, experience 3.9% compound average trend over three years (versus the 10%+ industry average over the past decade).
- 100% guarantee on performance -- We put up to 100% of our fee at risk based on mutually agreed upon targets.

OUR CASE MANAGEMENT GOALS

The goal of Case Management is to reduce fragmentation of health care delivery during a complex time in a person's life. Nurses are specially trained to work with patients, families, physicians, and facilities in an effort to coordinate all care. Through Case Management Care Coordination:

- The patient has an opportunity to improve quality of life and reduce out-of-pocket expenses.
- The plan has an opportunity to realize savings since there are great efforts to educate the managing physicians on the use of in-network providers and facilities, as well as how the benefit plan works.
- The Care Coordinators have an opportunity to help patients gain knowledge and understanding about how to care for themselves.

IDENTIFICATION
In addition to reviewing historical medical claims for identification, members are identified through "intercept" throughout course of care. Identifying sources include: Health Needs Assessment, Customer Service, Employer referral, Disease Management referral, pre-certification information, Utilization Review, Post-discharge follow-up and medical/Rx claims. The logic behind PIVIT will trigger an automatic referral to Case Management for patients with identified diagnoses, that exceed claim dollar thresholds ot that demonstrate high utilization patterns. Medical claim data is loaded nightly from the Claims Administrator and Rx data weekly from the PBM, so on a nightly basis additional logic is run triggering alerts that are acted on by case managers the next business day.

INTERCEPT
Real time intercept occurs in the following manner:

1. Provider request for treatment or services
2. Member calls requesting information
3. HR requests
4. Self-reported data (example HRA or Health profile)
5. Finally claims activity

CONDITIONS MANAGED
The Quantum Health Case Management program manages these conditions:

- Cancer
- Neurological conditions that are not under control (e.g., newly diagnosed MS)
- Post trauma (e.g., motor vehicle accidents or burns)
- Transplants
- Premature Infants

In addition patients whose claims payment exceed $25000 in a defined period or who have multiple ER or hospital admissions are flagged for case management evaluation and management. Criteria utilized for case management are regularly reviewed and updated in order to assure that our criteria and identification processes are timely and accurate.

CASE MANAGEMENT PROCESS
Throughout the Case Management process the following conditions are assessed and action is taken:

- Condition becomes exacerbated or acute
- There is a change in the psychosocial functions (example the member has loss of function due to progression of condition)
- Safety is compromised
- Over utilization of services or use of multiple providers
- Lack of an established treatment plan or ineffective treatment plan
- Underutilization of services
- Premature or delayed discharge from appropriate level of care
- Non-adherence to treatment or medication
- Lack of education related to condition, prognosis, or plan of care

Our program also has a number of highly innovative processes:

- The nurse becomes a patient advocate and contacts the physician and other members of the health care team making sure they are aware of benefits and services available.
- The Case Management process is initiated before the claim is incurred. Case managers are alerted to the case at the time of service or when treatment is requested.
- Since Quantum is a partner with the Client there are also referrals made to the case manger through the client HR team
- Case managers are involved throughout the continuum of care and this is possible since the provider and member have a single point of contact for all health care events
- Case managers have the opportunity to have access to data from claims, pharmacy, utilization review, and clinical notes in real time vs. having to request this information from other vendors or facilities
- Case Management services are integrated in Quantum Health's Care Coordination model. Case

managers are located in PODs designated to specific clients which allow them to meet Case Management criteria "real time".

PATIENT CONTACT

The number of times a person is contacted by Case Management Care Coordinators varies with the individual. It is based on his/her needs and the needs of his/her caregiver. However, people in active management are contacted at least once a month.

Frequent calls with providers occur during the course of the case. At a minimum, physicians and all provider members of the patient medical team are contacted whenever the patient has a change, anticipates procedures, or falls off the evidenced care path.

Case managers also assess and manage non-catastrophic high cost conditions.

COMPLETION

Individuals remain in management until the condition is under control. The average length of time a person is in management is six months. After Case Management is curtailed, people who have a chronic condition such as diabetes or heart disease are referred to Disease Management for ongoing follow-up. In other situations, they are discharged from Case Management and readmitted only if their condition changes.

Quantum Health's Transplant Overview

Quantum Health has managed all transplants including solid organ and blood for over 10 years. Quantum transplant Case Managers coordinate with the transplant coordinators at the COE and the plans transplant network coordinator including donor evaluation service. The transplant patient is followed from the time of evaluation through transplantation, and until the member returns to work or is in the follow up phase.

Quantum Health works with centers of excellence for transplant, burn units, and gastric surgeries and will consult the plan's PPO network. The member and physician are made aware of the centers at the time request for service is made. For all other services/treatment we rely on the managing physician to direct their patient to the most appropriate provider.

If we are coordinating with a vendor, the transplant coordinator would still contact the member and provide patient advocacy and would also contact upon discharge from any hospital stay. Additionally the nurse would continue to alert the Plan of the any transplant and the status.

These services are all included in Quantum Health's fee. Please see the attached pricing section for details.

Quantum Health's Medical Necessity Guidelines Overview

Pre-certification/pre-notification/medical necessity review (inpatient and outpatient) are each addressed in all areas of the Quantum Health program. We request that providers pre-cert more services than are typically requested. Pre-certs allow us to evaluate potentially unnecessary or duplicative care as well as over-utilization. Through our program, 3-5% of pre-cert requests end up being withdrawn by the requesting provider. It is also why we have been successful at consistently increasing primary care and preventive care utilization (+5%) and significantly decreasing specialist use (-7%), ER use (-6%), outpatient diagnostic utilization (-1%), outpatient surgery (-1%), and inpatient utilization (-22%).

Thus, we ask providers to submit a much broader set of pre-certs, which, in addition to the above, include:

(1) Referral notices from primary care physicians when they are referring a patient to a specialist
(2) MRIs/MRAs
(3) Outpatient surgery
(4) Chemotherapy, physical therapy, etc.
(5) DME over $500 and all rentals
(6) Dialysis
(7) Home health
(8) Hospice
(9) Transplants
(10) Sleep studies

Although pre-certification is the primary alert, members are identified through "intercept" during course of care. Identifying sources include: Health Needs Assessment, Customer Service, Employer referral, Disease Management referral, pre-certification information, Utilization Review, Post-discharge follow-up and medical/Rx claims. PSRs also have the ability to immediately transfer any patient who is having health care issues to a nurse irrespective of whether the patient meets technical "case management" criteria. The logic behind PIVIT will trigger an automatic referral to case management for patients with identified diagnoses. By "automatic" we literally mean immediate - i.e., a pre-cert for an MRI for a diagnosis of cancer will trigger an automatic alert immediately to a case manager. Medical claim data is loaded nightly from the claims administrator and Rx data weekly from the PBM. So, on a nightly basis additional logic is run, triggering alerts that are acted upon by case managers the next business day.

All requests for services requiring interpretation of clinical information will be reviewed against established criteria by a nurse. In the event there are no criteria available or the request does not meet the established criteria, the case will be reviewed by an MD or DO. Peer to Peer conversation is offered as well to establish a determination.

Cases are reviewed by the medical director when they do not meet InterQual criteria or NCCN guidelines, or when treatment/services requested are experimental and/or investigational in nature. The medical director is also available to discuss complex cases involving multiple providers/members of the health care team.

The medical necessity provision is plan specific based on SPD coverage of benefits. As previously stated, when the requested service or treatment does not meet the standardized criteria or is experimental/investigational, it is sent to the Medical director to review. Quantum Health is contracted with MCMC (Managing Care, Managing Claims) for like clinical peer review as well.

Subject: The Application of Medical Necessity Criteria for Coverage Determinations	Effective Date: 10/10/2013
Work Group: Clinical Services	Revision Date:
Author: Helen Imbernino	Review Date:
State/Federal Regulation: N/A	URAC Standard: N/A
Guideline Number: CS026	Signature: VP of Clinical Solutions

Guideline Summary:

Medical necessity coverage determinations at Quantum Health are based on the use of explicit clinical criteria that meet the following requirements:

1) Are clinically appropriate for the individual patient,
2) Are based on available scientific evidence, taking into account the availability and strength of medical evidence, and
3) Consider and evaluate services according to their likelihood to produce an incremental health benefit relative to any incremental cost over the next best alternative.

Criteria used to make benefit coverage determinations are based on the following hierarchy of decision rules:

1) The employer SPD language or specific benefit plan criteria. If the plan documents include, or exclude coverage for a specific treatment, medication or procedure, then the plan language governs the coverage decision.

2) Quantum Health adopted clinical criteria for medical necessity determinations, i.e., InterQual, or, if applicable, any internally developed guidelines (Medical Director Approved Criteria)

3) Mandates from the federal or state governments: applicability of these mandates depends on the specifics of the individual patient's insurance plan and coverage. Plans covered by the Employee Retirement Income Security Act of 1974 (ERISA) are more likely to be subject to government mandates than non-ERISA plans.

Application of Criteria:

1) The following criteria have been adopted by Quantum Health to evaluate requests for coverage:

Criteria		Service Type
1	InterQual Evidence Based Clinical Content	Used as primary criteria set for all services except as specified below
2	Aetna Clinical Policy Bulletins	2nd line criteria for requests not addressed by InterQual Criteria
3	Cigna Medical Coverage Policy	Primary criteria for behavioral health and substance abuse

4	Medicare Coverage Policy	Primary Criteria for: Home health SNF Inpatient Rehab Hospice
5.	NCCN Evidence Based Cancer Guidelines	Primary Criteria for chemotherapy agents and radiation (all surgical requests and diagnostics for cancer diagnosis will follow above hierarchy)

1. If a Quantum Health nurse is not able to justify coverage based on the use of the above criteria, or no applicable criteria is available, it is referred to a Medical Director for review.

2. Medical Director determinations will be based on the following:

   - An evaluation of the case against the applicable criteria in the hierarchical sequence listed above. If there are criteria that are directly applicable to the case, and the criteria have been correctly and appropriately applied, failure to meet those criteria should govern the coverage decision.

   - If, in the Medical Director's expert clinical judgment, there are specific extenuating circumstances or additional relevant clinical information specific to the case to justify an approval, the case may be approved. However, the circumstances of the decision should be documented and logged. Cases approved based on medical director clinical judgment will be periodically gathered for peer-review and used to assess inter-rater reliability in order to improve the consistency of clinical decision making at Quantum Health.

   - If there is no applicable criteria that addresses the clinical circumstances of the case the Medical Director may utilize the following external criteria:

     - Aetna Clinical Policy Bulletins (CPBs), or

     - Medical Specialty Society Guidelines for the management and treatment of specified clinical conditions.

3. If there are no applicable clinical criteria from the above sources, the Medical Director should seek external clinical consultation from a Quantum Health designated peer review consultant.

4. Any criteria or rationale utilized to deny coverage must be clearly documented, based on available clinical evidence and communicated in understandable language to the requesting practitioner and/or patient.

MANAGEMENT REVIEW PROCESS

To ensure consistency in the delivery and execution of these guidelines, adherence to the guidelines will be measured as part of the Quality Assurance process. The department manager will conduct random audits to ensure compliance.

EXCEPTIONS

Federal/State legislation and/or Plan-Specific language supersede the QUANTUM administrative guidelines in this procedure.

COMPLIANCE

Employees are to comply with all aspects of this guideline.

Quantum HEALTH

Municipality Case Study Summary

Quantum Health Boosts Savings for Major Southeastern City

By using Quantum Health, the client was projected to save 11%. However, to our client's delight, actual savings were—depending on calculation methodology—13–20%.

The Big Picture:

This major municipality with 2,791 employees (5,276 plan participants) has an aging workforce with multiple union contracts. Cost-shifting was not a viable option. They also had a high rate of diabetes and related complications, a problem typical to the Southeastern region of the U.S. Despite having a special diabetic program, they were consistently disappointed by lack of participation and the program's inability to improve outcomes. All told, the city continued to experience high trend and increases in claims.

The Big Idea:

Eliminate costly disconnects among plan participants by "connecting the dots" of health benefits, care management, and disease management through a single, real-time customer service source.

The Results:

Going above and beyond

To rein-in rising healthcare costs and spur plan participants to take a more active role in their wellbeing, the city gave Quantum Health a shot at increasing wellness participation and decreasing overall healthcare costs. We not only hit the target—we beat it!

Overall trend dropped 10 points

Thanks to the Quantum Health approach, the city was able to:

- Improve service—plan participants report very high satisfaction with Quantum Health services and support
- Increase engagement in disease management—for the preexisting diabetic management program, participation increased by more than 300% and helped improve outcomes
- Stabilize trend—overall trend dropped 10 points and has been held essentially flat, in spite of a large number of claims in Year 2
- Reduce healthcare costs—savings of 13-20% of projected costs were realized (depending on how savings are calculated)

Savings Results for major Southeastern City using the Quantum Health Approach:

Measurement Approach:	Savings PEPY:	% Savings:	Total Savings:
Methodology #1: Most Conservative	$2,897	13%	$7.8M
Methodology #2: Most Reasonable	$4,380	19%	$11.8M
Methodology #3: Most Aggressive	$4,789	20%	$12.9M

"Since implementing the Quantum Health program in 2007, our claims trend is essentially flat...and that's a drop of more than 10 points from where it had been in the past. We're proud that we have saved the taxpayers of the city millions of dollars over that time through effective case management, high-touch care coordination, and successfully engaging more employees in managing their health."

— Human Resource Director
Major Southeastern City

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Engagement Results

All Members

- 92% of households
- Averaged 4.4 conversations per year with each household

Medium Cost Members (4% had claims over $10,000)

- 99% working with a Care Coordinator
- 35% engaged with a Disease Manager

Members with Chronic Conditions (9% of the population)

- 73% working with a Care Coordinator
- 35% of high risk patients engaged in behavioral program

Members with Inpatient Admissions

- 65% of target admissions with a pre-admission conversation
- 90% of targeted discharges with post-discharge contact

Utilization Results

Type of Service	Actual vs. Expected
Primary Care Physician Use	↑ 14%
Specialist Use	↓ 5%
Emergency Room Use	↑ 4%
Outpatient Surgery	↓ 12%
Diagnostics	↓ 24%
Re-admissions	↓ 20%
Inpatient Admissions	↓ 18%
Inpatient Length of Stay	↓ 2%
Inpatient Days	↓ 19%

Adjustments for Other Factors

Planned and unplanned factors can influence healthcare costs during the course of any year. It isn't possible to identify all of them, or the extent to which they affect costs, but factors we could account for include the following:

- Plan design
- Contribution methodology
- Demographics
- Labor force change
- Geography
- Network discounts and vendors
- Management involvement

Calculating the Savings

Three methodologies were employed to arrive at the calculated savings:

- Methodology #1: Most Conservative
  Actual versus projected results adjusted for aging, new technology, and price inflation. This methodology does not factor in utilization trend other than age impact. If utilization was frozen at 2005 figures, this methodology reflects what the trend would have been.
- Methodology #2: Most Reasonable
  Actual versus projected results adjusted as above, also applying published average utilization trend. (Note: Average annual utilization trend was 3.66% medical and 3.36% Rx during the four-year test period.*)
- Methodology #3: Most Aggressive
  Actual results versus industry trend results†, which account for all factors including the utilization trend. This approach recognizes normal utilization inflation but is sometimes considered to overstate some factors, generally making this methodology more aggressive.

When establishing the projected cost trend for comparison purposes, we used observed claims from the previous 24 months and then applied industry trend to it.

*2007-2010 Segal Health Plan Cost Trend Studies

†2007-2010 Segal Health Plan Cost Trend Studies, Aon and other reports for claims only

The Guarantee:

100% Guarantee on Performance

Change isn't easy, but we guarantee it will be worth it...so much so that we will put up to 100% of our fee at risk, based on mutually agreed-upon targets. Our clients have three different at-risk options based on preference for risk versus reward. We also offer a fixed-fee option.

Overall, our clients receive significantly more service and better results while staying budget-neutral.

The Next Step:

If you are interested in more information regarding our capabilities or would like to review a highly detailed version of this case study, contact your Quantum Health Sales Executive:

- Toll-free at **1-877-498-9866**,
- Email **sales@quantum-health.com**, or
- Log-on to **www.quantum-health.com**

QH1104-03 (6/13)

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EMPYREAN

WWW.GOEMPYREAN.COM

August 13, 2013

Ms. Kara Trott

Chief Executive Officer

Quantum Health

7450 Huntington Park Drive

Columbus, OH 43235

Dear Ms. Trott:

This letter will describe the basis for projecting the financial impact on an employer's medical claims in the event that the employer were to terminate the Quantum Health interceptive health management model and implement a more traditional carrier based medical management program. I have also provided an estimate of anticipated level of financial impact, based on the actual claims cost of Quantum Health clients over the period from 2001 through 2011. A summary of the claims data used in this analysis will be forthcoming.

The Quantum Health approach is based on an interceptive model that aims to incorporate real time care coordination and clinical guidance across a wide range of health conditions. The model is based on a highly tailored care coordination and management program across multiple clinical levels (including the full integration of customer service with clinical and health management services, etc.) to provide a holistic approach for impacting the participant's utilization choices and health needs. In contrast, most traditional medical management programs are delivered through a number of specific components, each of which is focused around a more limited aspect of health care, such as utilization review, large case management, home health management, or wellness programs. These programs typically do not involve the same degree of care coordination or real time intervention as is present in the Quantum Health model, as evidenced by significant differences in engagement rates, pre-post utilization changes and differences in trend impact.

In terms of estimating the financial impact of a change between the Quantum Health model and the traditional medical management programs, I believe the analysis must consider the short term (initial year of change) and long term impact separately.

- Short Term Impact (initial year of change) - Using the data from over 75 Quantum Health clients collected over the period from 2000 to 2012, we have analyzed the change in average PEPY cost (both medical and Rx claim costs) for employers during the initial year of the Quantum

Health model. On average, employers experienced a reduction of 3.1% in actual claim costs for the year in which the Quantum Health model was implemented. This change in PMPM claim cost is net of any adjustments made for other factors such as changes in plan design, or the value of network discounts.

To properly evaluate the financial impact of the change from the traditional medical management programs to Quantum Health, it is necessary to add the impact of the underlying medical trend during the year of the change. For the years between 2000 and 2012, market average trend (using the annual trend studies published by AonHewitt, TowersWatson and The Segal Company) ranged between 6.0% and 15.7%. Using an average annual trend estimate of 9.1% (the lowest annual average during the period) the impact of the change to the Quantum Health model can be estimated as:

- Projected initial year change in PMPM claim cost maintaining the traditional medical management program: 9.1%
- Actual initial year change in PMPM claim cost under the Quantum Health model: (3.1%)

The net impact, in the first year, of moving from a traditional medical management approach to the Quantum Health model, including the impact of annual trend, averaged 12.1% during the period between 2000 and 2012 for the Quantum Health clients. Based on the data, it is reasonable to assume that a move from the Quantum Health model to a traditional medical management program would produce an increase in net claim costs of a similar magnitude, using current estimates of future claims trend.

- Long Term Impact (for years beyond the initial year of change) – Because much of the impact of medical management is realized over a multi-year period, it is appropriate to evaluate the financial impact of the different approaches to medical management over a 3 to 5 year period. The analysis conducted using the Quantum Health client data focused on determining the difference in the average rate of increase in claims cost for each year (trend) versus the corresponding average market trend for the same year. For the period between 2000 and 2012, the actual CAGR of all medical and Rx claims was 3.3% for the Quantum Health clients (the CAGR was 2.9% if catastrophic claims were removed from the analysis). This CAGR reflects the fact that in several years, the average annual trend rate was negative for the aggregate client enrollment.

For purposes of projecting the future total claims under the Quantum Health model it would be appropriate to apply a factor to the current market trend rates representing the ratio of the Quantum Health CAGR to market CAGR consistent with the actual ratios determined from the study data. Using those periods where at least 5 years of data are available to determine the CAGR, the study showed that the average Quantum Health trend ranged between 63% and 81% of the average market trend for the same period. In making a future projection for years

beginning in 2014, if the assumed market trend was set at 9%, then it would be reasonable to project the Quantum Health model trend between 5.5% and 7.2%.

This letter is intended to provide a general outline of a reasonable methodology for comparing the total claim cost under the Quantum Health model with a traditional medical management approach. As with any such analysis, there are numerous issues and caveats that should be discussed prior to making a final estimate. I would be glad to provide additional detail if that would be useful.

Sincerely,

Michael H. Taggart FSA

President

Empyrean Benefit Solutions, Inc.

9009 West Loop South

Houston, TX 77096

Member Engagement

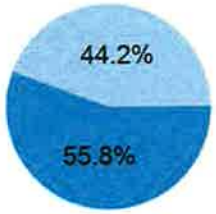
Members versus Providers - Contacts

Percent of Contacts

With Member
With Provider

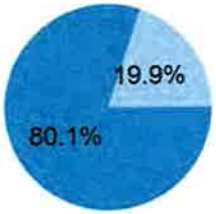
Overall Care Coordination

All

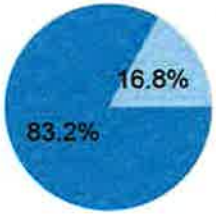


Members with claims > $10,000

Chronic Condition Members with Clinical Activity



High Risk Members - Engaged



In addition to assisting members directly, Quantum Health's Care Coordinators work closely with providers on behalf of members. This level of coordination helps eliminate redundancy and ensures that healthcare is used efficiently. Care Coordinators also work directly with providers' offices to help resolve claim issues for members.

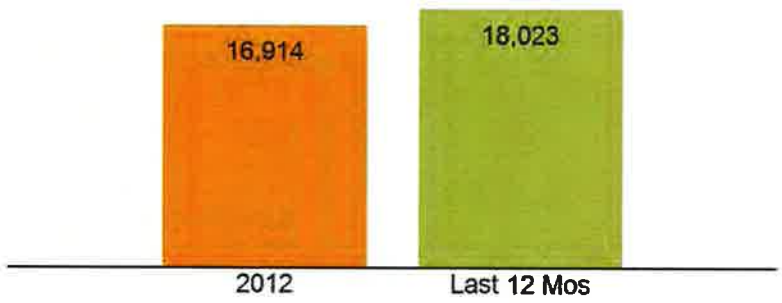
**Members with coverage effective at end of reporting period.*

Member Engagement

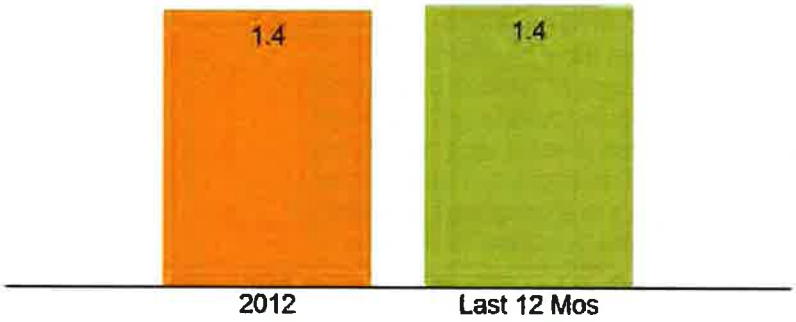
Patient Advocacy

	2012		Last 12 Months		Quantum Health Norm
	Total Issues	Per 1,000	Total Issues	Per 1,000	Per 1,000
Assistance with Precerts or Referrals	6,027	605	6,255	591	784
Claim Issue/Question	2,956	297	2,960	279	841
General Education and Guidance	1,440	145	2,019	191	344
General Feedback	122	12	180	17	38
Help with a Provider	2,149	216	2,136	202	529
Other Outreach	105	11	143	14	23
Understanding Benefits	4,115	413	4,330	409	1,144
Total	16,914	1,699	18,023	1,702	3,702

Total Issues Handled



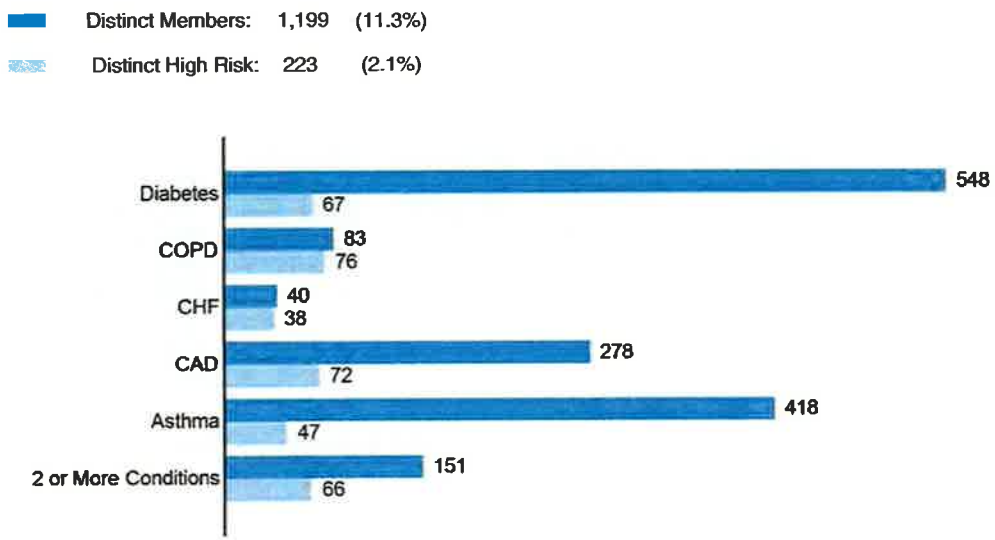
Average Issues Per Contact



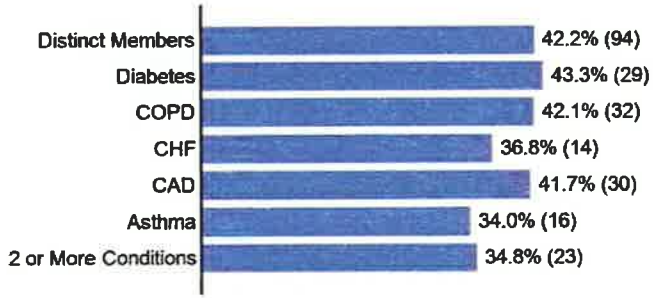
Member Engagement

Chronic Condition Management

Members With Chronic Conditions



Engaged High Risk Members



Members are identified for chronic condition management opportunities if they are found to have any of the following conditions: diabetes, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD) or asthma.

Quantum Health's chronic condition coaches reach out to members identified with chronic conditions by sending educational materials, health reminders, and a health survey. The survey asks condition-specific questions to aid in the risk stratification process. For members identified as high risk, a chronic condition coach will make an outreach call in addition to the periodic mailings and health reminders.

High risk members are considered "engaged" with CHC if they complete the health surveys and speak regularly with their assigned chronic condition coach. These members will also receive the educational materials and member-specific reports.

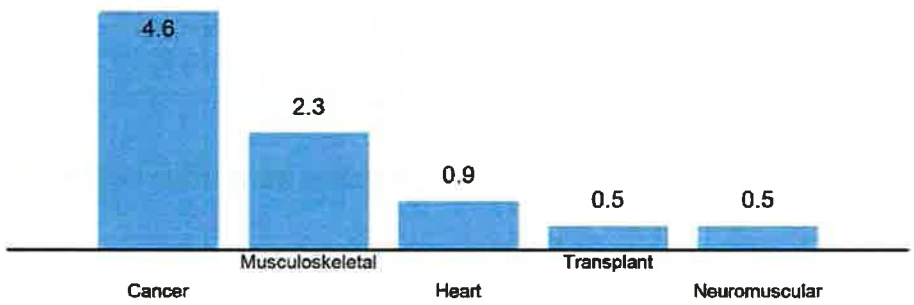
Each condition is counted if a member has multiple conditions, not just the primary. Therefore, the sum of each condition could be higher than the distinct member count. The following order determines the primary chronic condition: diabetes, CHF, COPD, CAD, asthma.

Of the 223 distinct high risk members, 42% of them have been engaged with a Chronic Condition nurse in the past year, compared to the Quantum Health norm of 52%.

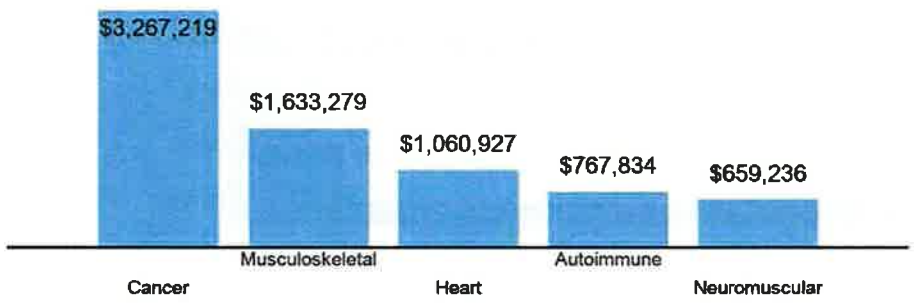
Member Engagement

Case Management and High Cost Cases

Top 5 Diagnoses by Prevalence (per 1,000)



Top 5 Diagnoses by Total Cost*



	Most Recent 12 Months			
	Cases	Per 1,000	Total Cost	Avg. Cost
Autoimmune	4	0.4	$767,834	$191,958
Cancer	49	4.6	$3,267,219	$66,678
Congenital	2	0.2	$519,754	$259,877
Cystic Fibrosis	1	0.1	$122,129	$122,129
End Stage Disease	4	0.4	$635,031	$158,758
Endocrine/Metabolic	2	0.2	$138,243	$69,122
Heart	10	0.9	$1,060,927	$106,093
High Risk Pregnancy	4	0.4	$80,622	$20,155
Infectious Disease	1	0.1	$33,415	$33,415
Mental Health	5	0.5	$127,201	$25,440
Morbid Obesity	1	0.1	$9,638	$9,638
Musculoskeletal	24	2.3	$1,633,279	$68,053
Neuromuscular	5	0.5	$659,236	$131,847
Non-Healing Wound	4	0.4	$260,891	$65,223
Other**	2	0.2	$230,480	$115,240
Pediatric	4	0.4	$341,981	$85,495
Respiratory	3	0.3	$277,645	$92,548
Stroke	1	0.1	$63,370	$63,370
Transplant	5	0.5	$475,581	$95,116
Trauma	4	0.4	$217,126	$54,281
TOTAL	135	12.8	$10,921,603	$80,901

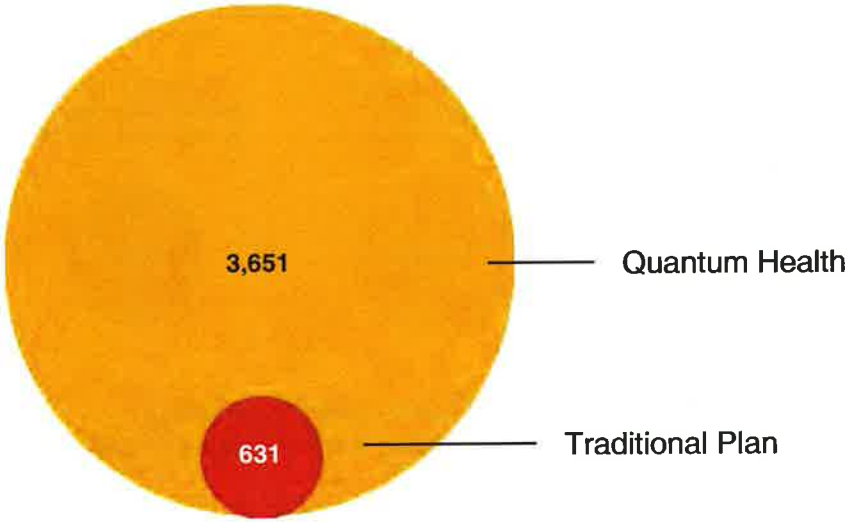
A total of 135 members (1.3%) have been identified for case management or high cost case review. These cases accounted for $10,921,603, or 21.7% of total claims.

**All medical and pharmacy claims are included under the identified condition for each member.*
***Other includes digestive, liver, general surgery, general medical and undiagnosed cases under nurse review. Kidney excludes end stage renal disease.*

Member Engagement

Episodes of Care

Involvement in Episodes of Care

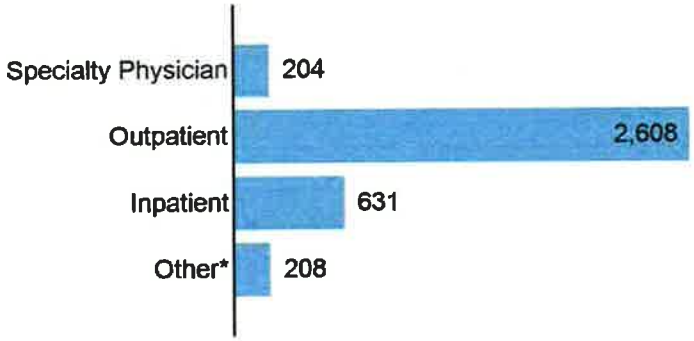


As a result of our referral and pre-notification process, Quantum Health Care Coordinators have been involved in coordination and concurrent case management in 3,651 episodes of care over the past twelve months. In contrast, a more traditional approach would have only touched 631 cases. In the Quantum Health model, 5 times more cases can be affected.

These cases have been reviewed for reduced plan exposure by:

- Focusing care to network providers
- Directing negotiations for services
- Arranging for patient care to be provided in the most appropriate and cost-effective settings
- Assisting with ongoing patient advocacy

Quantum Health's Involvement by Type of Care

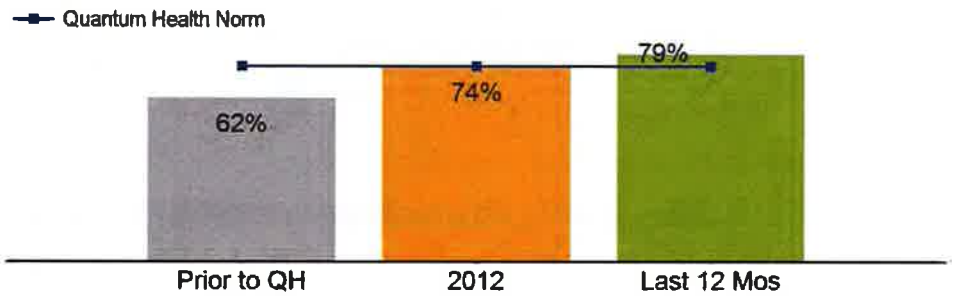


*Other includes durable medical equipment and home health care

Utilization

Primary Care

Percentage of Members Utilizing a Primary Care Physician

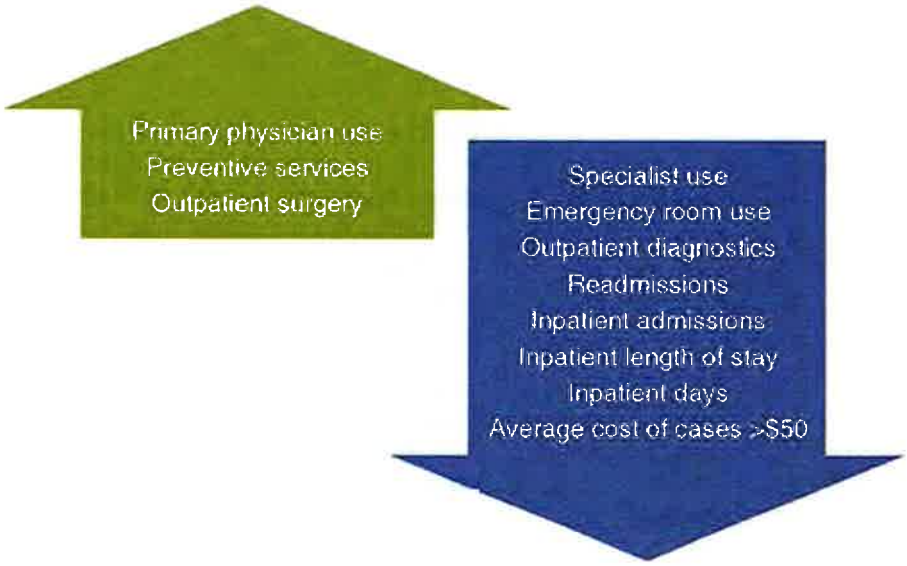


When members have established primary care physician (PCP) relationships and begin healthcare events with PCP visits, there is a tangible impact on both utilization and cost. Industry studies indicate that patients who have established relationships and utilize their primary care physicians incur 33% less cost overall**.

A total of 79% of members have used a PCP compared to the Quantum Health norm of 74%.

Impact of Primary Care Pattern Change -- Directional and Illustrative --

Utilization Goals



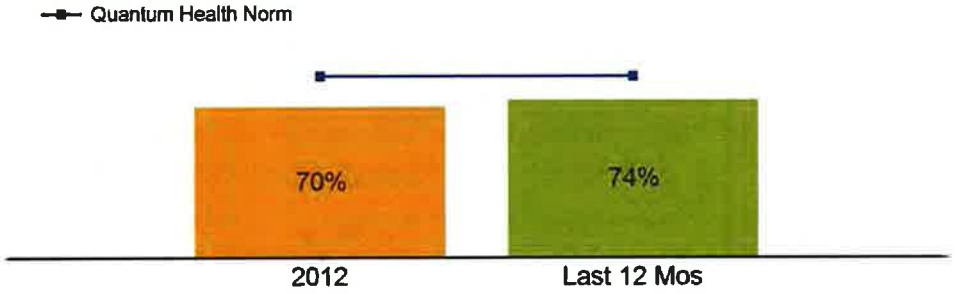
*Quantum Health norm difference between per member per year cost for members with PCP vs. members without a PCP.
**P. Franks and K. Fiscella, "Primary Care Physicions and Specialists as Personal Physicians: Health Care Expenditures and Mortality Experience," Journal of Family Practice 47, no. 2 (1998): 105-109.

Quantum HEALTH

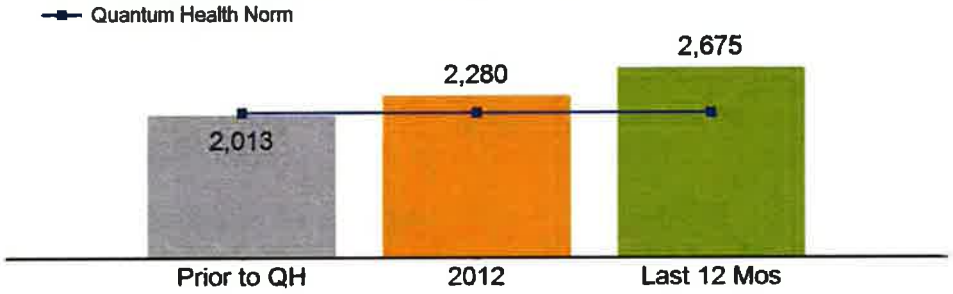
Utilization

Primary Care

Percentage of Members* with a Primary Care Physician Relationship



Primary Care Physician Visits (per 1,000)



Primary Care Use Comparison

	Prior to QH	2012	Last 12 Mos
Expected** Visits / 1,000	2,013	2,063	2,080
Actual Visits / 1,000	2,013	2,280	2,675
Difference	0	217	595
Percentage Difference	0.0%	10.5%	28.6%

Establishing a primary care physician relationship is essential for each member - this relationship provides the starting point for the most effective wellness programs and healthcare utilization. Quantum Health actively promotes this relationship and encourages all members to designate a primary care physician. When a Care Coordinator receives a call from a member who has not identified a primary care physician, the Care Coordinator will intercept and work with the member to establish one.

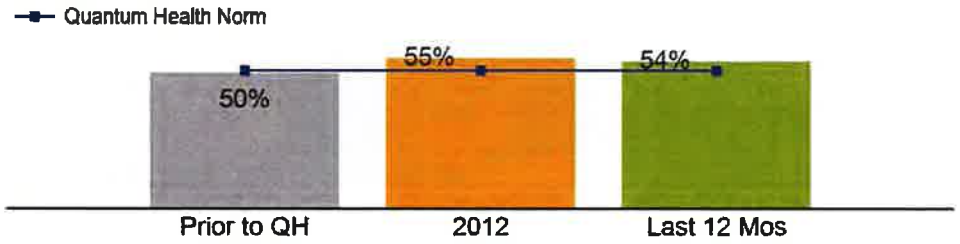
The percentage of members with a primary care physician relationship is comprised of both members who have designated and those who have seen but not designated a primary care physician. A total of 74% of members have established a relationship with a primary care physician to date compared to a Quantum Health norm of 85%. A total of 50% of members have a designated primary care physician. Additionally, members had 2,675 primary care physician visits per 1,000 compared to the Quantum Health norm of 2,047.

*Members with coverage effective at end of reporting period
**Source: Health, United States 2011, Centers for Disease Control and Prevention

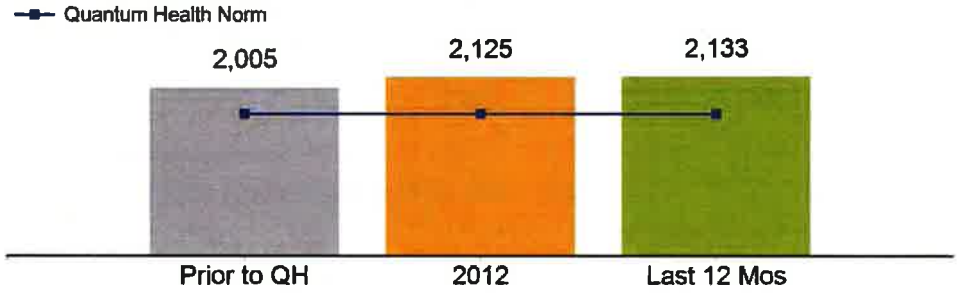
Utilization

Specialty Care

Percentage of Members Utilizing a Specialist



Specialist Visits (per 1,000)



Specialist Use Comparison

	Prior to QH	2012	Last 12 Mos
Expected* Visits / 1,000	2,005	2,111	2,148
Actual Visits / 1,000	2,005	2,125	2,133
Difference	0	14	-15
Percentage Difference	0.0%	0.7%	-0.7%

Source: Health, United States 2011, Centers for Disease Control and Prevention

As part of the Quantum Health model, we request referrals for specialty care such as specialist physician office visits, physical therapy, occupational therapy, outpatient mental health and substance abuse treatment.

When Care Coordinators receive specialty referral notifications, they review them to ensure that members are visiting in-network providers. If a referral to an out-of-network provider is received, a Care Coordinator will contact the referring primary care physician to discuss the network status to:

- Explain the benefit impact on the patient
- Provide a list of in-network specialists
- Arrange logistics, if desired, to transition the case to an in-network provider, which may also include communicating directly with the patient at the physician's request

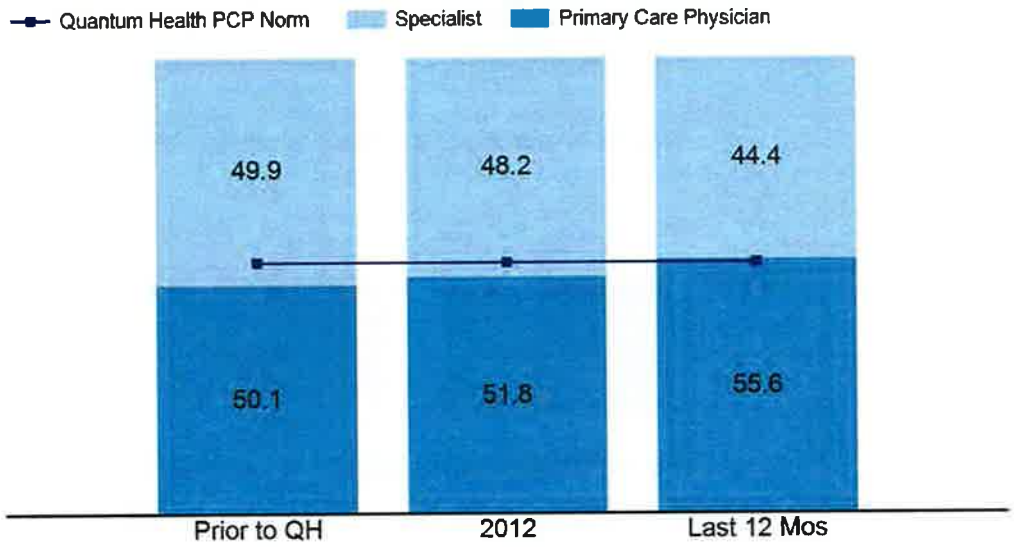
If the care is going to be referred to an out-of-network physician at patient request, a Care Coordinator will contact the patient and explain the benefit differential.

A total of 54% of members have used a specialist in the most recent year compared to the Quantum Health norm of 51%. Additionally, there were 2,133 visits per 1,000 compared to the Quantum Health norm of 1,690.

Utilization

PCP versus Specialist

Distribution of Office Visits



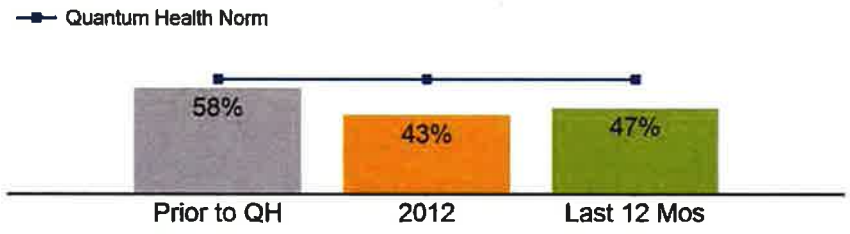
Ideally, all healthcare events should begin with a primary care physician. This helps eliminate self-referrals that are unnecessary and visits to the wrong type of specialist. The primary care physician can help triage the patient's healthcare challenge and recommend the best course of action, leading to more prudent use of the healthcare system. Additionally, when a primary care physician notifies our Care Coordinators of a specialist referral, our Care Coordinators are alerted on a real-time basis and can guide the patient through future healthcare use.

Primary care accounts for 55.6% of the total office visits, compared to the Quantum Health norm of 55.0%.

Utilization

Preventive Services

Percentage of Members* Utilizing a Preventive Service

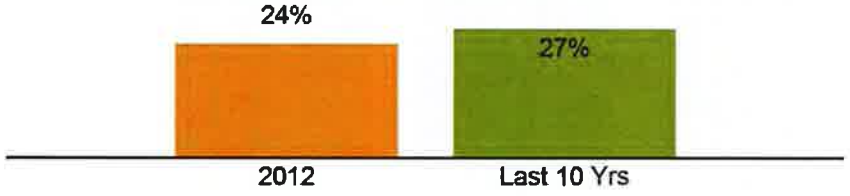


Quantum Health Care Coordinators, supported by various communication materials, promote age and gender appropriate preventive services. Through real-time alerts, Care Coordinators intercept members when they call, educate them on preventive services they may need, and communicate the related health benefits and incentives.

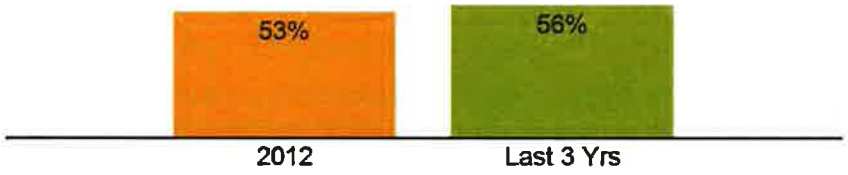
A total of 47% of members utilized a preventive service during the most recent twelve months compared to the Quantum Health norm of 63%.

Percentage of Members* Receiving Recommended Screenings

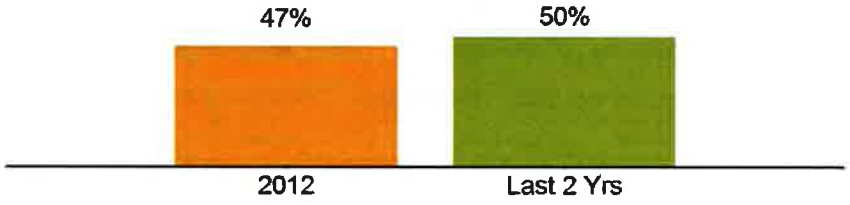
Colonoscopy (Within 10 years and Ages 50+)



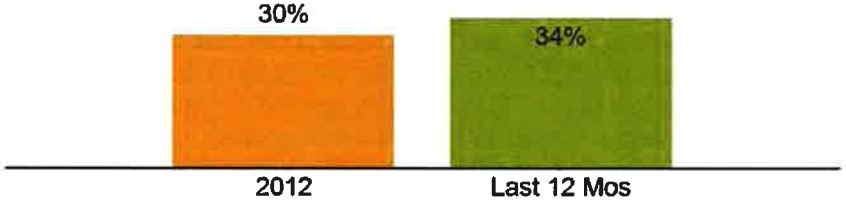
PAP Test (Within 3 years and Ages 20+)



Mammogram (Within 2 years and Ages 40+)



Routine Care (Within 1 year)

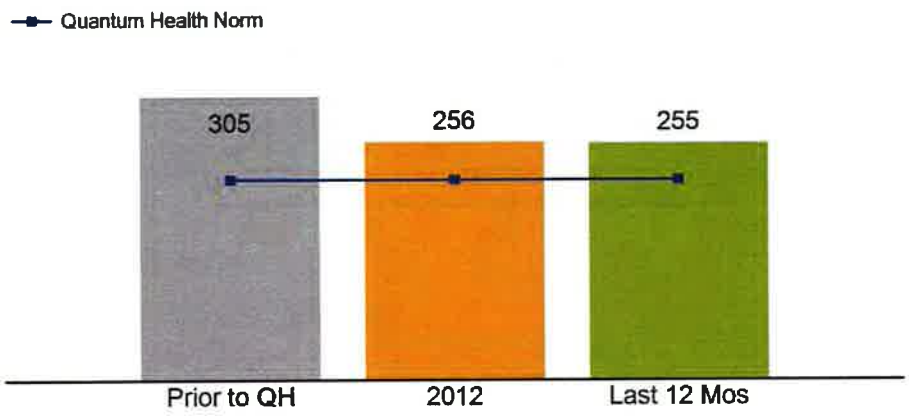


*Members enrolled at the end of the plan year or reporting period.
**Preventive service includes colonoscopy, mammogram, PAP, PSA, and routine care

Utilization

Emergency Visits

Emergency Visits (per 1,000)



Though emergency room (ER) visits are one of the more expensive care settings, they are often misused by patients with non-emergent conditions. Care Coordinators work to educate members to minimize emergency utilization.

The rate of members using the emergency room was 255 visits per 1,000 members during the most recent twelve months, compared to the Quantum Health norm of 216 per 1,000.

Emergency Use Comparison

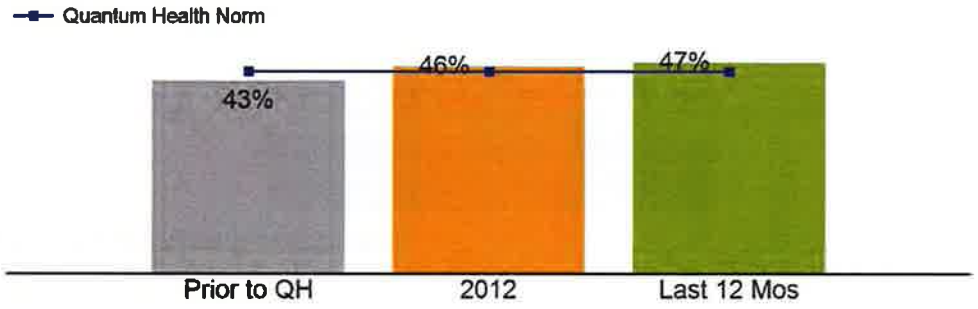
	Prior to QH	2012	Last 12 Mos
Expected* Visits / 1,000	305	317	321
Actual Visits / 1,000	305	256	255
Difference	0	-61	-66
Percentage Difference	0.0%	-19.1%	-20.5%

Source: Health, United States 2011, Centers for Disease Control and Prevention

Utilization

Emergency Visit Appropriateness

Percent Inappropriate*

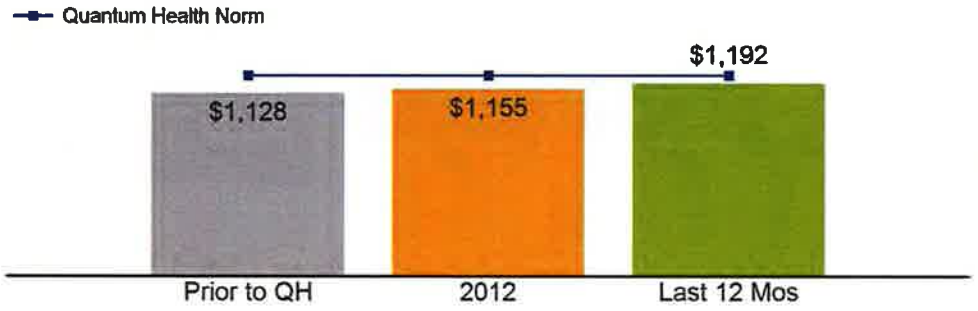


Patients frequently use emergency services out of convenience or because they do not have established primary care physicians. As a result, many emergency visits could potentially be handled in non-emergency settings.

With the Quantum Health model, inappropriate emergency utilization should diminish over time as Care Coordinators encourage members to designate primary care physicians and educate them on preventive visits and appropriate in-network providers.

During the most recent twelve months, 47% of all emergency visits were inappropriate, compared to the Quantum Health norm of 45%. The average cost per inappropriate visit was $1,192, compared to the Quantum Health norm of $1,239.

Cost of Inappropriate Visit



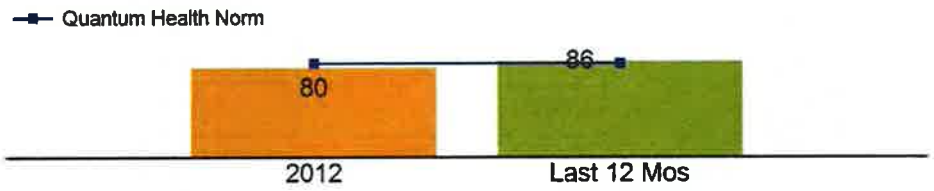
*A visit is considered "appropriate" for emergency care if the individual is treated for life-threatening, traumatic or other acute, serious needs that should not be delayed until a PCP can be seen. Examples include, but are not limited to, fractures, chest pain, asthma attacks, etc.

Utilization

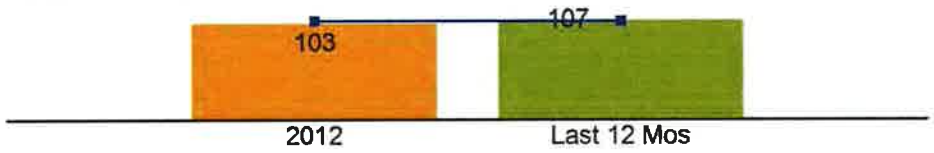
Outpatient Visits

Utilization Rates (per 1,000)

Outpatient Surgery



Outpatient Diagnostics



Outpatient Other*

OP Surgery Use Comparison

	2012	Last 12 Mos
Expected** Visits / 1,000	80	86
Actual Visits / 1,000	80	86
Difference	0	0
Percentage Difference	0.0%	0.0%

Note: Expected trends not available for Outpatient Diagnostics and Outpatient Other
** Other includes therapeutic procedures, therapies (PT, OT, ST), and education/training*
***Source: Health, United States 2011, Centers for Disease Control and Prevention*

Outpatient surgery includes therapeutic and diagnostic surgery. Our Care Coordinators review each notification to ensure that it meets plan criteria for medical appropriateness and is a covered benefit under the plan. Care Coordinators:

- Ensure that procedures will be performed by network providers whenever possible
- Redirect procedures from inpatient to outpatient settings whenever possible
- Identify procedures not covered by the Plan in advance, allowing patients to make more educated decisions

Outpatient diagnostic services include sleep studies, outpatient hospital testing, MRIs, etc. The same level of review is conducted on outpatient diagnostic services as is conducted on outpatient surgery. If a service meets plan criteria, a Care Coordinator will:

- Review the patient's record to ensure the patient has not already had the procedure
- Ensure that the service will be provided by a network provider whenever possible
- Facilitate a conference between the requesting physician and the specialist if the service is requested as part of a general "work up" to determine whether the specialist is needed

During the most recent twelve months, there were 86 outpatient surgeries per 1,000, compared to the Quantum Health norm of 84 and 107 outpatient diagnostic procedures per 1,000, compared to the Quantum Health norm of 106.

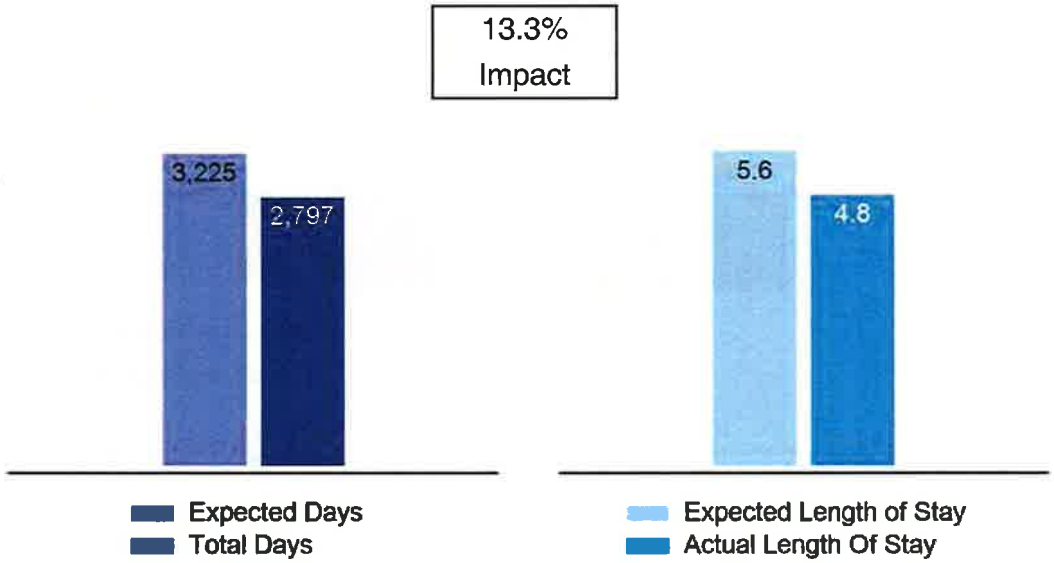
Utilization

Inpatient Days Avoided

Days Avoided*
-- Directional and Illustrative --

All inpatient cases receive concurrent, daily case management – days are not assigned upfront. Clinical Care Coordinators review status daily to ensure that patients meet Plan criteria for continued inpatient stay. They also begin discharge planning on the first day of the admission so that sub- and post-acute care services are established and discharge is not delayed.

The number of days avoided for each admission is the difference between the actual length of stay and the national norm based on the specific age and condition of the patient. Atypical admissions are excluded.



*Source: H-CUP (Healthcare Cost and Utilization Project), Nationwide Inpatient Sample
**Quantum Health norm average cost per day

Utilization

Inpatient Admissions

Inpatient Including Outliers*

	2012	Last 12 Months	Quantum Health Norm
Admissions per 1,000	51	55	53
Bed Days per 1,000	231	264	217
Average Length of Stay (Days)	4.5	4.8	4.1

Inpatient Excluding Outliers*

	2012	Last 12 Months	Quantum Health Norm
Admissions per 1,000	36	38	40
Bed Days per 1,000	104	106	104
Average Length of Stay (Days)	2.9	2.8	2.6

Inpatient stay coordination includes post-discharge and sub-acute Services, inpatient rehab and observation stays. Inpatient stays are all reviewed for coverage under the plan and plan criteria, but further evaluation is undertaken to determine whether the care can be provided in an outpatient care setting. If an inpatient stay is appropriate, Quantum Health nurses coordinate care by conducting daily, concurrent case review, prearranging post-discharge services, and obtaining permission to discharge according to criteria.

There were 73 outliers in the most recent twelve months. These outliers accounted for 177 admissions and 1,675 bed days.

Inpatient Use Comparison

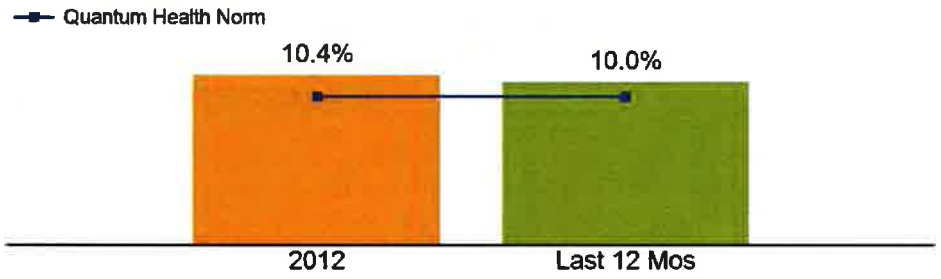
	2012	Last 12 Months
Expected** Admissions / 1,000	51	55
Actual Admissions / 1,000	51	55
Difference	0	0
Percentage Difference	0.0%	0.0%

**Outliers for inpatient utilization are those patients with three or more admissions or ten or more cumulative days.*
***Source: Health, United States 2011, Centers for Disease Control and Prevention*

Utilization

Inpatient Admissions

Re-admission 30 Day Rate*



Each patient (except routine OB admissions) is contacted three to five days after discharge to ensure the patient has understood discharge instructions and followed-up on any continuing care needs. The patient is also assessed at this time for ongoing Case Management or Chronic Condition Management opportunity.

Of all inpatient stays in the most recent twelve months, 10.0% of them resulted in re-admissions within 30 days, compared to the Quantum Health norm of 9.1%.

The average cost per inpatient admission was $22,650, compared to the Quantum Health norm of $19,314.

Average Cost per Admission (All Admissions)

**A re-admission is an additional inpatient admission occurring for an individual within a 30 day period, for any diagnosis. This calculation excludes transfers to other facilities, including skilled nursing and rehabilitation centers.*

Onboarding Plan

Logo Here

Task	Proposed Due Date	Revised Due Date	Completion Date	Owner	Comments
Implementation Agreements/Documents					
Sign Letter of Intent					
Sign Business Associate Agreement					
Sign PHI Roster					
Sign CHC Agreement					
Data Requests & Transfers					
Medical:					
Provide eligibility TEST file to QH					
Provide eligibility PRODUCTION file to QH					
Set up and implement eligibility PRODUCTION file feed					
Provide claims TEST file to QH					
Provide claims PRODUCTION file to QH					
Set up and implement claims PRODUCTION file feed (QH will need accumulators)					
Provide auth/pre-cert TEST file to TPA					
Provide auth/pre-cert PRODUCTION file to TPA					
Set up and implement auth/pre-cert PRODUCTION file					
Provide 2 yrs. detailed claim history to QH					
Provide 2 yrs. historical eligibility to QH					
Provide Case Management transition report to QH					
Provide report of current pre-certs on file (include patient/provider name, service,dx, etc.)					
Provide medical and Rx monthly agg report for prior benefit year ending XX/XX/XX (24 mos)					
Provide 2 yrs. historical call volume (daily) If not provided during proposal process					
RX:					
Hold call with PBM to discuss set up					
Provide pharmacy set-up document with co-pays, include/exclude, limits, etc.					
Set up monthly detailed pharmacy claims download with QH					
Provide 2 yrs.detailed pharmacy claims history					
Provide report of members currently using specialty drugs and injectables to QH					
Benefit Set-Up					
Confirm pre-cert list set-up including grace period and penalties					
Discuss process for transition of care					
Complete CHC Transplant Questionnaire					
Build benefits into Qbase					
Send Qbase snapshot to TPA & Consultant for approval					
Confirm claims system is set up to pay all specialist office visits at enhanced level for grace period of 90 days (if applicable)					
Provide CHC language to be included in SPD					
Provide copy of SPD amendment adding CHC program prior to final approval					
Provide final copy of SPD amendment adding CHC program					
Provide amendments for any plan changes or SPD's if re-written					

Logo Here

Task	Proposed Due Date	Revised Due Date	Completion Date	Owner	Comments
Member Communication					
Plan methods for educating members of CHC program					
Update and finalize employee materials					
Develop phone set up/script					
Provide approval of phone script					
Website live and approved by client					
Create ID cards and obtain approval of all parties					
Mail ID cards to member's homes					
Determine prize drawings for completion of Health/Care Profiles (if applicable)					
Drawings held and prizes provided (if applicable)					
EOB's - send customized logo and phone numbers to claims payer					
Miscellaneous					
Hold Culture Training for Care Coordinators					
Provide current/renewal Stop Loss contract					
Provide list of VIP's					
Obtain access to TPA claims system					
Provide TPA login for QH Gateway					
Provide QH Gateway training to TPA staff					
Post Implementation					
Email CHC Implementation Survey					

IT Disaster Recovery Plan

IT Disaster Recovery Plan

1. Purpose

2. Preparation Requirements

   i) Equipment
   ii) Software
   iii) Backups

3. Disaster Recovery Process

   a. Classification
   b. Notification
   c. Place Equipment Orders
   d. Recovering Communications
   e. Recovering Internet Environment
   f. Recovering Application Environment
   g. Recovering File Server and Other Services
   h. Recovering Data

4. Maintaining the Plan

5. Monitoring and Testing

6. Triggering Execution

7. Contacts

   a. IT Team
   b. Managers
   c. Associates
   d. Vendor/Business Partners
   e. Clients

8. Testing Log

9. Modification Log

1. Purpose

This disaster recovery plan is intended to cover any loss of system infrastructure services from a single service to the entire system from a catastrophic event. It only involves the plan for recovering system services and does not address office space or other operational issues.

2. Preparation Requirements

Equipment

Due to the speed of obsolescence and the ability of Quantum Health IT to use commodity servers, only minimal equipment is kept for immediate use after a disaster. The LTO tape backup unit was identified as the critical piece of equipment that is needed immediately when executing this plan and is not readily available from a local source. A backup server with an LTO tape unit installed is kept in a "Disaster Recovery Kit" kept at our off-site storage vendor, Fireproof. All other servers, PC's displays, printers, phones and networking equipment will need purchased locally to replace any lost equipment. Our current environment uses a significant amount of redundancy at all levels, which helps to mitigate risk and enhance uptime. In addition, our entire building is on generator backup for business continuity reasons.

Software

Operating systems and critical application software is included in our Disaster Recovery Kit stored at our off-site vendor, Fireproof. All other software used by the company is located on the backup tapes under \quantum05\qhealth\IT\Installs. All software that is needed for operations of our communication services should be stored in our Disaster Recovery Kit. It is the responsibility of the System Administrator to maintain the contents of the Disaster Recovery Kit.

Backups

Restoring from any type of data loss due to equipment failure, user error or catastrophic disaster depends on a complete and reliable backup being made at the end of each business day. It is critical that backup tapes be stored in the IT safe daily and at our off-site vendor weekly. It is the responsibility of the System Administrator to ensure backups are working properly, verified and kept in the safe or off-site.

Currently all major systems and storage are backed up. We run a daily incremental backup with a weekly full backup every weekend.

3. Disaster Recovery Process

Step 1: Classification

When a potential problem is discovered with one or more system services, IT staff must immediately determine the scope of the issue and notify the Director of Infrastructure of the situation, per the Incident Management Policy. The first priority is to gather enough information to classify the failure as one of the following three situations:

a) *Isolated* – An isolated failure involves one specific service, while other services are operating normally.

b) *Contained* - A contained failure involves a failure in a set of services, such as an internet failure, but other services are still operational.

c) *General* – A general failure involves a complete loss of most, if not all services, such as the result of a building fire.

Depending on the anticipated length of time the response to any of the above classified events will vary greatly. The chart below provides a basic summary of the response depending on several of these factors:

Anticipated Time until Service Restoration	Isolated Incident	Contained Incident	General Failure Incident
0 - 4 hours	Depending on the system or service in question IT staff will work with existing internal support processes and supporting vendors on restoration	Depending on the system or service in question IT staff will work with existing internal support processes and supporting vendors on restoration	If feasible at existing location and depending on the system or service in question IT staff will work with existing internal support processes and supporting vendors on restoration. If restoration is not feasible at current location than remote work options will be utilized.
8 hours	If Isolated system or service is still not restored, begin work on	Depending on the system or service in question IT staff will	Begin full Disaster Recovery and Business Continuity

	alternative restoration processes (such as new software/servers/service to provide needed functionality)	work with existing internal support processes and supporting vendors on restoration	procedures, including restoration of all systems and services as outlined below in this document
12 hours	All isolated systems and service outages will be restored by this time.	If contained system or service is still not restored, begin work on alternative restoration processes (such as new software/servers/service to provide needed functionality)	Continue DR/BCP plan while providing basic functionality to the business via PBX Parachute, Colo, and remote work options such as VPN services and terminal servers.
24 hours		All Contained incidents will be restored by this time	Continue DR/BCP plan while providing basic functionality to the business via PBX Parachute, , Colo, and remote work options such as VPN services.
48+ hours			All General Failure Incidents will be resolved by this time.

Step 2: Notification

The Director of Infrastructure should be notified immediately as part of the event Classification per the Incident Management Policy. Once an event is classified, all company employees must be notified, explaining the failure and the potential period of time the service will be down, per our Incident Management Policy. Email is the primary notification method, corporate voice mail is the second method and cell phone calls to each manager is the third method. Failures that involve an outside vendor, such as one of our ISP's or phone vendor, should be reported to that vendor immediately to help isolate the cause as either internal or external to Quantum Health. If the Tape unit is not available, a request should be immediately made for our Disaster Recovery Kit from our off-site storage vendor, Fireproof Storage (614-299-2121, ACCT CQU02 Box DR1 Password is known by Director of Infrastructure and Administration Staff. It is also located in the IT/System Administration/Security folder).

Step 3: Ordering New Equipment

Depending on the nature of the failure, services will be provided by a backup method, if available. Other failures require either using spare equipment or ordering new equipment. It is critical that any equipment needed, if any, be purchased locally or ordered as soon as possible following the event. Orders can be cancelled and equipment returned if it turns out not to be needed. The decision may be made to purchase lower spec equipment in the short term, while we wait for replacement equipment to arrive. The minimum equipment needed for each general component of our system is as follows:

System Component	Minimum Specification	Quantity
Communications	a) Quad-Core Intel, 8GB memory, SATA drives or better b) Cisco Call Manager c) 24+ port gigabit switch	4 1 2
Network	(a) Cisco 3750X switches (Core, Distribution, & Access layer) (a) Cisco ASA Firewalls	12 4
Internet	(b) Quad-Core Intel, 8GB memory, SATA drives or better	2
Applications	a) Quad-Core Intel, 24GB memory or more, 2TB SATA drives or better	4
File Server / Other	b) Quad-core Intel, 8GB memory, 4 TB storage space (a) Quad-core Intel, 8GB memory, 4 TB	1 1

	of available space (b) 16-port NetSatisfaction Fax Card	1
(b) PCs	(a) PC, 2GB memory, XP Pro, three 17" displays,	One for each on-site associate
(c) Printer	(a) Color laser printer/fax/scanner	1

Step 4: Recovering Communications

The IT SharePoint site is the primary repository of technical reference information for Quantum Health. The site is updated and added to on a regular basis by all IT staff and a copy is kept off-site at Fireproof. It is updated quarterly as part of the Disaster Recovery Review process and is also available on the backup tapes. If software of data is needed from a backup tape and the system tape unit is not operational, the Disaster Recovery Kit should be requested from our off-site storage vendor, Fireproof. This kit includes a spare tape backup PC and the necessary system software to begin the recovery process. Details on recovering each server can be found in the IT Wiki. This step requires that we have an operational Internet Service Provider. If we cannot get service from an ISP at our current location, a new location will need established that has broadband internet access available. The following communication services are to be restored in this step:

(a) Backup Server w/LTO Tape Unit (Stored Offsite)
(b) Domain Controller/DBStudio (Windows 2003 Server: Quantum05)
(c) Internet Access/Firewall (Cisco ASA's)
(d) Phone System with Voice Mail (Utilizing our PBX Parachute)
(e) Put up system maintenance page on all external websites
(f) Email (Windows 2003 Server: QHMail)

Step 5: Recovering Application Environment

The application environment should be restored only after the databases from the latest backup tapes have been restored. Details on recovering each server can be found in the IT Wiki. The following application services are to be restored in this step:

(a) Pivot/QBase/QHGateway/... (Windows 2003 Server: QHWeb1 & QHPIVIT)
(b) Zeacom (Windows 2003 Server, Zeacom Primary)
(c) OLTP Database Server (Windows 2003 Server: Quantum03)
(d) OLAP Database Server (Windows 2003 Server: QHDB01)
(e) ACT!/CERMe/Anti-Virus (Windows 2003 Server: Quantum12)

Step 6: Recovering Internet Environment

The firewall and ISP should be operational as part of the Communications recovery. Details on recovering each server can be found in the IT Wiki. The following internet services are to be restored in this step:

(a) Terminal Server (Windows 2003 Server: Quantum02)
(b) RD Web Terminal Servers (Windows 2008, QHRDWA-SRV, QHRDCB-SRV, QHRDSH01-SRV, QHRDSH-SRV, QHRDCB01-SRV, QHCA-SRV)
(c) Cell Phone Syncs
(d) Webserver for corporate and CCHCare websites (QHEXWEB1)

Step 7: Recovering File Server and Other Services

The file server contains the full restore from the backup tapes that may take up to ten hours to complete. Details on recovering each server can be found in the IT Wiki. The following application services are to be restored in this step:

(a) qhealth/... file shares (Windows 2003 Server: Quantum05)
(b) Fax server (Windows 2003 server w/Net Satisfaction board installed: QHFax)
(c) FTP server (Linux server: ftp1)
(d) VPI Sever (Station Side)
(e) VMWare Server (QHESX1)
(f) Subversion Repository
(g) Install new phone equipment (Cisco Call Manager/Publisher, Zeacom Desktop, VPI)

Step 8: Recovering Data

The goal of this step is to ensure that any work done before the complete data restore was finished is merged into the restored files to prevent loss. It is also important to ensure all automated processing has finished in a consistent state and to review each partner file transmission to ensure all were sent or received as expected during the failure and recovery period.

4. Maintaining the Plan

Twice a year, the IT team is to review this disaster recovery plan for all necessary changes and enhancements. As part of the review, the latest IT SharePoint site should be updated on a USB drive and stored at our off-site vendor, Fireproof. IT staff must keep the IT SharePoint updated as part of day-to-day operations. Any changes to this plan should be logged at the end of this document.

5. Monitoring and Testing

The System Administrator is responsible for performing a complete system shutdown twice a year to ensure all equipment comes up properly. Each component of the system must be restored on new or spare equipment within a two-year cycle to ensure success when needed. Testing should be logged in the test log at the end of this document.

6. Triggering Execution

IT staff must notify either the IT Manager or COO to trigger execution of the Disaster Recovery plan. If neither is available, the plan may be triggered on the authority of any senior manager.

7. Contacts

Fireproof Storage: 614-299-2121 Account: CQU02
Disaster Recovery Kit is labeled as DR1

IT Team Members:

Steve Wade, Director of Infrastructure	Cell: 614-579-9532
Matt McElheny, Database Developer	Cell: 614-506-4875
Tony Hasting, Senior System Administrator	Cell: 614-599-1219

Group Managers:

Kara Trott, CEO	Cell: 740-602-3407
Randy Gebhardt, COO	Cell: 614-395-3366
Eric Zechman, VP of Information Technology	Cell: 614-506-3281
Amy Crowell, VP of Patient Services	Cell: 740-360-4007
Sandy Freer, Director Quality Assurance	Cell: 614-530-7971
Mark Smith, Controller	Home: 614-868-8835
John Bradford, VP Client Services	Cell: 614-395-5952
Ron Wallace, Manager Data Services	Cell: 740-215-7199

See Associate Phone list and Business Partner Phone List in Appendix. Account Coordinators have the contact names and numbers for our clients.

7. Testing Log

Test Date	Component Tested	Improvements Identified	Action Plan Status
Mar. 2006	FTP Server	Password file was	Implemented

		missing from backups. FTP user account info was not documented.	
Nov 2006	Application / Databases	Server name references in code need linked names that may be redirected as needed. All databases need copied to a secondary database server, so recovery can be done quickly. New servers are needed with larger disk capacity.	Implemented
June 2007	Web Servers	Linux, PHP, MySQL need updated to latest version on regular basis for proper security. Backup webserver needed to allow quick recovery if primary web server is lost.	Implemented
Oct 2007	Terminal Server	ACT!, Acrobat and Call Reporter needed on backup terminal server to provide all services used by staff.	Implemented
10/19/2007	Email / Domain Cont. Test Recovery	Active directory could not be restored due to insufficient backup. Backup process changed to use NT Backup.	Implemented
03/21/2008	Phone System	Phone system restarted. Single call switchover only works for our main line. Need one call to route all our toll-free numbers to a third-party voice mail box. Need quarterly shutdown/restart of each system component to ensure proper operation.	Implemented
8/06/2008	Phone System	All phone and fax lines successfully re-routed to PBX-Parachute during Phone system upgrade. Faxes will be broken out so they can be re-routed separately.	Implemented
3/1/2009	DR Phase I Test	Completed full test of	Implemented.

		phase I, Server setup, database restore, application tests. Web configs need backed up and restore documentation needs updated.	
09/30/2009	Internet Failover Test	Failover enabled and disabled successfully	
07/17/2010	External website failover test	Manual switchover to a backup website successful. BGP needs implemented to provide an effective unattended failover solution.	Tony to propose equipment purchase for BGP capability at collocation site.
1/16/2012	Failover of the Cisco/Zeacom phone system from primary to secondary	Post Mortem revealed significant deficiencies in Zeacom failover	Worked with Vendor to remediate deficiency
1/12/13	Simulate QH power outage	One server battery backup unit issued a warning message, third floor IDF is not on generator power	Case opened with Dell to determine the root cause and resolve, rewire third floor IDF to be on generator power
2/3/13	Simulate building power outage	Two pod cubicles on first floor are not on generator power	Meet with electrician in early February 2013 to rewire these work area
2/3/13	Simulate building power outage	Newer pods on third floor are not on generator power	Meet with electrician in early February to secure quotes for rewiring

8. Modification Log

Date	Description of Change	Changed By	Reason
04/22/08	Added Phone System Test to Testing Log	Tom Gray	Updated to reflect to reflect phone system restart
9/02/08	Added phone system backup test to testing log.	Tom Gray	Phone backup plan implemented
11/04/08	Updated plan to reflect new order of restoring services	Tom Gray	Following IT DR Review Meeting
3/2/09	Updated to set DR plan review and server restarts to be twice/yr instead of quarterly. Added latest test results.	Tom Gray	Following review and latest testing
4/21/10	Updated manager list. Revised immediate equipment needs.	Tom Gray	Annual review of plan
9/1/11	Updated multiple fields	Rob Pyles	Semi-Annual Review of Plan
2/28/12	Updated with new equipment and Procedures to reflect current Environment	Rob Pyles	Semi-Annual Review of Plan
3/18/12	Updated with new timeline of action Based on incident and outage times	Rob Pyles	Semi-Annual Review of Plan
12/10/12	Updated IT and Manager contacts	Bob Shackelford	Semi-annual Review of Plan
1/12/13	Updated log for generator testing	Bob Shackelford	Generator testing
2/3/13	Updated log for generator testing	Bob Shackelford	Generator testing