Tab I

Master

Marcy Troescher State of Nevada, Purchasing Division 515 E. Musser Street, Suite 300 Carson City, NV 89701	
RFP:	3084
PROPOSAL COMPONENT:	PART II – COST PROPOSAL
PROPOSAL OPENING DATE:	December 3, 2013
PROPOSAL OPENING TIME:	2:00 PM
FOR:	Utilization Management and Large Case Management
VENDOR'S NAME:	***Quantum Health, Inc.***

TAB II – COST PROPOSAL - ATTACHMENT I

COST SCHEDULE

Vendor Name Quantum Health

Service	Plan Year 15 7/1/14 – 6/30/15 PMPM Rate	Plan Year 16 7/1/15 – 6/30/16 PMPM Rate	Plan Year 17 7/1/16 – 6/30/17 PMPM Rate	Plan Year 18 7/1/17 – 6/30/18 PMPM Rate	Plan Year 19 7/1/18 – 6/30/19 PMPM Rate
Implementation Fees	$190,000 *	N/A	N/A	N/A	N/A
Case management/Large case management	Included	Included	Included	Included	Included
Pre-certification	Included	Included	Included	Included	Included
Concurrent review	Included	Included	Included	Included	Included
Out-patient services pre-certification	Included	Included	Included	Included	Included
Retrospective review	Included	Included	Included	Included	Included
Management reporting	Included	Included	Included	Included	Included
Communication materials, printing, mailing charges, etc.	Included	Included	Included	Included	Included
Other – DM Services	Included	Included	Included	Included	Included
Quantum Health PMPM Rate *	$0-$18.25 PMPM**	$0-$18.25 PMPM**	$0-$18.25 PMPM**	$0-$18.80 PMPM**	$0-$19.36 PMPM**

*Based on 33,845 Members

**Assumes 3 years of fixed fees followed by an estimated 3% annual increase. Fees shown are based on pricing Option 1, the 100% at risk fee option, in which we share 50% of the savings up to a maximum of $18.25 pmpm. Other options include: Option 2 $2.95-$11.70 pmpm (Performance Based)
Option 3 $6.60-$11.70 pmpm (Performance Based)
Option 4 $9.90 pmpm (fixed Fee)

Tab III - ATTACHMENT J – COST 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.

Note: Only cost exceptions and/or assumptions should be identified on this attachment. Do not restate the technical exceptions and/or assumptions on this attachment.

Quantum Health, Inc.

Company Name

Signature

John Bradford, VP, 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	*Cost Schedule*	*Attachment I on previous page*	*We charge PMPM, not PPPM. Please see above Cost Schedule for information*

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 III of vendor's cost proposal.
This form MUST NOT be included in the technical proposal.

State of NV

Proposal to incorporate

Coordinated Health/Care™

Illustrative

November 26, 2013

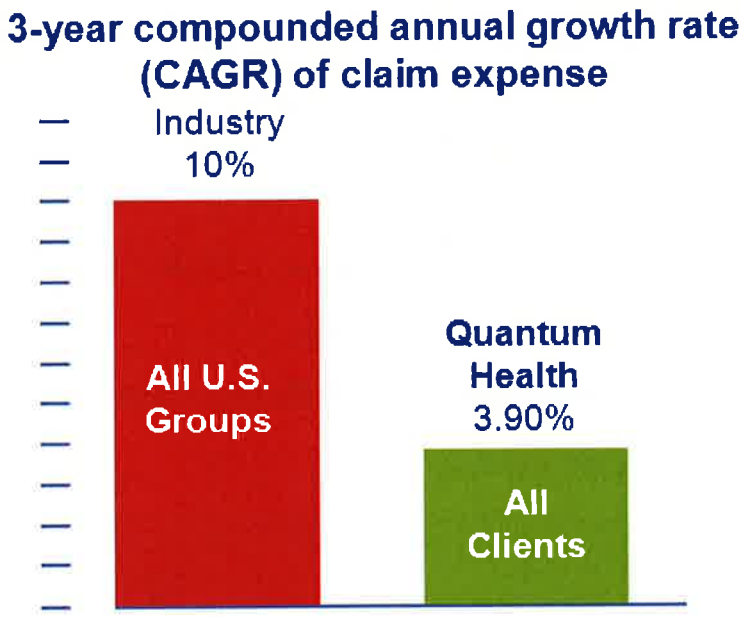
Effective Date: July 1, 2014

Executive summary

Quantum
HEALTH

Quantum HEALTH

Compare what the Quantum Health approach has accomplished – without cost shifting or network changes – to your recent results.



Net of all benefit, network & demographic changes.
Source: Year to year claims. 3-year CAGR

- Average first year cost trend is -1.1%
- Subsequent year trend averages of 7-8 points (from a dramatically lower base)
- 20% savings within 3 years without reducing benefits

Projected Savings

Projected costs based on your historical trends.

We begin our projections by analyzing your historical trends and comparing that to what our clients have achieved during the same period.

Although a number of factors can affect your specific results, the most important is where you are right now — your current costs and trend.

So we projected your future costs over a three-year period based on:

- Current annual costs $121,842,000
- Projected industry trend at 7.64%

What will happen over the next three (3) years if you continue at the same rate?

- **Your total annual costs will be $159,585,214**
- **Your trend will be at 7.64%**
- **Over the next three (3) years you will spend a total of $445,583,438**

(And by 2018 you could be facing significant excise tax liability.)

Projected savings if you implement the Quantum Health approach:

Once we have projected your costs under your current approach, we then estimate the opportunity for the Quantum Health approach to lower your costs and redirect your trend based on our current book of business:

- **94%** of our clients experience an immediate trend improvement in Year 1.
- **68%** of our clients drop below the national trend line (and many more started above national trend).
- **53%** actually show a **negative** trend.

If you begin working with Quantum Health on 7/1/2014, your total annual costs **including Quantum Health's fees** over the next three (3) years would be reduced to $396,966,821 resulting in:

- **10.9% savings or**
- **$48,616,617**

See Projected Savings for a more detailed examination of how we calculate costs and savings

Proof

Quantum Health's method to improve outcomes and reduce costs is more than a theory — it's scientifically proven.

For two years, we tracked 3,200 patients through the health care delivery system, understanding how they use it, where the gaps in care occur, and where the patients became confused and lost. We also spoke with 290 of their physicians to understand what had been ordered versus what actions were taken by the patients. This led us to an approach that has been proven effective with more than 340,000 members.

How does Quantum Health consistently deliver exceptional savings?

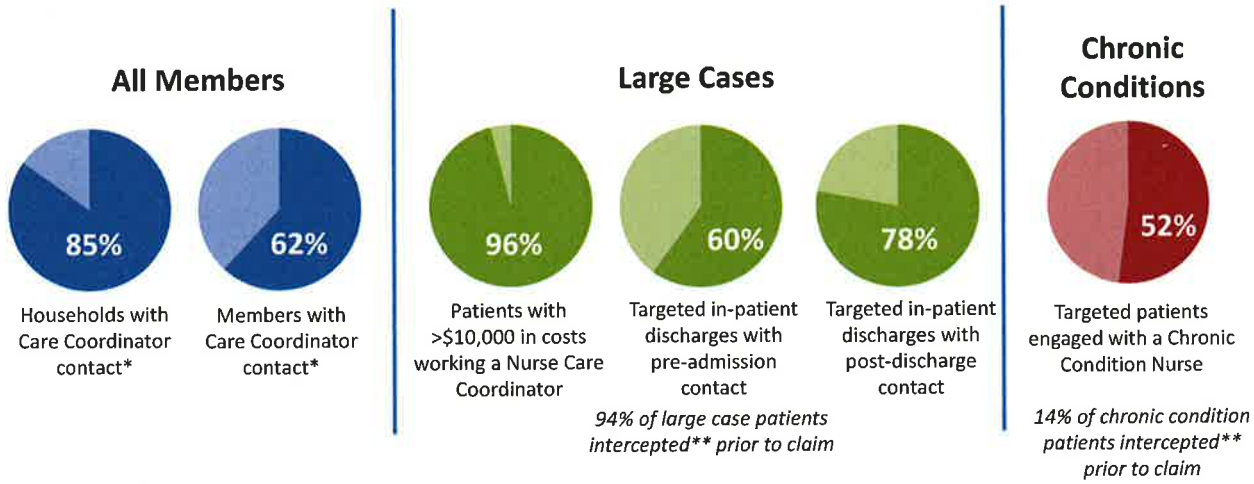
- We reorganize benefits delivery so our Care Coordinators are right in the middle of everything concerning your employees' health, benefits and treatment. When they need anything related to those issues, they call us. This allows us to turn every call into an opportunity to intercept the member and provide effective, real-time care coordination.
- We create a "Virtual Medical Home" for your employees with a proprietary technology platform that aggregates all essential data from multiple resources including benefits, eligibility, and claims and clinical information augmented by real-time conversations with physicians and patients that connects all of the dots so our Care Coordinators can do a much better job of connecting with your members. (See How We Deliver Savings for a diagram of the Virtual Medical Home.)
- Our Quantum Health Care Coordinators are resourceful, knowledgeable health care generalists augmented by a team of expert specialists — so your employees will have all of the trusted support they need, every time they call.
- Our Care Coordinators make the connections between primary and preventive care as well as between specialists and hospitals.
- We help employees make sense of the connection between their medical care, out-of-pocket expense, HRA or HSA accounts, and wellness benefits.

The result is an easier, more rewarding experience for your employees that provides coordination and guidance before, during and after a health care event, and helps employees understand what they need to know before they make decisions that could lead to unproductive, unnecessary and costly care.

Engagement is key: Member interception results

We create engagement by intercepting members at the critical decision moments. This ongoing relationship allows us to be there at the moments when your employees are making critical decisions.

Quantum Health Overall Engagement Results:



* "Contact" means a person-to-person conversation between a QH Care Coordinator and the member or a provider on the member's behalf; DOES NOT include passive mailings or emails.
** "Intercept" means that the member was identified and directed to CM based on a PSR call, information contained in a primary physician referral, pre-cert, or biometrics.

Implementation

Although it's impossible to dramatically reduce your claim costs without effort, we've done it more than 100 times before. And our clients have taught us well how to get things done without burdening you. (Be sure to ask about the implementation process when you call our references.) See the Implementation section for timeline and steps. It's a straightforward process designed to reduce your workload in the future.

Presenting and marketing the Quantum Health approach to your employees.

Quantum Health has a large catalog of materials and promotions from which to choose. And, like your member web site and the way we answer your 800 number, we will customize our approach with your brand and program name. Or you can choose what many of our clients do and brand your program as *Coordinated Health/Care™*. How you handle it is entirely up to you.

About Quantum Health

Quantum
HEALTH

Projected savings

Quantum
HEALTH

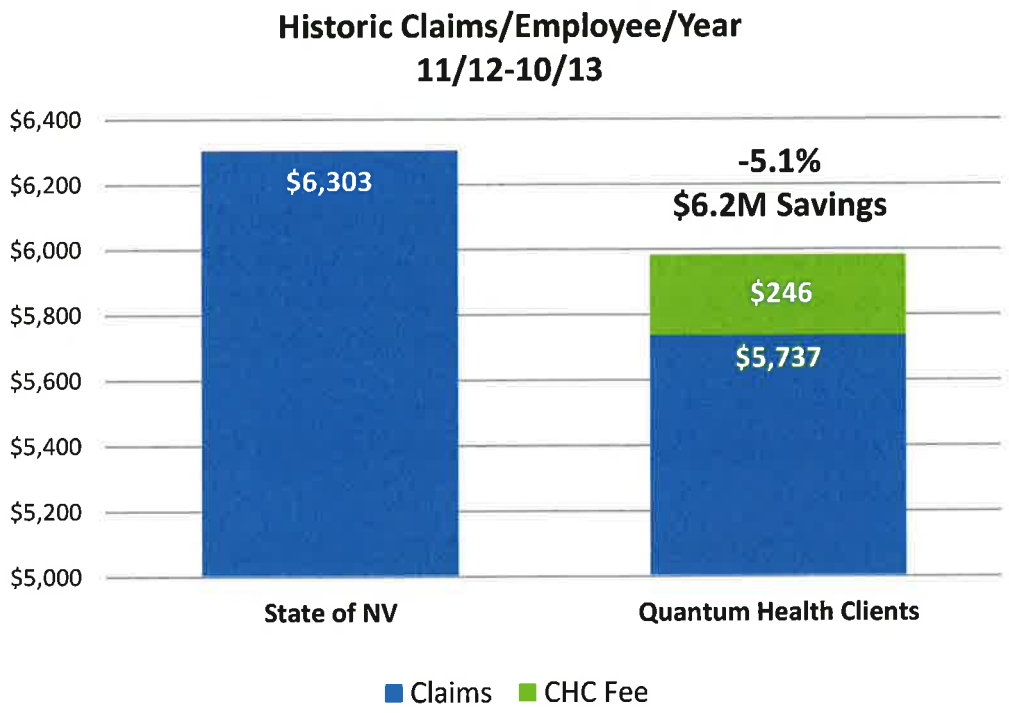
Projected Savings

Quantum HEALTH

Step 1: Comparing Historical Costs

We compared your actual annualized per employee costs for medical and pharmacy claims against how our average client performs against their projected experience to give an estimate of the potential impact we would have had on your plan had the Quantum Health program been in place during this time period.

Your savings would have been 5% or $6,186,496, after payment of Quantum Health fees.



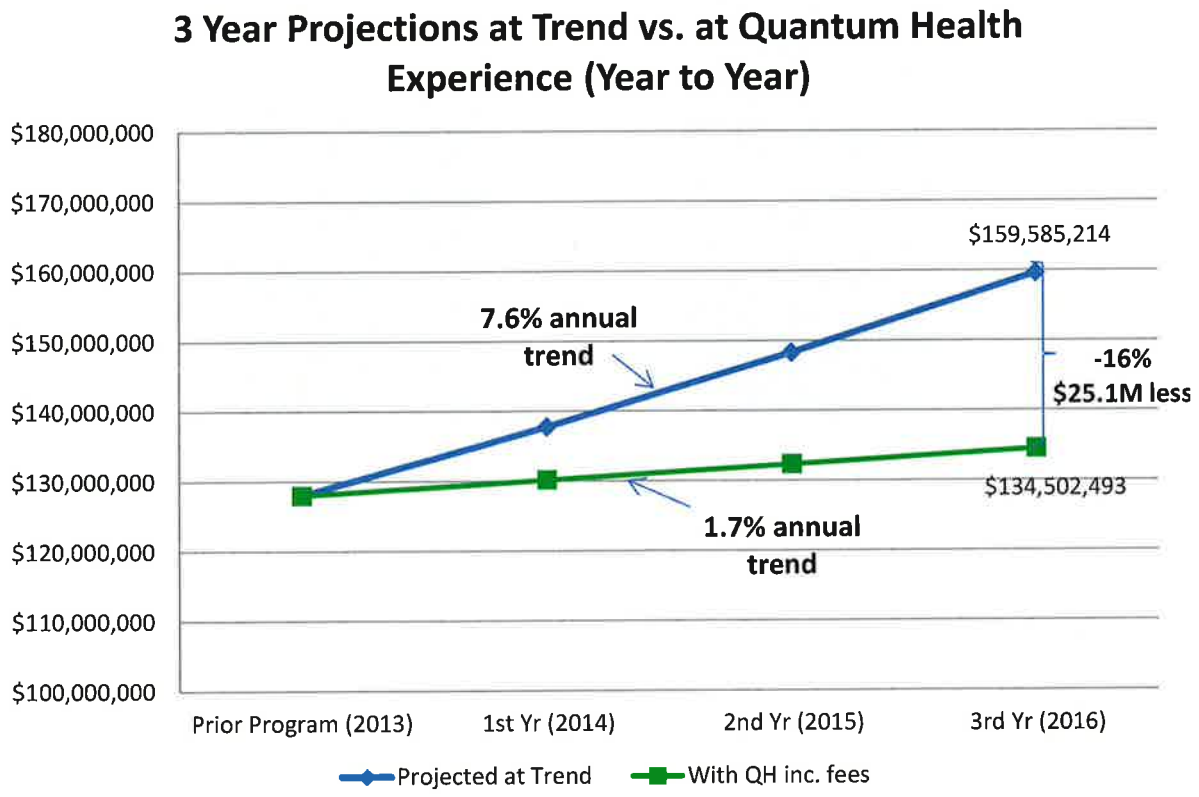
Costs are annualized for 11/12-10/13. Quantum Health Fees are budget-neutral because they come entirely from savings. Fees shown in this illustration are based on the maximum under Options 2 or 3. Fees per employee per year are estimated at $246 and in total are estimated to be $4,751,838 or 43% of your savings.

NOTE: This analysis is preliminary and is intended to be directional only. It is based on the data provided during the proposal process compared to Quantum Health's normative data as validated by independent actuaries. Actual results may vary from Quantum Health norms due to actual case mix and other factors unknown at this time. Once the target budgets are established, Quantum Health's guarantee will apply putting up to 100% of fees at risk.

To understand this projection, the following key elements in our methodology need to be explained:

Industry Trend projections. The Industry Trend projection assumes that State of NV makes no significant changes to how its plan is managed and projects claims expense forward based on current trends being experienced by self-funded employers. Currently such trends are 7.90% medical and 6.30% pharmacy. Because your results might not be consistent with industry trend this analysis is meant to be directional (see Step 3).

Quantum Health Experience projections. Quantum Health projections are based on our book of business reflecting 375 plan years of actual experience on a year-by-year basis of all employers using our programs. Costs per member in each year of the program are compared to costs per member of the year immediately prior to the implementation of the program.



1. Prior Program 2013 costs are projected based on claims for 11/2/2011-11/1/2013.
2. Quantum Health projections based on 375 plan years of experience for 3 consecutive years including Quantum Health fees. Quantum Health fees are projected based on greater of 50% of savings or maximum under Options 2 or 3 (see pricing for additional detail).

Your Contribution Methodology. Contribution strategy can be used to steer members to less rich plans or to increase employee contributions as a percentage of projected total.

Demographics. Our projections were adjusted for your population's demographics.

Labor Force Change. We assumed your work force will be stable but you may experience acquisitions, layoffs or closings.

Geography. Costs around the country vary. The Quantum Health book of business includes groups across the nation but concentrations of members in higher or lower cost areas can be relevant to your results.

Network Discounts & Vendors. Network discounts can vary. Regardless of the network you use, Quantum Health's interception approach can increase the number of members using higher quality and more efficient providers.

Management Involvement. Studies show that active involvement by executive management can have an impact on results. For the vast majority of our clients this is not a factor.

Large Claims. A "bad year" with an unusual number of high cost claims can occur anytime, to any company. Our book of business includes good years as well as bad.

The core idea of this analysis is to help you understand what to expect. The following is the range of results you might achieve based on our book of business:

For more detailed information on actual clients' results, see Case Studies in Section 5: Proof. After four years in the program, the range of our clients' performance looks like this:

After 4 Years in Program

Trend ranges:	*Avg Compounded Annual Trend*	*# of Groups with > 4 Years In Program*	*% of Groups*
Groups with negative average trend		1	5%
Groups with trend 0%-4%:	1.6%	6	32%
Groups with trend 4-7%	5.4%	7	37%
Groups with trend 7-10%	8.2%	5	26%
Groups with trend 10-12%		0	0%
Groups with trend 12-15%		0	0%
Groups with trend >15%		0	0%
Total:	4.6%	19	
Percentage of Groups with trend <7%			74%
Percentage of Groups with trend <12%			100%

Note: Keeping in mind that many of our clients had trends exceeding 12% when they started with us these results are significant. It's why we have the confidence to put 100% of our fees at risk.

Results do vary.

What groups are best suited for the Quantum Health program:

- Size, geography, and industry don't matter (unless turnover is >30%)
- Union and non-union are equally good
- "Medium" sick and "medium" old populations (largest portion of population 30-55 and fastest-growing group >40) show fastest results with negative trend year 1
- Older (avg. age >45) and very sick populations take longer but show significant improvement by year 3
- Very young and "well" population results are less dramatic (fewer opportunities to impact)

As of July 31, 2009, 89% of year one groups have beat industry trend for that year and 53% of groups had better trend than they did under their prior program.

Quantum HEALTH

Proof

State of NV *Coordinated Health/Care*

Reorganizing benefits delivery is more than a theory. It's scientifically proven.

Current approaches to benefits delivery have consistently produced disappointing results. That's why we've spent years perfecting a better way.

For two years, we tracked 3,200 patients through the health care delivery system to:

- understand how they use the system
- locate where the gaps in care occur
- discover where the patients became confused and lost

We also spoke with 290 of their physicians to understand what had been ordered versus what actions the patients actually took.

Armed with this information, we incubated solutions to improve the process to deliver better outcomes and lower costs. During that period of study, we developed a way to reorganize benefits delivery that has proven to provide more coordinated care at a much better price.

Then, over a four-year period, we proved the efficacy of our approach with over 100,000 members. And that's how we created the first fundamentally different, evidence-based approach.

We discovered that leveraging human nature is more productive than fighting it.

Many programs are predicated on convincing employees to change behavior and be more accountable for their healthcare. But they consistently produce disappointing results because they attempt to educate people into making a behavioral change rather than working to facilitate that change by leveraging the innate behaviors that cause employees to act in their own best interests.

Case Study Summary

The following is an excerpt from a comprehensive case study. For the complete case study, including detailed data and methodologies, go to www.quantum-health.com/results/studies or request copies from your Sales Executive.

Actual Quantum Health Client Case Study: Southeastern City

This client was projected to save 11% using Quantum Health. Actual savings were 13–20%, depending on calculation methodology.

The City

This major Southeastern municipality grew from 2,477 employees (4,570 total enrollees) to 2,791 employees (5,276 enrollees) during the 3-year period 2007-2009.

The Problem

The City had an aging workforce with multiple union contracts. Cost shifting was not a viable option. They also had a very high rate of diabetes and related complications, a problem typical to the Southeastern region of the U.S. A special diabetic program had previously been implemented where members received a low, global co-pay for all of their diabetes-related treatments as well as routine exams in return for participation in a hospital-based diabetes education program. The City also had a wellness screening program for employees. They were consistently disappointed by the lack of participation and the inability of the program to produce improved outcomes. And they continued to experience high trend and increases in claims.

The Goal

The City saw strong possibilities in the Quantum Health approach that integrated care coordination and care management with health management and a single source of customer service. They believed it could:

- Improve service to enrollees
- Reduce health care costs
- Increase member engagement in health management/wellness

The Results

- Overall trend dropped 10 points and has been held essentially flat, in spite of a large number of claims in Year 2
- Members report very high satisfaction with Quantum Health services and support

How we deliver savings

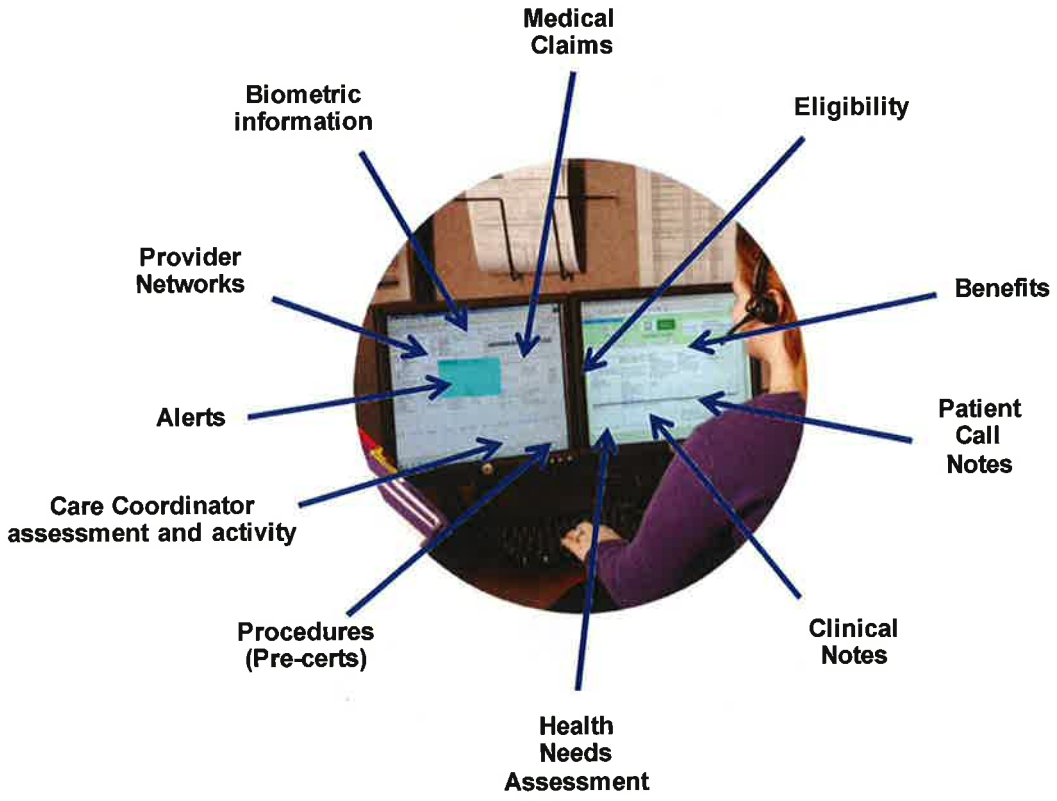
Quantum
HEALTH

Quantum HEALTH

Our "Virtual Medical Home" approach connects all of the dots so we can do a much better job of connecting with employees.

Healthcare and health benefits are not intuitive. So it's critical for all relevant information to be put in context for the patient — and be used in real-time to most effectively coordinate care. That's why we become your employees' "Virtual Medical Home." Our "Virtual Medical Home" operates on a single, proprietary system that aggregates all essential data from multiple resources, including benefits, eligibility, claims and clinical information. And we augment that data with information we gather during real-time conversations with patients and providers. We provide a consistent service for every employee, whether you use single or multiple carriers. And the employee's "Virtual Medical Home" stays in place, even if you switch carriers.

An essential factor in the success of this approach is our Quantum Health Care Coordinators. These resourceful, knowledgeable health care generalists are augmented by a team of expert specialists — so your employees will have all of the trusted support they need, every time they call.



What changes?

Quantum
HEALTH

What Changes?

Quantum HEALTH

Claims Payer & PBM	Enrollment & Eligibility	Care Management & Wellness	Related Benefits Administration	Related Benefits Triage
Claims Administration **Customer Service** **Coverage** **Claims Eligibility** **Provider Selection** **Claims Advocacy** Provider Networks	Decision Support Customer Service Enrollment Administration	**Case Management** **Complex Case Management** **Care Coordination** **Pre-Certification & UR** **Chronic Condition Management** **Incentive Programs** **Patient Advocacy** Wellness Onsite Clinics	EAP Administration FSA Administration Disability/FMLA Administration COBRA Administration HSA/HRA Administration	EAP FSA **Disability/FMLA** **COBRA** **HSA/HRA**

*Highlighted services provided by Quantum Health, all others remain responsibility of current vendor

Second, tweak design.

Depending on your current program minor benefit design and enrollment changes may be necessary. There are four key elements that support our results. Some of these you may already have:

1. Decrease the member's out-of-pocket expense for seeing a primary physician relative to specialty care
2. Decrease the member's out-of-pocket cost for specialty care if their primary physician notifies us that they have recommended they see a specialist
3. Providers are to notify Quantum Health when they are planning:
   - Inpatient and skilled nursing facility admission
   - Outpatient surgeries
   - MRIs /MRAs / PET Scans
   - Oncology care and services (chemotherapy, radiation therapy etc.)
   - Home health care and services
   - DME rentals and purchases over $500
   - Hospice care
   - Organ and bone marrow transplants
   - Speech Therapy
   - Physical and Occupational Therapies

Establishing a Primary Physician is essential. That's why each time a member calls in who has not yet identified their primary physician, our Care Coordinators intercept them to find out if they have one and, if they do not, encourage them to establish a relationship with a primary physician.

Knowing which primary physicians that members are seeing helps us alert their providers to care gaps and concerns. That way, our Provider Relations staff can connect with and educate their office staff about our services. We did our homework with providers and their staff and we've learned how to be a value to them, not a burden (see Member and Provider Satisfaction Section). This increases cooperation for our Care Coordinators and makes them more effective.

Referral notifications are designed to alert our Care Coordinators that what is going on with a specific member could be meaningful and costly. *This is a significantly different approach than the typical, and often abandoned, referral processes designed only to assess appropriateness of care and give the provider an approval.* These approaches rarely result in denials and nothing more is done.

For a Quantum Health Care Coordinator, these specialist notifications are the earliest possible opportunity to intercept the member before they go down a wrong, wasteful road. They are rich with valuable diagnosis and service information that is used to intercept a member for Disease or Case Management, as well as immediate care coordination — making sure the proposed care is covered, the specialist is in-network, confirming the specialist is appropriate to the condition, and that the specialist does the necessary diagnostics in advance so the appointment can be productive (avoiding a second one). And, if the primary physician is ordering a battery of tests, the Care Coordinator can verify what is necessary so we can eliminate unnecessary and duplicative tests, etc.

Being alert to the situation at the point of diagnosis, when the patient has the most questions, is the best opportunity to influence the trajectory of the case. This simply cannot happen if the interception doesn't occur until a cost threshold has been hit. That is why the pre/post studies show that Quantum Health reduces the cost of cases in the set >$50,000 by an average of 5% and why trend is consistently lower.

Pre-certifications for specific procedures have proven to be effective in coordinating the care to mitigate expenses to the highest possible degree. We prefer to have knowledge far in advance of the pre-cert but because we use the notification to actively intercept the member, we have significantly more impact that other approaches.

1 "Few People in the United States Can Identify Primary Care Physicians," The Robert Graham Center, Policy Studies in Family Practice and Primary Care, No. 27, May 2004, reporting on results of the Future of Family Medicine Project survey conducted in 2002

Member & provider satisfaction

Quantum
HEALTH

Member Story: How to intercept a Diabetic who wouldn't take his Disease Manager's calls

An insulin pump is not a "cure" for diabetes. That's what the Disease Management Nurse wanted Don to understand. Don is a Level 3 (most serious) diabetic and he hadn't responded to several phone messages, nor to the note she had sent. If Don had been in a traditional health plan, that would have been the end of it. With Quantum Health, the approach — and his outcome — was significantly different.

When Don called in about getting a new insulin pump, the Quantum Health PIVIT® system alerted the Care Coordinator that his Disease Management Nurse, Diane, wanted to talk to him. So she immediately transferred his call to Diane.

Don admitted he was not self-managing, explaining he couldn't afford the supplies. And he believed his pump had "cured" him.

After gently explaining why that wasn't the case, Diane began to work with Don to help him find practical ways he could improve his health and enjoy life more. She even showed him how to get supplies at no charge. Don was skeptical, but he began returning her calls and eventually even confided his frustrations about all of the ways his diabetes was limiting his life. Within six months, Don had changed from a non-compliant diabetic whose condition was out-of-control to one who reported he was truly enjoying life again.

Quantum HEALTH

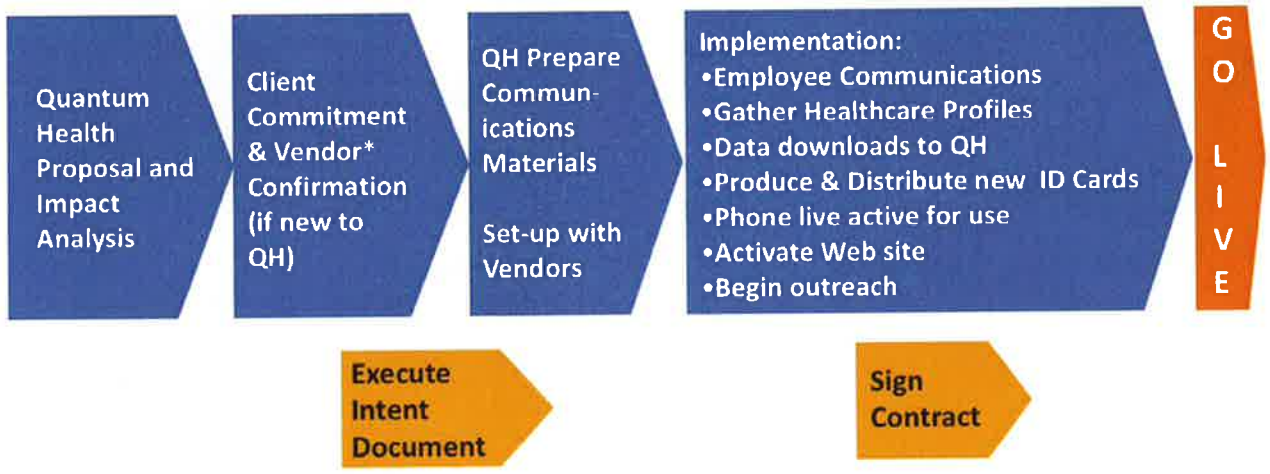
Implementation

State of NV *Coordinated Health/Care*

You're already busy. And although it's impossible to dramatically reduce your claim costs without effort, you should know we've done it more than 85 times before. And our clients have taught us how to get things done without burdening you. (Be sure and ask about the implementation process when you call our references.) We've learned to start implementing as early as possible. In fact, we're already working on your implementation while we are getting to know you, your claims history, and performing the impact analysis.

Activity prior to effective date

We like to have at least 60 days from the date of your commitment to the effective date, if we are implementing with a Claims Payer with whom Quantum Health is already interfaced. If we need to set-up interfaces with a Claims Payer with whom we are not already interfaced, we like to have at least 90 days. However, we can accommodate shorter times if needed.



*Vendors = payer, network, PBM

Fees

Quantum
HEALTH

Quantum HEALTH

***The Performance-based Fee Options 1, 2 and 3 are subject to the following:**

1. **Credible claim history on the whole group that allows a claim target to be calculated and agreed-upon.**
2. **Agreement by Client to incorporate a benefit incentive for primary care and referred specialists in order to encourage reduction of self-navigation and facilitate early notifications to CHC.**

If data is not available and/or a primary care incentive is not adopted then Client is limited to Option 4: Fixed Fee.

Implementation Fee (All Options):	$190,000 to be paid 50% at Initial Implementation Meeting and 50% on date of first employee communication session, not subject to performance formula. Implementation fee includes customization of all materials, ID cards, initial communications series and introductory web-based tutorial and video, set-up of interfaces and workflows with all other vendors, member access to Plan website and Care Coordinators through the dedicated 800# during the implementation period. In addition, to support written and video communication, at least one Quantum Health staff member will go to all major locations to provide on-site questions/answer and introductory sessions. A major location is defined as a location where at least 20% of the total covered employees on the Plan are located, subject to a minimum of 300 employees. If on-site presentations are required at smaller locations, Quantum Health will charge an additional fee of $1,000 per day of meetings plus travel and lodging expenses. If through acquisition or otherwise, more than 200 employees are added at one time, there will be a one-time fee of $5.10 per employee charged to cover communications and pre-servicing costs for such additional employees. This amount will be charged on the date that communications are distributed or made available to such added employees.

Notes:

1. Member is each individual covered under the Program (e.g., employee plus dependents).
2. Total claims target is estimated based on PMPM rates (see next page) times current members for contract period. Actual claims target may differ based on fluctuations in enrollment count. Claims target for each month is based on number of members times PMPM rates. Total claims targets for the plan year will be the greater of 90% of the above totals OR the per member per month rate indicated below times on the actual number of members/month.
3. During the first year of the Quantum Health model, "difference" will be based on actual paid claims. If run-out claims are not available, the "difference" will be based on actual paid claims for dates of service on or after the effective date plus a factor for lag reserve based on indicated days lag.
4. Monthly advance is fully credited against performance fee due. If performance fee is lower than monthly advances for year, then difference is paid back.
5. Price is based on the assumption that the group's plan design does not change and the group's service requirements fall within normal range for employee turnover, demographics, and severity including the following: annual turnover not to exceed 10%, call volume not to exceed a call ratio of 0.24 (measured quarterly), high risk members not exceeding 3.5% of the total group. The guaranteed price is also based on the plan designs disclosed at the time of proposal, and additional disclosures in plan design, incentives, requiring additional pre-certs beyond our standard list, or other unusual plan designs may require an adjustment in price.

Claims beyond the normal specific deductible for any patient lasered or excluded, claims accumulated against an aggregating specific policy or claims for services not covered under the aggregate or specific stop loss policy, will not accumulate against the claim targets. If there is more than a 5% change in the number of members, these targets may be modified based on updated demographic data.

If credit has been provided prospectively for plan design, network or similar changes that are not reflected in the historical data, at year end the prospective credit shall be compared against the actual impact of such changes realized by the Plan. If the actual varies more than 10% from the prospective credit, the claim targets shall be adjusted to reflect the actual impact realized by the Plan.

The claims analysis on the previous page is based on incomplete paid data for the current plan year. Finalization of the claims target will be based on receipt of complete paid claims for the current plan year. Final claim target will also be adjusted by any applicable plan design or network changes. Quantum Health fee rates are firm as long as this proposal is accepted for an effective date of not later than the third month after the proposed effective date [i.e., if proposed for January, rates will hold until March].

Quantum Health may pay a finder's fee to your broker. Payment of such a finder's fee by Quantum Health does not change the amount of advance or performance fee structure on your account.

Sample Contract

This sample contract reflects the fee option selected by more than 75% of our clients to enable you to review the details of how the performance-based structure and reconciliation process works. The specific terms of your contract may vary from those in this sample.

acknowledges that it does not have any power to add to, subtract from or modify any terms of the Plan document or SPD or to change or add any benefit provided under the Plan. Quantum Health acknowledges that it must obtain the approval of the Plan Sponsor to authorize payment for any healthcare services for Enrollees that are not covered by the terms of the Plan document or SPD.

Section 1.3. Business Associate Agreement. Quantum Health acknowledges that it is a business associate of the Plan within the meaning of the HIPAA Privacy Rule. Quantum Health agrees to execute a business associate agreement with the Plan to comply with the HIPAA Privacy Rule.

Section 1.4. Data Transfers by Company. Quantum Health agrees to implement the data transfers with the TPA needed to ensure the transfer of authorization data to enable timely and accurate adjudication of claims.

Section 2. Obligations of the Plan Sponsor

Section 2.1. Program Cooperation. The Plan Sponsor agrees to cooperate with Quantum Health and to direct the TPA and any entity providing services to the Plan to cooperate with Quantum Health. The Plan Sponsor agrees to authorize the sharing of protected health information among all entities servicing the Plan with Quantum Health. Quantum Health agrees to share protected health information regarding the Enrollees with the TPA to support Plan administration. Furthermore, the Plan Sponsor agrees to execute such documentation that is necessary or appropriate to allow such protected health information regarding the Enrollees to be shared under this Section 2.1 within the guidelines of the HIPAA Privacy Rule.

Section 2.2. Data Transfers. The Plan Sponsor agrees to direct the TPA to transfer eligibility and claims data to Quantum Health based on the protocols mutually agreed upon by the TPA and Quantum Health. The Plan Sponsor acknowledges that the TPA's performance of these obligations is essential to Quantum Health's ability to fulfill its obligations under this Agreement. If the TPA fails to fulfill these obligations or to meet Quantum Health's performance standards, the Plan Sponsor agrees to work with Quantum Health in causing such TPA to comply or to change to another TPA. If the Plan Sponsor refuses to assist in causing such compliance or changing the TPA, then Quantum Health may treat such refusal as cause for purpose of terminating this Agreement pursuant to Section 6.4.

Section 2.3. Plan Design and SPD. In order to incorporate the Program within the Plan, the Plan Sponsor agrees to amend, to the extent necessary, the Plan document and SPD to include and maintain, at a minimum, the following provisions:

(a) *Coordinating Physician.* A mechanism for each Enrollee to designate a primary care physician as his or her coordinating physician.

(b) *Notification Process.* An incentive structure in the Plan for an Enrollee to obtain a referral to a specialist from a primary care physician.

regulations, including HIPAA. The Plan Sponsor agrees to ensure that the Plan document and SPD includes:

(a) *Protected Health Information.* The language required under HIPAA to enable the Plan Sponsor, as sponsoring employer of the Plan, to receive protected health information, including designating the individuals or class of individuals who may receive protected health information from Quantum Health and the TPA.

(b) *Processing Claims.* The language required by the U.S. Department of Labor regulations to timely process pre-service and post-service claims and to timely handle appeals of claims decisions.

The Plan Sponsor agrees to require the Plan to obtain any consent or authorization that may be required under HIPAA to enable Quantum Health to use and disclose protected health information regarding an Enrollee in carrying out its obligations under this Agreement. In addition, the Plan Sponsor agrees to require the Plan to obtain a business associate contract from any entity performing functions on behalf of the Plan.

Section 3. Plan Servicing Structure.

Section 3.1. TPA, PBM, Specific Deductible and Network Structure. The Plan structure, including the TPA, the specific deductible, the PBM, and network structure is set forth in Schedule 2. The Plan Sponsor acknowledges that the TPA, the PBM, specific deductible, and the network structure are material to Quantum Health's ability to perform its duties and obligations and to earn its fees.

Section 3.2. Modification in Plan Servicing Structure. The Plan Sponsor may modify Schedule 2 from time to time only with the consent of Quantum Health. Any change in the TPA, PBM, specific deductible or provider network, may give rise to Quantum Health's right to modify the Claims Target as set forth in Section 5.7, implement a minimum fee as per Section 4.6, and/or terminate this Agreement for cause as per Section 6.4.

Section 4. Compensation

Section 4.1. Performance-Based Fee. For each Plan Year during the term of this Agreement, the Plan Sponsor agrees to pay Quantum Health a performance-based fee ("Fee") as set forth on Schedule 3 attached to this Agreement, as revised during the term of this Agreement. The Fee shall be based on the performance of the Plan as measured by claims experience against the Claims Targets established pursuant to Section 5.

Section 4.2. Monthly Advance. During the term of this Agreement, the Plan Sponsor agrees to advance Quantum Health a portion of the performance-based fee that may be earned by Quantum Health under Section 4.1. The amount of the monthly advance shall be set forth on Schedule 3 attached to this Agreement, as updated at Scheduled Renewal. The Plan Sponsor agrees to pay the monthly advance to Quantum Health within ten (10) days of receipt of invoice for services for such month. The amount of the monthly advance shall be based on the number of Enrollees on the first day of each month. Except as otherwise provided in this Agreement, Quantum Health acknowledges that the monthly advance shall be offset against

Section 5.1. Claims Targets. For each Plan Year during the term of this Agreement, the parties agree to establish Claims Targets as provided in this Section 5. The applicable Claims Targets for each year shall be set forth on Schedule 3, or, for renewals, on a Renewal Schedule. Nothing in this Agreement shall require the Plan Sponsor to pre-fund the Claims Targets since it is maintained solely for the purpose of determining the performance-based fee earned by Quantum Health under Section 4.

Section 5.2. Claims Categories. The Claims Targets shall be divided into 3 categories of expenses - basic medical services, complex medical services and pharmacy benefits ("service category or categories"). Allocation of claims targets by service category shall be based on an analysis of historical data, specific stop loss risk thresholds, and age/sex factors.

(a) ***Basic Medical Services.*** Basic medical services shall be those services that are not Complex Medical Services, which are set forth in Schedule 4 attached to this Agreement.

(b) ***Complex Medical Services.*** Complex medical services shall be those services that are specified on Schedule 4. Schedule 4 may be modified from time to time with the mutual consent of the parties, provided that any material modification shall require a re-allocation of the medical portion of the Claims Targets among the Basic and Complex categories.

(c) ***Pharmacy.*** Pharmacy shall be those expenses related to the Plan's coverage of prescription drug benefits for the Enrollees, net of any rebates or other credits to the Plan Sponsor. Administrative charges related to pharmacy benefits shall not be considered as a "claim".

Section 5.3. Calculation of Total Claims Target for Reconciliation. Claims Targets shall be established per Enrollee per month (PMPM) basis. Claims targets for an applicable Plan Year for purposes of determining the compensation under Section 4.1 shall be based on the greater of the following:

(a) The PMPM Claims Target for the applicable service category multiplied by the actual number of Enrollees each month; or

(b) 90% of the projected Total Claims Target for such service category based on the number of Enrollees in the first month of such Plan Year.

Section 5.4. Reconciliation of Experience to Claims Targets. To determine the Fee earned under Section 4.1, the actual claims during the applicable Plan Year shall be accumulated against the Total Claims Target for each applicable service category. A Fee shall be earned if the actual claims accumulated against the Total Claims Target for a service category are below such Total Claims Target. Unless Plan Sponsor has selected a global target fee option indicated on Schedule 3, the Fee is determined against each service category independently, so a Fee may be earned in basic medical but not in complex medical. Unless otherwise specified in Schedule 3 or a Renewal Schedule, all claims paid by the Plan Sponsor for dates of service after the Effective Date shall be accumulated against the Claims Targets, except for the following:

(a) Claims that are reimbursed under the effective specific or aggregate stop loss policy;

(b) Actuarially indicated claims impact based on actual changes in the distribution of Enrollees by age/sex comparing the initial month of the immediate prior Plan Year against the initial month for the Renewal Plan Year; and

(c) Actuarial impact of any changes in the specific deductible level.

At renewal, the monthly advance and any applicable minimum or fee cap then in effect shall be increased by an amount equal to medical CPI based on the prior 12 months, all cities inflation rate for medical services as published by BLS for the report issued three months prior to the effective date of the renewal (i.e., October published report for January renewal).

Section 5.7. Modification of Claims Targets. The Claims Targets may be adjusted upon the occurrence of any of the following:

(a) A change of 5% in the number of Enrollees compared to the number of Enrollees in the first month of the Plan Year may result in a change in the age/sex factors if there is a resulting change in the group demographics.

(b) A change in the provider networks that impacts more than 30% of the Enrollees will result in a change in the Claims Targets for medical services based on the impact of a discount differential from the prior network, provided that a repricing study is conducted that indicates a quantifiable impact based on the actual distribution of claims by provider based on a statistically significant set of claims. In the event that the Program was implemented as a replacement to an institutional carrier's program and Claims Targets were based on the carrier's discount structure, and the network change is due to a better match against the carrier's discount structure, no further credit shall be provided since the Claims Targets were based on the historic experience incorporating such discounts.

(c) A change in the PBM or underlying pricing structure for prescriptions will result in a change in the Claims Targets for pharmacy services, provided that a repricing study is conducted that indicates a quantifiable impact based on the actual distribution of claims by provider based on a statistically significant set of claims. In the event that the PBM is changed to match a historic pricing structure on which the Claims Targets were based, no further credit shall be provided since the Claims Targets were based on the historic experience incorporating such original pricing structure; or

(d) Material changes in plan design, such as deductibles, maximum out-of-pocket or, for pharmacy benefits, copay or coinsurance structures, will result in a change in the applicable Claims Targets based on the actuarially indicated impact of such change.

Section 5.8. Methodology for adjustments due to network, PBM or plan design changes. Upon notification of a change in the network, PBM or plan design triggering a modification to the Claims Targets pursuant to Section 5.7, the applicable Claims Target shall be adjusted prospectively based on repricing or actuarial studies projecting the impact of such network, PBM or plan design change. However, at Plan Year End or nine (9) months after the effective date of such modification (whichever is earlier), a report shall be run to validate the actual impact of such network, PBM or plan design change ("Validation Report") and such actual data shall be used for purposes of final reconciliation of such Plan Year. To the extent that such

Section 6.4. Termination with Cause. Either party may terminate this Agreement, with cause, by giving notice to the other party in the event that:

(a) *Material Breach.* The breaching party fails to cure any material breach within 45 days after receiving notice from the non-breaching party stating the alleged material breach. Material breach shall include but not limited to failure to timely pay claims to providers within the time frame established under an applicable state prompt pay law or a material change in the benefit design of the Plan that, in the opinion of Quantum Health, adversely affects its ability to effectively operate the Program.

(b) *Insolvency.* The other party files, or has filed against it, any proceeding in bankruptcy or otherwise to protect the party from creditors.

Section 6.5. Termination without Cause. This Agreement may be mutually terminated, without cause, at any time by an agreement executed by each party. In addition after the Initial Plan Year, either party may terminate this Agreement, without cause, at any time upon 90-days notice to the other party.

Section 6.6. Effect of Termination. Upon termination of this Agreement for any reason, all rights, duties and obligations of each party shall cease effective as of the date of termination, except as provided in this Section 6.5. Upon such termination, Quantum Health shall be entitled to the compensation due under Section 4 through the effective date of termination. Quantum Health shall be responsible for completing the final reconciliation under Section 5.10 through the period ending on the effective date of termination. Following termination the parties shall remain bound by the mutual covenants set forth in Section 7, which covenants shall survive termination of this Agreement. In addition, the following terms shall also apply:

(a) *Termination or Non-Renewal where Total Claims are below Total Claim Targets.*

(1) Mid-Year Termination. In the event of a mid-plan year termination without cause pursuant to Section 6.5, if the Total Claims for the immediate prior Plan Year was below the Total Claim Target for such prior Plan Year, a termination fee in an amount equal to the annualized maximum or fixed fee, if subsequently selected by the Plan Sponsor, for the current Plan Year less any amounts paid through the effective date of termination, including the final reconciliation, shall be paid to Quantum Health. Such termination fee shall be due on the effective date of termination and shall be in addition to any fees due for insufficient notice pursuant to Section 6.6(b).

(2) Non-Renewal. In the event of a non-renewal pursuant to Section 6.2, if the Total Claims for the ending Plan Year are below the Total Claim Target for such ending Plan Year, a termination fee in an amount equal to 50% of the annualized maximum or fixed fee, if subsequently selected by the Plan Sponsor, for the ending Plan Year shall be paid to Quantum Health. Such termination fee shall be due on the effective date of termination and shall be in addition to any amounts due for the ending

the Plan with an electronic file of data related to the Plan. Such written request should provide the specific data desired and a reasonable timeframe and format for such data file.

Section 8.2. Notices. Any notice required under this Agreement must be in writing. The notice may be given by (i) personal delivery; (ii) first class mail, postage prepaid; (iii) overnight delivery by a national delivery service; or (iv) fax or electronic mail with confirmation of receipt. The notice must be addressed to the address set forth below the signatures or to such other address as the party may subsequently designate by a notice to the other party.

Section 8.3. Binding Effect. Each party shall at all times be acting and performing as an independent contractor. This Agreement shall be binding upon, and inure to the benefit of, each party and its successors and assigns. No person may claim to be a third party beneficiary under this Agreement. Neither party may assign this Agreement without the prior consent of the other party; except that Quantum Health may assign this Agreement to another Quantum Health wholly-owned subsidiary. This Agreement may be amended only by a written agreement executed by each party.

Section 8.4. Construction. This Agreement constitutes the entire understanding between the parties and supersedes all prior and contemporaneous understandings or agreements between the parties with respect to the subject matter of this Agreement. The failure of a party to insist upon strict performance of this Agreement shall not modify any provision of this Agreement, render it unenforceable or waive any subsequent breach. Should any provision of this Agreement be held unenforceable or invalid for any reason, including subsequent legislation or regulations, the remaining provisions of this Agreement shall continue in full force and effect and the parties agree to use their best efforts to arrive at mutually agreeable alternative terms. This Agreement shall be governed by ERISA and, to the extent not inconsistent with ERISA, by the laws of the State of Ohio.

SIGNATURES

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date first set forth above.

[PLAN SPONSOR]

By: _____

Its:
Address:
_____
_____
Tele. No. _____
FAX No. _____

COORDINATED CARE PROGRAMS, LLC

By: _____
Kara J. Trott
Its: Chief Executive Officer
Address:
7450 Huntington Park Drive
Columbus, Ohio 43235-4658
Tele. No. 800-257-2038
FAX No. 800-347-9660

SCHEDULE 1
Scope of Services Included in Coordinated Health/Care Program

Part 1: Implementation Fee.
The implementation period typically occurs in the 30-90 days prior to the effective date of the Coordinated Health/Care program.

Included Services. Included in the Implementation Fee for the Coordinated Health/Care Program are the following services:

1. Facilitation of and participation in set-up meeting with Plan Sponsor, TPA and benefits consultant in order to complete the Implementation Guide;
2. Completion and distribution of the Implementation Guide documenting primary care coordination and other incentive structures, plan criteria, plan design guidelines, implementation process, etc.;
3. Facilitation of and participation in weekly implementation reviews with Plan Sponsor, TPA and benefits consultant during the implementation period and for up to 30 days after the effective date or until the Plan Sponsor and CHC mutually agree that all items are completed;
4. Preparation of standard communication materials customized for Plan Sponsor, including an introductory presentation introducing CHC for employees, collection of primary care physician designation, Short Health Survey and supporting print materials;
5. Production of all communication materials related to CHC and distribution to members as per methodology agreed-upon in implementation meeting;
6. Set-up of data interfaces and warm transfer protocols with TPA, PBM, EAP and other services (if applicable);
7. Set-up, approval and issuance of initial ID cards unless existing payer can produce ID cards to include information included in Quantum Health specifications. If Quantum Health produces ID cards, includes mailing of cards to member's home.
8. Set-up of Plan Sponsor's Q-Base web page (internal to Quantum Health) and access to HR Dashboard and TPA access to QH Gateway.
9. Set-up of Plan Sponsor's member website that shall be branded in Plan Sponsor's name with Plan-specific information and mutually agreed-upon Plan-specific messaging, presented in the standard Coordinated Health/Care format;
10. Set-up of Plan Sponsor's dedicated 800# with customized script;
11. Roll-out of a multi-media communications campaign including print communications, web-based videos hosted either through Plan Sponsor's internal system, eligibility or enrollment vendor, or dedicated website hosted by Quantum Health (or any or all of the above), and for members who do not have internet access at home or at work, video content will be provided on a DVD format and information collected via paper forms. In addition, to support written and video communication, at least one Quantum Health staff member will go to all major locations to provide on-site questions/answer and introductory sessions. A major location is defined as a location where at least 20% of the total covered employees on the Plan are located, subject to a minimum of 300 employees. If on-site presentations are required at smaller locations, Quantum Health will charge an additional fee of $1,000 per day of meetings plus travel and lodging expenses.
12. For members, access to the Care Coordinators during the implementation process both through the 800# and website during the implementation period, subject to the below limitation. The phone line and website will be accessible no later than the 1st date on which member communications begin. ***Limitation:*** Prior to the effective date, Care Coordinators will be available only to assist members in understanding the role of the Care Coordinators, the incentive structure implemented with the Coordinated Health/Care program, and to initiate any care

Part 2: Coordinated Health/Care Program Fee

Included. The following services are included in the CHC Program Fee:

1. Customer Service & Advocacy.
    a. Quoting of benefits and eligibility for medical claims for services for all dates of service on or after the effective date subject to timely receipt of eligibility data. This does not include dental and vision plans;
    b. Explain pharmacy benefits to members and assist in resolving pharmacy benefit problems subject to access to the PBM system and timely receipt of pharmacy claim data;
    c. Assistance for members with claim questions for medical benefits for all dates of service on or after the effective date subject to timely receipt of medical claim data;
    d. Make warm transfers to other vendors (TPA, PBM, EAP, etc.) as needed to resolve questions, to obtain additional information or receive specific services;
    e. Use customer service contact with members to provide education on care coordination, use of primary care physicians, and to inform members of benefit incentives;
    f. Patient Service Reps will be available 8:00am-9:00pm ET, Monday-Friday;
    g. Enable web access to PSRs through the Plan Sponsor's dedicated website;
    h. Assist members in locating in-network providers, which is limited to checking the PPO website or calling the PPO to obtain provider network status, provided that CHC does not represent that such provider is in-network and members will be informed that they should verify network status with their provider at the time of service;
    i. Integration of decision-support tools available through Plan Sponsor or other vendors and assistance to members to utilize such tools in their healthcare decision process;
    j. Handle and process appeals on behalf of the Plan Sponsor according to the process mutually agreed upon with the Plan Sponsor, TPA, Stop Loss Carrier and CHC;
2. Primary Care Incentive Administration.
    a. Administer the incentive structure for encouraging primary care use and primary care coordination (i.e., referral or similar process), and provide information to TPA or other to adjudicate according to incentive;
    b. Use referral information to coordinate care and identify patients for disease and case management;
3. Facilitate coordination of healthcare process, including:
    a. Utilization Review and concurrent/episodic care coordination.
        i. Review proposed services against plan criteria and make coverage determinations on behalf of the Plan Sponsor;
        ii. Provide concurrent case management of in-patient stays and post-discharge follow-up for patients with inpatient stays as appropriate;
        iii. Utilize pre-cert information to coordinate care and identify patients for disease and case management;
    b. Case management. The list of diagnosis for which complex case management will be offered includes but is not limited to: cancer, auto immune diseases, high risk pregnancy, newly diagnosed birth defect, transplant, multiple trauma, newly diagnosed stroke, blood disorders such as hemophilia, and conditions requiring inpatient stays of 10 days or more. Case management activities shall include but not be limited to:
        i. Identification from customer service contact, Short Health Survey, HRA, referral, pre-cert, patient and physician referrals and claim data of patients
        ii. Case management activities with such patients, including consultation with the patient and their providers;

3. If data cannot be provided in an electronic format, an additional charge of $15 per participant will apply

vi. Access to and development of a program for patients to utilize "Know Your Risks, Know Your Numbers"™ on Plan Sponsor's website, including notices to patients, materials for data entry and development and administration of incentive structure for participation;

vii. Following an HRA/biometric screening or patient use of KYRKYN, Care Coordinator outreach via phone for any individual defined as high risk based on Program and standard medical criteria. Such individual will be educated on their risk factors and directed to resources to assist in management of such risk factors. Care Coordinator education shall be limited to one session unless the patient meets criteria for on-going complex case or chronic condition case management.

5. Member Education and Communication.
   a. Customized messaging on Plan Sponsor website;
   b. 3 mass communications per year on relevant healthcare topics;
   c. Attendance at annual re-enrollment meetings as needed, subject to same guidelines outlined in the Implementation section;
   d. Translation of all materials into languages other than English provided that 20% or more of the employees require such translation. In the event that materials are required to be translated and such translation is for less than 20% of the covered employees, then Quantum Health shall be reimbursed the direct cost for translation services.
6. Reporting.
   a. Standard quarterly reporting to Plan Sponsor of plan performance indicators including but not limited to demographics, case mix analysis, financial analysis, utilization rates, large case analysis, chronic case analysis, health status indicators and other care coordination factors;
   b. Maintenance of an HR Dashboard with specified reporting accessible by the Plan Sponsor, benefit consultant, stop loss carrier and claim payer;
   c. More detailed analysis of utilization or claim data to enable more detailed understanding of indicated patterns;
7. Consultative Assistance. Consultative assistance to the Plan Sponsor and Plan Sponsor's benefit consultant related to health management and health promotion, including:
   a. Recommendations on benefit coverage based on changes in medical treatment and technology;
   b. Recommendations on incentive design to facilitate primary care coordination, patient engagement in preventive care activities, participation incentives;
   c. Recommendations on wellness initiatives based on relevance for Plan Sponsor's population;
   d. Recommendations on wellness vendors for risk assessments/biometrics and other risk management programs.
8. ID card reissues. One ID card reissue per renewal due to Benefit, Network, TPA or PBM changes. Additional reissues are subject to additional fees.

Services Available for Additional Fees. The following services are not included within the normal scope of the Coordinated Health/Care program but are available for additional fees:

- Customer service and advocacy support for claims incurred prior to Coordinated Health/Care program. This typically would only occur during the transition period for the 3-9 months following the effective date.
- Administration of a standards-based (outcomes based) incentive program based on specific health status factors of the patients (i.e., blood pressure, etc.)

SCHEDULE 2

Effective as of: [EFFECTIVE DATE]

Third Party Administrator: [TPA]

Specific Deductible: [$XX]

Pharmacy Benefit Manager: [PBM]

Network Structure:

Network	Coverage
[Specify the applicable network(s) and for which areas. If network structure is complex, reference a "network set-up structure" that is incorporated by reference.]	

Monthly Advance	$XX.XX per Enrollee per month
Fee Cap:	Greater of $XXX,XXX or $XX.XX per enrollee per month
Minimum Fee:	Greater of $xx,xxx or $Xx.xx per enrollee per month
Implementation Fee:	$XXXX to be paid prior to initiation of employee education meetings, not subject to performance formula.

18. Long-term ventilator support or any condition requiring ventilator support of an unspecified time period
19. Sepsis
20. Inpatient and outpatient mental health services
21. Inpatient and outpatient substance abuse services
22. Lithotripsy (ESWL) and related procedures
23. Genetic counseling or screening services
24. Hospice
25. Pediatric acute care services and pediatric surgeries
26. Surgical treatment of morbid obesity
27. Services requiring treatment in a tertiary or specialized facility
28. Services for a patient with 3 or more co-morbid conditions

Inclusion of specific examples is not exclusive. All services rendered to a patient and related to one of the above conditions shall be considered complex medical services. Such complex medical services include all physician services, outpatient care, inpatient care and ancillary or other services rendered in the care and treatment of the condition. Care and treatment rendered to the same patient that is unrelated to the complex medical conditions shall be treated as a separate episode for such patient and shall be accumulated against the appropriate service category.

Appendix

Included in this appendix are additional documents to assist in evaluation of our program and effectiveness. Attached are the following:

- *Third Party Verification of Quantum Health Program Results Through 2011*, by Michael Taggart, F.S.A., M.A.A.A.

  – ***"Overall I found that Quantum Health appears to achieve significant reductions in the cost trend . . . and does so over many years. When compared to results in the industry, the QH results exceed savings of other claims administrators and health insurers."***

  Michael Taggart has over 30 years of senior-level experience creating and implementing healthcare strategy, including serving as U.S. Practice Leader for Healthcare Analytics at Aon Consulting, President/Cofounder of Synhrgy HR Technologies, and Principal and Regional Healthcare Practice Leader at Mercer Consulting.

  He is a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries

- DPMC Audit and Financial Guarantee of Quantum Health Savings Methodology

Purpose of the Study

Quantum Health (QH) is a healthcare management and care coordination firm providing comprehensive consumer focused services that assist individuals in managing their healthcare needs across a wide spectrum of conditions and health statuses. QH is engaged by the plan sponsor (the employer) and provides services directly to individuals covered under employer sponsored medical programs. QH is not responsible for the claim adjudication process, nor does QH have involvement in the negotiation of provider network contracts.

Because plan sponsors are concerned about their ability to manage total medical and pharmacy (healthcare) costs without compromising the delivery of appropriate medical care, the value of QH services is evaluated in terms of their ability to manage the total cost of the plan while achieving high levels of participant satisfaction. The purpose of this study was to examine the financial outcomes of QH clients over a multi-year period and measure those outcomes in relation to market outcomes for the same periods.

Review of the Data

QH provided information on the claims and membership of each client between the years 2000 and 2012. The information was taken from the claims and enrollment data provided by the claims administrator and/or PBM of each client to Quantum Health. For each client, the primary data elements used in the completion of this study included:

- Aggregate participating employees and total plan members by calendar year for each employer.
- Aggregate paid medical and Rx claims (separately) for each calendar year.
- The aggregate amount of catastrophic claims paid in excess of employer's stop loss limit on any participant during a calendar year. In the interest of working as closely as possible with the actual paid claims, we used the actual stop loss limit in place each year for each employer, rather than attempting to impose a fixed stop loss limit across all employers.
- Estimated change in the value of the benefit plan offered to participants based on changes in plan design and/or contracted PPO networks. The projected changes due to plan design or provider network changes were prepared by the payer managing the provider network or a consultant working directly for the plan sponsor. QH was provided with the projected impact of any such changes, but did not have direct input into the development of the projections.

The data was provided by QH in an electronic spreadsheet. I did not audit the source data, but I have reviewed the data for reasonableness. QH provided additional information and clarifications to the data based on the specific questions raised during my review of the data. I believe the resulting data is within reasonable limits and is appropriate for the analysis.

Organization of the Study

In order to evaluate the financial experience of the QH clients in relation to general market trends for self-funded employer plans, the decision was made to evaluate the QH data on a cohort basis, with each client assigned to a cohort based on the initial year in which the QH services were first implemented. In part, this approach was adopted in consideration of the fact that many QH clients experience a net drop in claims cost during the initial year of QH services. Based on their experience working with clients, QH believes that their services are effective in reducing the level of redundant or unnecessary medical services better than any other program available in the market. In such cases, it is logical to expect that the QH savings would be largest in the initial year of operation, whereas in the following years, QH savings would be incremental in nature. Organizing the data on a calendar cohort basis makes it possible for us to compare the trend rates of QH clients during the initial year as well as the CAGR of medical trend over longer periods.

Factors Impacting Healthcare Costs Over Time

Because the study was based on aggregate claims data, there are several adjustments which can be made in order to maintain comparable data over the time period:

- Population changes – For most QH clients, the population over the time period was relatively stable. We did not obtain detailed demographic data on the covered population on an annual basis, so it is possible that the results may be impacted by certain changes in the group. One concern would be the impact of an aging of the covered group over time. In organizations where there is a relatively stable workforce, the average age of the covered group may be expected to rise over a multi-year period, particularly in situations where the general economic conditions are less favorable and there are fewer opportunities with competing employers. Such conditions were generally present during the 2008 – 2012 period. Because detailed demographic information was not available, we cannot determine the extent to which the stated trend rates are impacted by the changes in the covered group.
- Plan design changes – Adjustments were made to remove the impact of plan design changes based on the payer or consultants' calculation.
- Changes in provider networks – Adjustments were made to remove the impact of changes in provider network discounts based on the payer or consultants' calculation.

Notes:

The following measures were developed:

- *The most fundamental measure of the financial outcomes is the actual year over year change in healthcare costs (trend) for each employer. The annual trend was determined for each employer and for each year for which data was available. Where the employer made changes to the medical plan (such as a change in the plan design or the contracted provider network), the financial results were adjusted to compensate for that change using data supplied by the employer's consultant or payer.*
- *The aggregated trend results across all clients were then calculated. The aggregate trends represent an average trend weighted by the number of participants within each client. In order to evaluate the potential impact of these large claims, we have calculated the annual trend rate using both the total claims paid in each year and separately after removing the amount above the stop loss attachment point for catastrophic claims from the data.*
- *The Compound Annual Growth Rate (CAGR) in medical and pharmacy claims is over the full period during which QH is responsible for providing services.*
- *Finally, comparison was made of the aggregate QH client medical trends to the average market trends for most self-funded employer medical plans and client specific actuarially projected trend for large groups over the same period. To determine the market trends experienced by employer plans, we have used three independent market surveys published by AonHewitt and Towers Watson.*

of randomness), chronic disease events, ER visits, and high-cost diagnostic utilization should decrease, while primary care visits and preventive screens should increase. Specialist visits normally decline but occasionally there are enough specific situations where specialists are under-utilized that specialist visits as a whole increase.

A demographic change – usually as a result of an acquisition, layoff, or early retirement buyout – is also often suggested as a cause for improved trend. This can be tested via the "plausibility indicator" of checking to see if primary care visits and preventive screenings fall too, and/or average age (or the percentage of employees over 50) declines. That would mean that utilization of every resource group is falling, a situation which could not be attributed solely to good management.

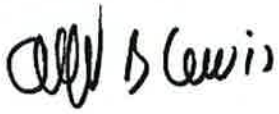
Notwithstanding those uncontrollable circumstances, the standard methodology proposed by Quantum Health for validating claim savings based on observed changes in utilization is also valid and subject to the DMPC's guarantee.

DMPC Approach

For clients accessing this guarantee, the DMPC will issue an audit letter addressing Quantum Health's proposed methodology. Quantum Health may share that letter with the benefits consultants and the client. If the client's benefit consultants subsequently find a significant "systematic error" in the Quantum Health methodology that makes the Quantum Health methodology noticeably more likely to overstate savings and hence less valid than an alternative methodology used by the consultant, the client will be entitled to a settlement from DMPC of the contractually agreed amount, up to $100,000.

Quantum Health may also present metrics not covered by the guarantee. Excluding such additional metrics from the guarantee does NOT mean that DMPC believes them to be invalid, but rather that such other metrics don't reach the very high standard needed for DMPC to accept financial risk for endorsing them in an auditor's letter.

Sincerely,



Al Lewis

The Disease Management Purchasing Consortium (DMPC) is the largest source of contracting support, outcomes and evaluations, and professional and corporate certifications in Disease and Population Health Management. DMPC members include more than 100 health plans, major employers, states, and unions.

Twenty-five of those payors have earned DMPC Certification for Savings Measurement Validity, a feat difficult and respected enough that recipients receive "Best in Disease Management" awards, bestowed by the Health Industries Research Companies in their annual DM/ Wellness industry reports. Additionally, more than 200 individuals have satisfied the requirements to achieve DMPC Certification in Critical Outcomes Report Analysis.

Executive Director Al Lewis, the signatory on the auditor's letter, was the founder and the first president of the Disease Management Association of America. If you search Google, Lewis is credited as being the "inventor of the Disease Management industry." He has authored two books including *Emerging Trends in Disease Management,* and is a frequent op-ed contributor whose essays appear regularly in the *The San Francisco Chronicle* and *Newsweek.*

For more information:
877-498-9866
info@Quantum-Health.com
www.quantum-health.com

References

References available upon notification of selection as a finalist.