

STATE OF OHIO  
DEPARTMENT OF ADMINISTRATIVE SERVICES  
GENERAL SERVICES DIVISION  
OFFICE OF PROCUREMENT SERVICES  
4200 SURFACE ROAD, COLUMBUS, OH 43228-1395

SERVICES CONTRACT: STATE OF OHIO EMPLOYEE POPULATION HEALTH MANAGEMENT (PHM) PROGRAM

CONTRACT No.: CSP902609

EFFECTIVE DATES: 07/01/2009 – 06/30/2012

The Department of Administrative Services has accepted Proposals submitted in response to Request for Proposal (RFP) No. CSP902609, that opened on October 27, 2008. The evaluation of the Proposal responses has been completed. The Offeror listed herein has been determined to be the highest ranking Offeror and has been awarded a Contract for the services listed. The respective Proposal response, including Contract Terms & Conditions, any Proposal amendment, special Contract Terms & Conditions, specifications, pricing schedules and any attachments incorporated by reference and accepted by DAS become a part of this Services Contract.

This Services Contract is effective beginning and ending on the dates noted above unless, prior to the expiration date, the Contract is renewed, terminated, or cancelled in accordance with the Contract Terms and Conditions.

This Services Contract is available to the Ohio Department of Administrative Services, Benefits Administration Services Office as applicable.

The Department of Administrative Services is eligible to utilize the contracted services in any amount and at any time as determined by the agency. The State makes no representation or guarantee that the agency will purchase the volume of services as advertised in the Request for Proposal.

Questions regarding this and/or the Services Contract may be directed to:

Dana L. King, CPPB  
dana.king@das.state.oh.us

This Services Contract and any Amendments thereto are available from the DAS Web site at the following address:



[www.ohio.gov/procure](http://www.ohio.gov/procure)

CONTRACT REQUIREMENT SYNOPSIS: This section gives only a summary of the Project requirements and the Contractor's responsibilities. The Contractor shall:

1. Coordinate all aspects of the PHM program and serve as the single point of accountability and management for the program (i.e., "General Contractor").
2. Demonstrate proven participation, satisfaction, impact, and outcomes of PHM programs.
3. Administer an incentive program.
4. Develop and provide quality tools (e.g., Web site, health assessment, etc.) to support and achieve PHM program goals.
5. Measure and report PHM program results.
6. Provide committed account management and staff resources to support the large, dispersed State population.
7. Provide customer service.

#### DEFINITIONS.

"ACD" – Refers to an Automatic Call Distributor, a device that distributes incoming telephone calls to a specific group of stations.

"A.D.A.M." – Refers to a provider of on-line health education resources for consumers, including a medical library.

"Amendments" - All amendments and modifications to this Contract shall be in writing and shall be coordinated through the DAS Office of Procurement Services.

"Average Speed of Answer (ASA)" – The average number of seconds it takes the Contractor's employee to answer a Member or provider telephone call. Timing of the ASA begins after the caller chooses the ACD prompt.

"Baseline Period" - The aggregate medical and pharmacy claim amounts paid by the State for Eligible Members for claims incurred during the 24 months immediately preceding the Commencement Date.

"Body Mass Index (BMI)" – Refers to a measure of body fat based on height and weight.

"Care Management Team(s)" – Refers to Contractor-specified multi-disciplinary teams who are responsible for all PHM program services provided to individual Eligible Members.

"Clinical Advisory Panel" - Refers to a group of board certified physicians who ensure that decisions are consistent with best practices and make recommendations for improvements where necessary.

"Commencement Date" – Shall be July 1, 2009, the date upon which the Contractor shall commence providing PHM services to transition members. October 1, 2009 is the date, under Contract CSP902609, the Contractor shall commence providing PHM services for the State's entire population.

"Contractor" – Refers to Innovative Resource Group, LLC dba APS Healthcare.

"Contract Period" – The period commencing on the Effective Date of the Contract and extending until the end date of the Contract.

"Covered Disease" - A disease or condition identified in the Disease Management section for which the Contractor shall provide Disease Management services pursuant to this Contract.

"Disease Management (DM)" – Refers to a system of coordinated health care interventions and communications for individuals with Covered Diseases in which patient self-care efforts are significant.

“Eligible Employee” – Each employee hired by the State and covered by a Health Plan as of the first of each respective month.

“Eligible Member” – Each person who, as determined solely by the State, is eligible for PHM benefits pursuant to this Contract, and said person’s qualified dependents. For the purposes of Disease Management, Eligible Members shall include those 18 years of age and older for all conditions except diabetes and asthma, in which the minimum age is 6.

“Eligibility” - Refers to the State’s rules and criteria that determine whether an individual qualifies for the Program.

“Engaged” – Refers to a Member who has been successfully contacted and has not opted out of the program. Excludes all members receiving mail-based communications only.

“Enrollment Specialist” – A non-clinical member of the Care Management Team who is responsible for assisting Eligible Members in understanding and accessing all PHM program elements, including entering of demographic and clinical data into the Contractor’s system and triaging Eligible Members to other Care Management Team members.

“Excluded Members” – Refers to individuals who, during any and all periods of time covered by the Contract Period, are diagnosed or undergo treatment for HIV/AIDS, transplants, or infertility. Excluded Members are eligible to receive PHM program services, but are not included in the calculation of clinical or financial performance metrics.

“FTE” – Full time equivalent.

“Health Coach” – Refers to a clinical member of the Care Management Team who is responsible for Eligible Member outreach, assessments, and interventions including health education, counseling, provider coordination and referrals. Primary Health Coaches are Registered Nurses and are responsible for leading the Care Management Teams.

“Health Educator Counselor” – Refers to a clinical member of the Care Management Team who counsels Eligible Members onsite regarding biometric screening results and provides recommendations for follow-up.

“Health Insurance Portability and Accountability Act (HIPAA)” – A federal law enacted by Congress in 1996. HIPAA is designed to improve individual’s access to health care throughout the country, as well as require health care providers and health plans to more efficiently and securely share health care data and information. HIPAA privacy regulations establish standards for protecting individuals’ medical records and other personal health information.

“Health Plan” - The self-insured state of Ohio group health insurance plan. Also referred to as the Plan.

“Health Risk Assessment (HRA)” – A questionnaire used to assess current health risks of individuals.

“IVR” - Interactive Voice Response or IVR is an automated telephone information system that interacts with callers and channels caller to the appropriate place.

“Licenses and Certifications” - The parties represent and warrant that they have obtained or will obtain and shall, throughout the term of this Agreement, maintain all necessary licenses, filings, and certifications to perform their duties under this Agreement.

“Lifestyle Management (LM)” – Refers to PHM program elements that are designed to promote changes in Eligible Members’ behaviors of daily living that negatively impact their health and well-being.

“Measurement Group” – All Eligible Members (i.e., excluding Excluded Members) who are enrolled in the Health Plan for at least three (3) months in both the Baseline and Measurement Periods.

“Measurement Period” – For the purpose of determining return on investment (ROI), the Measurement Period shall be measured annually beginning October 1, 2009 through September 30, of the respective term. For the purpose of determining all other non-financial guarantees, the Measurement Period shall be consistent with each Contract year, beginning July 1 and ending the following June 30.

“NCQA” – Refers to the National Committee for Quality Assurance, a private, nonprofit organization dedicated to assessing and reporting on the quality of managed care plans, physician organizations, disease management programs and other health-related programs.

“Network” – Refers to local, regional and national health care providers contracted with the Health Plan to provide care to Eligible Members.

“Nurse Advice Line” – Refers to a service providing Eligible Members with toll-free telephone access 24 hours a day 7 days a week (24/7) to registered nurses to answer Eligible Members’ health-related questions.

“Outreach Coordinator” – Refers to health educator members of the Care Management Team who are based in Ohio and responsible for promoting the PHM program to Eligible Members and Treating Providers, and administering the PHM program elements at worksites, during health and benefit open enrollment fairs and worksite screening events.

“Paid Claims” – The aggregate medical and pharmacy claims amounts paid by the State for claims incurred by Eligible Members during the respective period, the Baseline Period or the Measurement Period.

“Participant” - An Eligible Member or his/her enrolled dependents covered under a Health Plan who participates in any of the programs included in this Contract. For Disease Management services, a Participant is an Eligible Member who meets the participation criteria for a Covered Disease and who has not notified the Contractor verbally or in writing that he/she does not wish to participate in the program for which they have been identified.

“Participation Rate” –The number of Eligible Members who engage in and/or complete a PHM Program Element divided by the total number of Eligible Members.

“Percent Abandoned Calls” – Shall be determined by measuring the number of Eligible Members who call the Contractor and hang up before reaching a live person, excluding calls in which the caller hangs up within the first ten (10) seconds.

“Protected Health Information (PHI)” – Refers to any individually identifiable health information including data that is explicitly linked to a particular individual as well as health information that contains data items which reasonably could be expected to allow individual identification.

“Pharmacy Benefit Manager (PBM)” - A company under contract with the State to manage a pharmacy network, fill drug prescriptions, conduct drug utilization review, outcomes management, and other pharmacy related activities.

“Per Employee Per Month (PEPM)” – Refers to the basis upon which fees are paid for PHM program services and means the State shall pay a set dollar amount for each Eligible Employee enrolled in a Health Plan on the first of the month.

“Population Health Management (PHM)” – Refers to a comprehensive approach to health management that involves the integration, coordination, and management of all of a population's healthcare needs covering the full continuum of health, from health and wellness to serious illness.

“Population Health Management (PHM) Program Element” – Refers to all services and components offered by the Contractor to assist Eligible Members in improving and/or maintaining their health, including HRAs, LM services, DM, and worksite health screenings.

“Predicted Risk Index (PRI)” – Refers to the Contractor’s methodology for measuring and evaluating the relative health risk of individuals and the population in aggregate using the Adjusted Clinical Groups™ model (Johns Hopkins University) to assign Eligible Members to morbidity categories based on patterns of disease and expected resource requirements.

“Program” – Refers to the specifications agreed to in this Contract and such other specifications as the parties may reasonably agree upon from time to time.

“Provider” – Refers to the physician or provider primarily responsible for managing the treatment of an Eligible Member.

“Return on Investment (ROI)” – Refers to the savings resulting from the Program, determined by dividing the Total Savings for a Measurement Period by the Total PHM Fees paid to the Contractor during the same Measurement Period.

“Risk Stratification” – Risk stratification refers to a process of prospectively determining the risk of an individual (or population in aggregate) for future health conditions, complications, and potentially costs based upon an evaluation of certain characteristics of the individual (or the population) such as lifestyle behaviors.

“Scheduled Maintenance” - Any maintenance work that has been planned and included on an approved Maintenance Schedule. Planned maintenance is any maintenance activity for which a pre-determined job procedure has been documented, for which all labor, materials, tools, and equipment required to carry out the task have been estimated, and their availability ensured before commencement of the task. Scheduled maintenance is a list of Planned Maintenance tasks to be performed during a given time period, together with the expected start times and durations of each of these tasks. Scheduled maintenance includes database reorganizations, application of software corrections and adjustments. These tasks are necessary to provide recovery capabilities, maintain performance levels, and keep system stable, reliable and current.

“State” - Refers to the state of Ohio, through any of its departments, agencies, or representatives.

“Total PHM Fees” - Refers to total PEPM amounts paid by the State to the Contractor according to the PHM Program fee schedule for the Program.

“Total Fees” – Refers to the total fees paid to the Contractor during the Contract Period, not all of which are subject to an ROI calculation.

“Total Savings” – Refers to the total amounts saved by the State, as determined by multiplying the Total Claims for the Measurement Period by the difference between “1” and the Measurement Period PRI divided by the Baseline Period PRI.

“Transition Members” – Refers to those Eligible Members who were previously eligible for the State’s PHM Program , were services by another PHM Contractor, and effective July 1, 2009 are eligible for services under this Contract.

“Turnover Rate” – Shall be calculated annually by dividing the number of full-time employees who terminated employment, both voluntary and involuntary (e.g., resignation, retirement, discharge, death and excluding layoffs or job eliminations, transfers, or departures of temporary staff), by the number of full-time employees on the active payroll.

“URAC” – Refers to the Utilization Review Accreditation Commission, an independent, nonprofit organization that promotes health care quality through its accreditation and certification programs available to a variety of health care organizations.

“Utilization Management” – The evaluation of the appropriateness, medical need and efficiency of health care services, procedures, and facilities according to established criteria or guidelines and under the provisions of a Health Plan. Utilization management typically involves proactive procedures and processes including pre-certification, concurrent review, and discharge planning.

“Wellness” – Refers to an active process of becoming aware of and making choices toward a more successful existence and attaining or maintaining good health.

“Wellness Coordinator” – Employees or representatives of the State who agree to be available to Eligible Members to answer questions about the PHM program and facilitate Eligible Members’ participation in the Program.

“Wellness Coach” – A clinical member of the Care Management Team who is responsible for conducting baseline assessments of Eligible Members, working with Eligible Members on the identification of goals and development of a plan of care, identifying barriers to achieving goals and learning/strategizing with the Health Coach to identify ways for individual Eligible Members to overcome barriers.

“Year 1” - July 1, 2009 through June 30, 2010. This definition exclusively refers to the Contract Period. Any references to Year 1 in the performance guarantees and ROI measurement shall be in accordance with the dates defined in the Measurement Period.

“Year 2” – July 1, 2010 through June 30, 2011. This definition exclusively refers to the Contract Period. Any references to Year 2 in the performance guarantees and ROI measurement shall be in accordance with the dates defined in the Measurement Period.

“Year 3” – July 1, 2011 through June 30, 2012. This definition exclusively refers to the Contract Period. Any references to Year 3 in the performance guarantees and ROI measurement shall be in accordance with the dates defined in the Measurement Period.

MUTUALLY AGREED UPON CLARIFICATIONS AND MODIFICATIONS – POPULATION HEALTH MANAGEMENT (PHM) PROGRAM

1. The general Terms and Conditions for the Contract are contained in Attachment Three of the RFP for Project. The Contract consists of:
  - a. The original RFP and any addendums.
  - b. The documents and materials incorporated by reference in the RFP.
  - c. The Contactor's Proposals, as amended, clarified, and accepted by the State.
  - d. The documents and materials incorporated by reference in the Offeror's Proposal and subsequent accepted clarifications.
  - e. Any related amendments issued subsequent to Contract award.
2. The BAS Office and the Contractor shall notify the DAS, Office of Procurement Services within ten (10) business days in the event of a change in personnel, financial, or contact information.
3. Contract Term. The term of this Contract shall be from 7/1/09 through 6/30/12. The State may renew this Contract for one (1) additional two (2) year period, subject to and contingent upon the discretionary decision of the Ohio General Assembly; the appropriation of funds for this activity; and the satisfactory performance of the Contractor.
4. The State reserves the right to negotiate cooperative purchasing efforts with other government entities during the initial or renewal Contract term(s).
5. The Contractor shall provide the DAS Office of Procurement updated insurance forms for the Contractor's organization on an annual basis, or as appropriate when changes go into effect.
6. For the initial Contract term, it is the State's intent to purchase services in the following categories:
  - a. General Contractor (GC)
  - b. Disease Management (DM)
  - c. Health Decision Support and Health Action Programs
  - d. Health Risk Assessment (HRA)
  - e. Lifestyle Behavioral Change (LM)
  - f. Incentive Management (IM)
  - g. Worksite Health Screenings
7. Job Description. Job Title: Executive Director, Ohio Service Center Commercial Division
  - a. Summary of Responsibilities. This position is a highly organized and detail oriented professional with lead operational responsibility for care management programs for the commercial division in the Ohio Service Center including disease management and health/wellness.
  - b. Essential duties include, but are not limited to the following:
    - 1). Overall operational responsibility for the Ohio Service Center.
    - 2). Responsibility for the Service Center operational effectiveness, clinical excellence, and customer and employee satisfaction to support the attainment of desired outcomes.
    - 3). Liaison with the Contractor's partners.
  - c. Qualification requirements: Minimum of five (5) years progressive management leadership experience; Two (2) years managed care experience; Experience managing multimillion dollar budgets; Exceptional communication skills including verbal, writing, and presentation; Demonstrated knowledge of clinical practice and processes; Demonstrated knowledge of outcome based performance; Demonstrated effectiveness interacting with and meeting the needs of external and internal customers; Ability to handle multiple projects on different timelines; and Ability to work well under pressure.

8. Ohio Ethics and Elections Law.

a. Ethics Law

Contractor hereby certifies that all applicable parties listed in Division (I)(3) or (J)(3) of O.R.C. Section 3517.13 are in full compliance with Divisions (I)(1) and (J)(1) of O.R.C. Section 3517.13.

In accordance with Executive Order 2007-01S, Contractor, by signature on this document, certifies: (1) it has reviewed and understands Executive Order 2007-01S, (2) has reviewed and understands the Ohio ethics and conflict of interest laws, and (3) will take no action inconsistent with those laws and this order. The Contractor understands that failure to comply with Executive Order 2007-01S is, in itself, grounds for termination of this contract and may result in the loss of other contracts with the State of Ohio.

Contractor certifies that it is currently in compliance and will continue to adhere to the requirements of Ohio ethics laws.

b. Political Contributions

The Contractor affirms in its cover letter that, as applicable to the Contractor, all personal and business associates are in compliance with Chapter 3517 of the Revised Code regarding limitations on political contributions and will remain in compliance for the duration of the Contract and with all applicable provisions that extend beyond the expiration of the Contract.

9. The State shall ensure accurate historical claims data from the third party payors is sent in a timely manner to the Contractor in an agreed upon format which the Contractor can receive, analyze and test for accuracy. Data transmissions determine the stratification and ultimate outreach to members.
10. The Contractor shall sign and return to the state of Ohio the Business Associate Agreement in Supplement One of the RFP.

## GENERAL CONTRACTOR RESPONSIBILITIES

### 1.0 Prime Integrator

#### 1.1 Description of Services.

The Contractor shall serve as General Contractor or prime integrator to the state of Ohio for Population Health Management services. As the General Contractor, the Contractor shall develop and implement a fully integrated, comprehensive PHM strategy and program to change behavior and improve the health of the state of Ohio Eligible Members enrolled in health insurance through the State's health plans.

The Contractor shall identify potential joint opportunities to enhance coordination of care, improve member outcomes, and increase health care cost savings to the state of Ohio.

The Contractor's services shall be fully integrated and seamless so that Eligible Members shall perceive they are receiving services from a single source, branded as a single program, not services from disparate contractor organizations.

As the General Contractor, the Contractor shall:

Serve as the State's single point of contact for account relationship management issues and problem resolution.

Educate, engage, and communicate the PHM program to Eligible Members.

Act as the primary interface point for all PHM services and facilitate cross referrals, information and data sharing with other benefit providers to the State, to ensure each Member is managed in the most holistic way to maximize Member outcomes.

Provide measurement and reporting of the Program's effectiveness to the State.

All work performed by the Contractor shall be performed within the continental United States, and all state of Ohio data shall be kept within the continental United States.

#### 1.2 Account Management. As the General Contractor, the Contractor shall provide account management services to the State including:

Provide implementation, strategic guidance, communications, analysis, and ongoing management of the program.

Educate and cross train the Contractor's internal staff and external partners about the various services available to Eligible Members under the PHM program to ensure a common understanding of the Program and its objectives.

Define clear roles and responsibilities for continuity of care and to reduce duplication of services.

Provide a detailed implementation plan which includes critical tasks, timeframes, and resources within three (3) weeks of the PHM Contract award.

Provide integrated billing of all services which clearly outlines the services, fees, timeframes during which services are rendered, and the number of Eligible Employees for which services are billed.

Establish and maintain a Service Center in Columbus, Ohio to provide Program coordination services, customer service support, coaching services for disease management and lifestyle behavior change participants, and general health education outreach services. The Brookfield, Wisconsin Service Center shall be used as a back-up to the Columbus Service Center, with the State's knowledge and permission.

Columbus, Ohio-based staff shall include at a minimum one (1) Executive Director, one (1) Operations Manager, and two (2) Outreach Coordinators. The Contractor shall maintain at all times staffing adequate to meet all deliverables provided herein.

At a minimum, 16 FTEs shall be designated to the state of Ohio account, including six (6) RN Health Coaches and two (2) LPN Health Coaches.

Should any changes be made to the agreed upon staffing, the State reserves the right to approve such changes.

The State may approve the selection decisions for the Contractor's Ohio-based employees, including the Executive Director, Operations Manager, and Outreach Coordinators. The State may withdraw approval of the Contractor's Executive Director.

The Contractor shall manage the Columbus Service Center with employee skill and service levels acceptable to the State. The Contractor shall submit a contingency plan to perform state of Ohio work in an alternate location in the event that work in the Columbus Ohio Service Center does not meet the State's expectations, i.e., the employees' skill levels or the service levels do not meet with the State's approval.

The Contractor shall monitor the quality of LM and DM coaching programs by monitoring Coaches' calls with participants, conducting case audits of Coaches' work, and providing continuing education for Coaches.

The Contractor shall fully cooperate with the State and provide all necessary assistance to the State in transitioning Participants, enrollment and participation data, and other pertinent information to the State or a third party designated by the State upon Contract expiration or termination.

The Contractor shall participate in weekly conference calls during the implementation process for the purpose of progress reviews and the open exchange of relevant information. Following implementation, regular conference calls will be conducted to continue the exchange of information. The Contractor, including the Executive Director, Medical Director, and other key staff, shall attend an annual account review meeting in Columbus no later than 135 days following the conclusion of the Contract year. At the conclusion of the Contract, the annual account review meeting shall be waived, although the Contractor shall be responsible for submitting the final year's reports including Performance Guarantee Analysis and for performing transition responsibilities as outlined elsewhere in the Contract.

The Contractor's Executive Director shall maintain regular contact with the State's liaison in order to facilitate problem solving and the smooth exchange of information.

The Contractor shall participate in annual and semi-annual assessments, conducted by the State, of the Contractor's account service performance. Performance shall be assessed using a mutually agreed upon survey tool of various account service metrics.

The Contractor shall not change PHM subcontractors without notification and mutual agreement from the State.

- 1.3 Service Provider Interface. As the General Contractor, the Contractor shall provide interface and coordination with other service providers. Interface and coordination shall include, but not be limited to:

Upon execution of the Contract, the Contractor will participate in a vendor summit with the State's other business partners including the State's health plans, the pharmacy benefit manager, the EAP and others as deemed necessary in order to facilitate program transition and coordination of care. The Contractor shall maintain regular contact with the State's other business partners involved in providing services to Eligible Members.

Establish and maintain seamless interface protocols (cross-referral criteria to ensure each party knows when and how to refer Eligible Members to other programs within specific timeframes to be established by the Contractor, "warm connect" processes, coordination of care services, and follow-up criteria and timeframes) to ensure the hand off and care coordination between programs is transparent to Eligible Members and that Eligible Members are referred to the appropriate services as quickly as possible.

Provide program educational materials and referral information to encourage cross referrals between all programs.

Identify potential joint opportunities to enhance coordination of care.

With the State, identify liaisons within each subcontracting organization to clarify questions involving Eligible Member issues, resolving issues quickly, and consulting on complex cases.

The State shall participate in key discussions between the Contractor and key business partners, including but not limited to the health plans, the PBM, and Health Media on issues pertaining to the State's PHM program such as: Implementation, Eligible Member communications, referrals, reporting, and Eligible Member engagement.

1.4 Measurement and Reporting. As the General Contractor, the Contractor shall provide measurement and reporting services, including:

Put fees at risk to ensure performance.

Provide integrated, consolidated, timely, and accurate reporting of quarterly and annual activities, performance, and results.

Conduct quarterly meetings with the State's representatives to review reports, discuss the program's status and formulate action plans for improvement, if warranted.

1.5 Miscellaneous Requirements.

Accreditation. The Contractor shall maintain either URAC or NCQA certification for its PHM-related products, where applicable, and ensure certifications are provided to the State upon accreditation.

Implementation. The Contractor shall facilitate a full team conference call with all involved parties within one (1) week of Contract award. The Contractor shall facilitate a face-to-face kick-off meeting within two (2) weeks of the all team conference call. The purpose of the meeting shall be to review the Contractor-prepared detailed implementation plan detailing essential tasks, timeframes, and resources. The Contractor shall provide a detailed Implementation Plan for transition from the State's current population health management business partners to the Contractor.

The implementation plan shall include the following target dates:

6/15/09 - Initial PHM program communications materials mailed by the Contractor to homes of Eligible Members transitioning from two (2) previous PHM vendors; transition materials mailed to homes of DM participants. A draft of the communications materials shall be provided to the State by 6/1/09.

7/1/09 – Full access to custom APS Healthcare/state of Ohio Web site; presence of Columbus Ohio Service Center Executive Director; fully operational Columbus Ohio Service Center; customer service support 800# dedicated to the state of Ohio.

9/15/09 – PHM program communication materials mailed by the Contractor to the homes of Eligible Members enrolled in Ohio Med, Paramount, and The Health Plan.

In order for the Contractor to meet the timeliness requirements outlined above, the State must facilitate the following actions:

The Contractor will be supplied with clean eligibility file in an accepted format by 5/1/09.

By 5/19/09, the Contractor will receive transitional care files from United Healthcare and Aetna that will allow the Contractor to effectively identify and outreach to members already enrolled in disease management. Failure to receive this information in a timely, complete and accurate format may result in a delay of disease management outreach.

Subsequent implementation activities are dependent upon receipt of clean medical and pharmacy claims data from the State's other vendors and fully executed Business Associate Agreements.

The State shall provide timely review and, where necessary, approval of the Contractor's submissions.

## 2.0 Data Exchange

- 2.1 The Contractor shall provide data exchanges with other organizations and the State including the following:

The Contractor shall receive and load a biweekly eligibility file from the State. The file is an 834 HIPAA file generated from PeopleSoft. The Contractor shall be expected to update its system biweekly to reflect data as prescribed by the State (including but not limited to agency, location, health plan enrollment employee ID number, employee ID number, address, phone, etc.). On a monthly basis, the Contractor shall be expected to update its files to reflect accurate program participation and completion data per member.

Prior to the Program effective date communicated to members, the Contractor shall be provided with 24 months of utilization and claims data for members transitioning to the Contractor and be expected to analyze and stratify the health plans' claims to develop a baseline for future measurement purposes and to identify members for outreach.

On no less than a monthly basis, the Contractor shall receive files from the State's health plans, PBM, and other partners to aid in the prompt identification of candidates for the PHM program elements (e.g., LM, DM). The Contractor shall be expected to upload the data to its system in a timely manner on at least a monthly basis. On a quarterly basis, the Contractor shall be expected to provide the State's data management vendor, currently Thomson Reuters, data files including participation, health risk stratification, and other data as directed by the State.

When interfacing with subcontractors, the Contractor shall integrate all data on a single IT platform or, at a minimum, accommodate the electronic exchange of data between the Contractor, the Contractor's subcontractors, the state of Ohio, and the State's other business partners such as health plans. Manual preparation and transmission of information will not be accepted.

All subcontractors are expected to adhere to the same data processing requirements. At a minimum, the Contractor should receive monthly updates from its subcontractors for reporting purposes and in order to respond to inquiries from members and the State.

The Contractor shall incorporate Eligible Members' HRA results, medical claims, pharmaceutical claims, biometric, other health information, and status of incentive rewards into its IT application in order to assess the health status of the population, stratify the population by risk, and provide Health Coaches with access for use in assisting Eligible Members with their health needs and incentive questions. The Contractor shall provide Health Coaches with access to Eligible Members' health data and benefits services so Coaches can provide holistic health care to Eligible Members.

- 2.2 Incentive Management. The Contractor shall receive data from the State, refresh files, and provide data to the State regarding incentive recipients:

2.2.1 Data to the State – The Contractor shall compile records of Eligible Members' attainment of incentive awards and send electronic files to the State as often as monthly in a layout format provided by the State consistent with the State's PeopleSoft HRIS system identifying incentive participants, award amounts, level of participation, date of award, and any other data required by the State.

2.2.2 Data reconciliation – The Contractor shall reconcile the file it receives from the State with the outbound file supplied by the Contractor to the State.

### 3.0 Identification, Engagement, and Risk Stratification.

- 3.1 The Contractor shall provide identification, engagement, and risk stratification services to the State including:

The Contractor shall utilize multiple sources to identify potential participants in the PHM program including medical, pharmacy and behavioral claims data; HRA data; biometric screening data; referrals from the participant, providers, the State and the State's health plans and other benefit partners. On a monthly basis, the Contractor shall refresh its database to ensure the most up-to-date data is considered during the identification process.

The Contractor is expected to verify eligibility before performing any services (e.g., biometric screenings).

The Contractor shall provide two (2) Columbus-based outreach coordinators who shall be dedicated to the engagement of state of Ohio members and promotion of the State's PHM program. The outreach coordinators shall also serve as a resource for agency benefits and wellness coordinators. Outreach coordinators shall attend approximately 50 agency health fairs and biometric screening events around the State. In addition, outreach coordinators shall make agency site visits for the purposes of engaging members and conducting on-site educational programs.

Additionally, the Contractor shall be expected to utilize a variety of means to identify and risk stratify, including but not limited to, predictive modeling that encompasses medical and pharmacy claims, HRA results, and biometric results. The Contractor is expected to conduct the identification and risk stratification process no less than quarterly.

The Contractor shall integrate all aspects of its program to accommodate, for example, the needs of members who are identified for more than one PHM program (e.g., LM and DM), the integration of which shall ensure a seamless experience for members.

The State expects the Contractor to continue to make outbound calls to potential participants (LM, DM, etc.) until 3 months before contract termination. In the last three (3) months of the Contract, the Contractor shall be expected to continue to service enrolled participants and new participants who opt into the Program.

The Contractor shall assign Eligible Members who complete the HRA a *lifestyle score*. The *lifestyle score* will be used to identify and stratify members for the LM or DM programs. Candidates for DM will also be identified via monthly claims data using informatics tools including Johns Hopkins Adjusted Clinical Groups Case-Mix System, predictive modeling, and the Contractor's Treatment Gap Analysis tool. Regardless of the identification means, members identified for LM and/or DM will be stratified into three (3) risk levels – low, moderate, and high as described below.

Low-Risk Members – Members who have been identified as at-risk but whose health status is good and whose self-care practices are sufficient to properly manage their lifestyle risk, disease/condition. Low risk members for LM tend to have only one biometric or lifestyle risk, and tend to be motivated and confident to make changes in their lives.

Moderate Risk Members – Members who are at-risk or whose health status or self-care practices need improvement. Moderate risk members may also have only one (1) or two (2) biometric or lifestyle risks, but they lack either the motivation or confidence to make the appropriate lifestyle change.

High Risk Members – Members who require aggressive intervention because of their disease/condition and/or self-care skills. High risk members have self-reported that their health/general quality of life is fair or poor and/or they have two (2) or more bio-behavioral risks and self-report low motivation/low self-confidence to positively make and sustain healthy lifestyle changes.

Members identified as high risk shall be automatically invited to participate in the DM program while low risk members shall be stratified into the LM program with moderate risk individuals entering LM and/or DM programs. Within the DM program, individuals shall be further stratified into DM high, moderate and low profiles. DM participants stratified as high or moderate shall receive ongoing coordination and contractor-facilitated communication with providers to address issues and alerts related to identified gaps in treatment or increased utilization.

Any Eligible Member, regardless of risk level, who desires one-on-one telephonic coaching or in-person coaching from an Outreach Coordinator, may contact the Contractor and request coaching. In addition, Eligible Members can be referred by physicians, case managers, identified via health fairs, identified through claims analysis, and via worksite biometric health screenings.

Any Eligible Member whose HRA and/or biometric results indicate either BMI equal to or greater than 30, positive response to using tobacco products, positive response to significant alcohol use, high blood pressure, high blood sugar, high cholesterol, high stress, or positive screen for depression shall also be identified and proactively outreached for participation in the PHM program.

3.2 Engagement. The Contractor shall provide comprehensive tactics to inform and educate Eligible Members of the PHM program and promote member engagement in the program.

The two (2) fulltime Outreach Coordinators in the Columbus, Ohio Service Center shall be responsible for providing on-site educational activities to engage Eligible Members.

Regardless of risk level and readiness to change, the Contractor shall proactively outreach by telephone to 100% of the State's members who are identified by the Contractor as appropriate for an LM or DM program following completion of the HRA, participation in a biometric screening, attendance at a Brown Bag educational event, identification via the Contractor's claims analysis, or via referral.

Eligible Members who complete the HRA shall be contacted by phone and/or in person within three (3) weeks of HRA completion if identified as appropriate for health coaching.

In an attempt to reach identified members, the Contractor shall place three (3) phone calls/e-mails over a two (2) week period at varying times of the day to identified members. Prior to placing the first call, the Contractor shall utilize a variety of resources to obtain correct phone numbers, including but not limited to phone listing vendors, software and identification of phone number during registration processes, and attempt to confirm accurate phone numbers during on-site activities. The Contractor shall continue use of phone append services as a routine part of the IVR outreach campaign to targeted or identified members.

If a member is unable to be reached after the series of 3 phone calls/e-mails over a two (2) week time period, the member is placed into the ongoing "unable to reach" phone queue. IVR outreach and targeted mailings (e.g., "We're looking for you" postcard) outreach will be ongoing until either the member is engaged or opts out. Members who are still unable to be contacted after exhausting all avenues will continue to receive periodic educational mailings; undergo "watchful monitoring" in which each time the Contractor refreshes the claims data it receives, the member's claims are reviewed and if their condition changes, meaning they are re-identified as being at-risk, they are returned to active status and the appropriate PHM initiatives are employed.

The initial call with the Health Coach shall include a baseline assessment, requiring on average no more than 30 minutes of the participant's time. Health Coaches shall work with participants to identify a plan of care including goals, interventions, and identification of barriers to achieving goals and learning/strategizing with the Coach to identify ways to overcome the barriers.

Beyond outbound calls made by the Contractor to each participant, members shall be continuously encouraged to contact the program via phone through engagement, promotional and educational mailings to their home and on-site utilizing the Contractor's locally-based Outreach Coordinators and the State's Wellness Coordinators.

On an ongoing basis, the Contractor shall engage in a variety of outreach efforts via mail, e-mail, telephone, and broader strategies to solicit participation in the program. Broader population-based strategies shall include, at a minimum, on-site education provided during Health Fairs, Brown Bags and Biometric Screenings, collaboration with Agency Wellness Coordinators and committees, posters displayed in areas frequented by State employees; providing articles for inclusion in the State's newsletter and/or posting on the Web; and distribution of monthly tip-sheets to agencies.

4.0 Communications. The Contractor shall provide services to Eligible Members and health care providers to communicate PHM services, including:

4.1 Description of Services

The Contractor shall provide consistent Contractor and/or state of Ohio branding of all tools and resources available to Eligible Members, integration of the State's PHM program specifics, and information specific to state of Ohio Eligible Members.

The Contractor shall develop a multi-layered communications campaign to market the full range of PHM services provided by the Contractor to Eligible Members. Member education components shall include the following: engagement by local Outreach Coordinators; members' access to clinicians; access to on-line tools 24/7; distribution of health and preventive self-management reminders and education; distribution of print educational materials; distribution of bi-annual "Vitality" magazine; access to on-site lunch-and-learn sessions; the Contractor's participation in health fairs and wellness events; e-mail announcements, posters, brochures and business cards; quarterly program mailings to Eligible Members' homes; the Contractor's submission of content to the State's wellness print and on-line communications; and assistance to Wellness Coordinators to promote the Program.

Launch and Re-launch Communications – The Contractor shall create, produce, and send launch communications to Eligible Members' homes. The Contractor shall send mailing of initial PHM program materials and transition materials to transitioning participating Eligible Members' homes by 6/15/09. Re-launch communications shall be sent to current Eligible Members' homes by 9/15/09. Communications shall continue on a regular basis for the duration of the Contract.

The State shall review and approve all communications, including print and electronic, provided to the State's Eligible Members and Participants prior to submission to Eligible Members/Participants.

4.2 Provider Engagement.

The Contractor shall aggressively conduct outreach to Ohio providers and their staff through face-to-face meetings, medical society presentations and through outreach to business office managers to include an overview of PHM services and patient and provider communications, including enrollment information.

The Contractor shall establish collaborative partnerships with community-based providers from regional hospitals, physicians, and ancillary providers who are available to offer assistance with referrals, outreach, and engagement.

The Contractor shall work with the State to mutually define a vision and guiding principles for a Clinical Advisory Panel. The Contractor and the State shall determine the purpose and desired outcomes of the panel as well as the frequency of meetings.

The Contractor's locally-based Health Coaches and Outreach Coordinators shall meet with high volume providers to obtain feedback and input on the Contractor's services.

4.3 Union Engagement

The Contractor shall outreach to the State's labor unions and labor-management groups, including union leadership and agency labor-management committees. The Contractor shall work with labor leadership to educate them about the Program and solicit their support among their members.

5.0 Customer Service.

5.1 The Contractor shall provide customer service support to state of Ohio Eligible Members.

The Columbus Ohio Service Center shall be supported by after-hours messaging system and e-mail; response rate within one (1) business day.

Customer service shall be a single point of contact for Eligible Members provided by a staff that is dedicated or designated to the State account. The unit shall be knowledgeable about the details of the State's program and responsible for responding to all member program inquiries including those regarding incentives, requests for technical assistance, and concerns about the program. Formal complaints shall be acknowledged within five (5) business days of receipt and resolved within 30 calendar days

The customer service portal shall include a single, dedicated toll-free number for use by State members only. A live customer service representative shall be available 8:00 AM to 8:00 PM Monday through Friday.

Average speed of answer (ASA), defined as the average number of seconds it takes the Contractor's employee to answer an Eligible Member or provider telephone call, shall average 30 seconds or less. Timing of the ASA begins after the caller chooses the ACD prompt.

The percent of abandoned calls shall be less than 5%, measured by the number of callers who hang up before reaching a live person, excluding calls in which the caller hangs up within the first ten (10) seconds.

The Contractor shall monitor the quality of the calls received by the Contractor's service staff and provide call quality monitoring on a regular basis, no less than quarterly. Call monitoring and silent telephone monitoring results shall meet a 90% minimal compliance level.

6.0 Web Portal.

- 6.1 The Contractor shall provide a Web portal through which Eligible Members can access health-related information, tools, and resources.

The Contractor shall provide a comprehensive custom Web portal tailored to the state of Ohio program through which Eligible Members can access all PHM-related programs. Portal shall be user-centric and include instructions for its use.

The Contractor shall provide administrative access to the Web site so the State's program managers can provide assistance to inquiring members. The Contractor shall track member traffic to the Web site (e.g., new vs. repeat users, hits per month, etc.).

This portal shall be branded for the State and customized to reflect the demographics and needs of the State's members and the Program offerings. For example, "*Take Charge! Live Well!*", the State's branded PHM program, should be noted throughout the site if so requested by the State.

The Web portal shall include access to on-line services including the health risk assessment, on-line lifestyle change educational modules, and resources for all members of the population, including healthy and low risk members, moderate risk, and high risk members. Access to all health-related information shall be available through one site.

- 6.2 On-line lifestyle change educational modules shall include:

- 6.2.1 Commit to Quit tobacco cessation,
- 6.2.2 Healthy Weigh weight management,
- 6.2.3 Eat Right nutrition improvement program,
- 6.2.4 Bounce Back stress management program,
- 6.2.5 Care for Your Back program,
- 6.2.6 Overcoming Depression, and
- 6.2.7 Overcoming Insomnia.

- 6.3 Web Access. The Contractor's Web portal, resulting connective services, and access to Web services shall be available to Eligible Members with 99.9% availability for unscheduled down time. Scheduled maintenance for the Web site is any maintenance work that has been planned and included on a maintenance schedule approved by the State. Scheduled maintenance shall be conducted after 12:00 a.m. (midnight) and prior to 6:00 a.m. (EST – Columbus, OH time) and shall not exceed more than six (6) hours per week.

In the event that downtime interferes with membership access, the State reserves the right to discuss the matter with the Contractor and request adjustments to the Web site availability that shall meet Eligible Members' needs.

The Contractor shall alert the State's account liaison of any Contractor system down time, either scheduled or unscheduled. The Contractor shall re-establish connection within 24 hours of a business day, with the exception of scheduled routine maintenance.

The content on the Web site to which the State's Eligible Members shall have access shall be co-branded, approved by the State, and tested before 7/1/2009.

The Contractor shall maintain a Web site that is fully operational to Eligible Members. Fully operational includes, but is not limited to: the Web site is accessible to Eligible Members as noted above, the Web site is designed for use by individuals with a sixth-grade level education, and Web links work correctly.

7.0 Health Risk Assessment (HRA) Services. The Contractor shall provide a high-quality, HIPAA-compliant, validated health risk assessment questionnaire and related services. These services shall include the following:

7.1 HRA Instrument. The Contractor shall provide a State approved Health Risk Assessment (HRA) for each Eligible Member annually.

The HRA shall assess key health areas including weight, nutrition, physical activity, tobacco use, stress management, alcohol consumption, biometrics, preventive care, mental health, and health and medical history. The HRA shall gauge the participant's willingness to change.

The Contractor shall provide Web-based and print HRA in both English and Spanish, if requested by the state of Ohio.

Print and Web-based HRAs shall request Eligible Member's home, work, and cell telephone number without an additional fee.

The State of Ohio shall review and approve print and Web-based HRA formats, suppressing any questions objectionable to the State and adding customized questions (up to five [5] questions) at no additional cost to the State. The resulting HRA shall meet reasonable presentation standards.

7.2. HRA Completion Options. The Contractor shall provide each Eligible Member access to their choice of either a Web-based or paper HRA to complete on an annual basis and in successive years. Eligible Members may choose to complete a HRA in person, with the assistance of a local Outreach Coordinator at certain worksite events.

7.3 Print HRA – The Contractor shall mail a paper HRA to Eligible Members' homes, as requested, process the HRA upon return, and mail a paper individual profile within 7 business days to the Eligible Member at no additional cost to the State.

7.4 Web-based HRA – The Contractor shall provide a Web-based HRA that allows users the ability to review and edit responses and to save their information for completion at a later time. The Contractor shall make the Web-based HRA available 24 hours a day, seven (7) days a week, except for scheduled system maintenance times.

7.5 Assistance. The Contractor's staff shall assist Eligible Members in completing the Web-based and paper HRA, as needed.

7.6 HRA Communications and Promotions. The Contractor shall promote completion of HRAs by supplying Eligible Members with information on HRA confidentiality, how data shall be used, and advantages of participation.

The Contractor shall promote the HRA to Eligible Members through e-mail announcements, posters, brochures, direct mailings to Eligible Members' homes, Web site, on-site lunch and learns at the State's locations, articles prepared by the Contractor in the State's benefits communications, participation in the State's-sponsored health fairs, providing text to the State for posting on the State's Web site, and presentations at meetings with key State stakeholders.

7.7 HRA Results. The Contractor shall provide individual results to Eligible Members participating in the HRA, including an overall health evaluation and personalized and tailored action plan taking into account the Eligible Member's unique responses and readiness to change. The participant report shall also include identification of health priorities and recommendations, one-page summary of results including progress over time, links to additional health information, links to risk reduction program information, action steps, offer to provide copy of results to participant's physician, and overall health score. The Contractor shall target e-mails and promotions based on individual's results.

- 8.0 8.0 Worksite Health Screenings.
- 8.1 The Contractor, in partnership with The Kronos Group, shall provide worksite health screenings and counseling to Eligible Members to increase their knowledge of their own health and to promote preventive screenings.
- Eligible Members at large work sites shall have access to health screenings once a year.
- The Contractor shall be responsible for all screening logistics including securing staffing and coordinating details with the State's sites.
- 8.2 Screening Sites.
- The Contractor shall conduct screenings at work sites employing 100 or more Eligible Member employees (approximately 50 sites). For Eligible Members who work at smaller work sites or are dependents of an Eligible Member, the Contractor shall work with the State to link Eligible Members to screening services.
- 8.3 Description of Screenings.
- Screening package shall include non-fasting total cholesterol, HDL, diabetes/glucose testing, blood pressure measurement, weight measurement, height (self-reported), BMI calculation, and 3-to-5 minutes of post-results counseling.
- Blood draws for screenings shall be conducted using the finger-stick method.
- The Health Educator Counselor shall provide written results and explain results in 3-to-5 minute post-screening counseling to participant at conclusion of screening. Counseling shall include an explanation of test results, coaching on modifiable risk factors, and referrals to appropriate resources including, but not limited to, LM resources and treating physicians depending upon the level of risk. In cases where participant values place the participant at high risk, a referral form is used to advise the participant of the seriousness of the screening findings and a recommendation within an appropriate time-frame to seek follow-up care.
- 8.4 Engaging and Scheduling Participants. The state of Ohio and the Contractor shall collaboratively promote the biometric screening events.
- 8.4.1 The state of Ohio – The State shall promote participation in the event through its agency Wellness Coordinators and provide benefits communications to site employees. The State may choose to incent participation in worksite screenings.
- 8.4.2 The Contractor – The Contractor shall promote participation through site posters and mailings and promotional materials sent to site employees. The Contractor shall provide telephone scheduling for Eligible Members use.
- 8.4.3 On-Site Screening Staff – The Contractor shall provide a minimum of two (2) staff members for each screening site who have training in clinical techniques, quality control measures, bio-hazard/safety, appropriate state regulations, and HIPAA security and privacy regulations. Each event shall have a team lead.
- Counseling shall be conducted by educators/counselors with a minimum of a bachelor's degree and three (3) years experience with worksite wellness programs.
- Screenings shall be conducted by certified or licensed health professionals including phlebotomists, medical technicians, LPNs and RNs with at least three (3) years of clinical experience.
- 8.5 Additional Costs. The State shall not incur costs, above and beyond agreed upon fees paid, for travel, supplies, shipping and handling of supplies, telephone scheduling, and printing of marketing materials used to promote worksite health screenings.

9.0 Lifestyle Behavior Change.

9.1 Covered Services.

The Contractor shall provide lifestyle behavior change services via the Web, by phone, or in-person to Eligible Members. Lifestyle behavior change topics shall include back care, blood pressure, cholesterol management, nutrition, physical activity, tobacco cessation, stress management, and weight management.

Description of Services. Eligible Members identified as candidates for LM shall receive the following services, depending upon their risk level as identified by the Contractor.

Nature of Services Provided	Low Risk	Moderate Risk	High Risk
Access to Columbus-based Outreach Coordinators	X	X	X
Proactive outreach/welcome call by a Health Coach	X	X	X
Access to a Health Coach any time between the hours of 8:00 a.m. to 8:00 p.m. EST, Monday through Friday, including self-referrals	X	X	X
24/7 access to on-line LM programs and on-line tools	X	X	X
Monitoring and follow-up to ensure members who have started an LM program are continually engaged and completing activities	X	X	X
Help accessing local community human and social service resources such as transportation and medication assistance.	X	X	X
Welcome mailing.	X	X	X
Quarterly health and preventative self management reminders and educational materials	X	X	X
Semi-annual Vitality Magazine distributed to home.	X	X	X
Successful telephonic engagement (i.e., contact via phone between a Health Coach and the participant)	Minimum 4 calls/year	Minimum 5 calls/year	Minimum 12 calls/year

- 9.2 Telephonic Lifestyle Coaching. Coaching shall be provided telephonically and in-person by Health Coaches and Outreach Coordinators. Sessions shall include: readiness assessment and modification techniques; education and support; assistance in behavioral change; assistance in goal setting and achieving results; health monitoring; identifying and removing obstacles to effective self-management; assistance in using the Web-based tools and features; and coordination with Eligible Members' appropriate benefits to assist Eligible Members in addressing pertinent health issues.

The frequency of contact varies depending upon the participant's assessed risk level. Minimum successful telephone contact between a Health Coach and participant shall be as follows:

Low Risk:	Minimum of four (4) successful contacts per year
Moderate Risk:	Minimum of five (5) successful contacts per year
High Risk:	Minimum of 12 successful contacts per year

The actual frequency and duration of actual contact, including the number of calls and mailings will vary and be individualized according to the participant's health risk; the goal(s) they are working towards; their motivation; their confidence-level to make and sustain healthy lifestyle changes; their preference for call frequency; and any barriers they may need to overcome in order to achieve their goal(s).

Duration. On average, participants shall receive approximately 3.5 hours of one-on-one coaching over the course of 12 months with sessions lasting up to 30 minutes. On average, participants shall work with a Coach over a six (6) month period per lifestyle issue.

- 9.3 Health Coaches and Other Staff.

Registered Nurse Health Coaches shall be the primary staff responsible for providing coaching to Lifestyle behavior change participants. Coach: participant assignments shall be made based upon each Coach's skills and participant needs and goals.

Health Coaches shall be located in the Contractor's Service Center in Columbus, Ohio with back-up staffing provided by Brookfield, Wisconsin Health Coaches.

Other staff representing multiple disciplines including, but not limited to Registered Dietitians, Physical and Occupational Therapists, Licensed Social Workers, Certified Diabetes Educators, nutritionists, smoking cessation experts, exercise physiologists, pharmacists and physicians shall supplement the coaching provided by the primary Health Coach.

Health Coaches shall be responsible for:

Increasing participants' understanding of their specific health risks.

Motivating and empowering participants to make positive health decisions.

Assisting participants in establishing lifestyle behavior change goals and guiding participants through their personal wellness plan.

Educating participants on proper diet and exercise, smoking cessation and stress management.

Educating participants on their various benefits and how to access services.

Referring participants to other appropriate health benefits and resources (e.g., EAP, utilization management/case management).

Assisting with identifying obstacles to compliance and developing solutions tailored to participants' needs.

Linking participants to community resources.

Providing support and guidance.

Reinforcing scheduling routine testing, screening, and preventive care.

For phone-based LM participants, scheduling the next call at the end of each contact with the participant.

The Contractor shall provide Outreach Coordinators in key locations, including Columbus to administer the health improvement programs at worksites, during health and benefit open enrollment fairs and worksite screening events. The Contractor and the State shall collaboratively identify the health and benefit fairs the Contractor will attend.

- 9.4 Web-based Lifestyle Behavior Change. On-line lifestyle behavior change programs shall serve as a supplement to the Contractor's telephonic Health Coaching. On-line lifestyle behavior change programs focus on nutrition improvement, weight management, stress management, tobacco/smoking cessation, back care, depression, and insomnia. Programs shall include action plans customized according to each participant's lifestyle; identify and leverage motivators for change; and include tailored strategies to overcoming barriers to change:

**Eat Right! Nutrition Improvement Program.** By providing creative strategies for improving eating habits over time, Eat Right! Shall give participants the knowledge to make healthy food selections and the tools to maintain healthful eating habits in challenging situations. Eat Right! Shall be an eight (8) week program, which provides a customized, four-part action plan that shall be straightforward and easy to use. After answering detailed questions about eating habits and behaviors, the participant shall receive a 16-page tailored action plan, which includes personalized techniques for making healthy choices when dining out, shopping, and preparing meals.

**The Healthy Weigh! Weight Management Program.** The Healthy Weigh! shall comprehensively address three (3) critical elements of successful weight loss and maintenance: nutritional habits (food); physical activity patterns (body); and the psychological, emotional, and behavioral patterns (mind) that influence them. This three-pronged methodology shall be significantly more comprehensive than traditional weight management interventions and support programs. The Healthy Weigh! shall not be a pre-set nutrition and exercise plan, but instead teach participants how to make their own smart decisions about managing their weight. The Healthy Weigh! Weight Management Program is a six (6) week program.

**Bounce Back! Stress Management Program.** Bounce Back! shall be a five (5) week program, which provides a customized, four-part action plan that is straightforward and easy to use. After answering a series of in-depth questions about stress-related issues, the participant shall receive a 16-page tailored action plan, which includes personalized techniques for modifying behavior and attitudes related to stress management.

**Commit to Quit! Tobacco/Smoking Cessation Program.** Commit to Quit! shall provide a customized, four-part action plan that is straightforward and easy to use, with a program length based on the participant's chosen quit date. After answering detailed questions about smoking-related issues, the participant shall receive a 16-page tailored action plan that identifies motivations to give up smoking, the factors favoring success, and the barriers to quitting. Most importantly, the plan shall give participants tailored strategies for overcoming barriers and effective steps for managing withdrawal. The Commit to Quit! Tobacco/Smoking Cessation Program is a twelve (12) week program.

**Care for Your Back Low Back Pain Program.** Care for Your Back is a tailored approach to behavior change for the prevention and treatment of low back pain. The program addresses a member's motivations, drivers, barriers, hobbies and interests, work environment, exercise, knowledge of lifting and stretching, health status, low back pain history and specific lifestyle-related behaviors and therapeutic subtleties such as the relationship between issues like weight, smoking and stress on low back pain.

Overcoming Depression. The Overcoming Depression program provides strategies and exercises to build motivation. The program includes symptom management tools such as encouraging members to receive medical screenings, developing a plan to become more active and engaged in life, relaxation and visualization exercises and developing coping strategies for depressive symptoms, such as low motivation. The program also provides coping strategies for painful feelings such as sadness and anxiety. The relapse prevention plan helps the member identify early warning signs of depression and to develop an action plan to follow in the event of a relapse. Overcoming Depression provides access to social support through a moderated discussion board to communicate with those who have similar problems.

Overcoming Insomnia. Insomnia Program. Overcoming Insomnia is a six-week on-line program that uses techniques based on sound clinical evidence to help members recover from insomnia. Program features include: interactive exercises to assess sleep patterns, identify thoughts and behaviors that interfere with sleep, and monitor progress; sleep scheduling customized for each member; cognitive behavioral tools and techniques; gradual, effective tapering of sleep medication; evaluation of lifestyle habits and recommendations for change; and personalized feedback and reminders to help practice new skills and stay on track.

Eligible Members who choose to participate in Web-based lifestyle behavior change programs shall have access to three (3) follow-up tailored action plans through a private sign-in mechanism. Tailored action plans are delivered at certain intervals depending on the program and the member's lifestyle score and risk level.

10. Disease Management Services.

10.1 Covered Diseases. The Contractor's Disease Management services shall be provided to Eligible Members for five (5) disease states. The conditions included under disease management category are:

- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- Coronary Artery Disease
- Congestive Heart Failure
- Diabetes

10.2. Description of Services. Eligible Members identified as potential participants shall be automatically enrolled in the Program with the option to opt out. Potential participants shall receive the following services based upon their risk level as identified by the Contractor.

Nature of Services Provided	Low Risk	Moderate Risk	High Risk
Send introduction letter upon identification and initial claims stratification.	X	X	X
Make proactive outreach/welcome call by Health Coach.	X	X	X
Perform 2nd level stratification assessment.	X	X	X
Perform baseline and co-morbid Assessment, including depression assessment	X	X	X
Perform treatment gap assessment.		X	X
Develop a plan of care with the Eligible Member which: a. Includes specific long- and short- term goals. b. Includes specific Eligible Member and care management team interventions. c. Sets specific dates for completions of goals.		X	X
Collaborate with the participant's provider, Disability, Behavioral Health, and/or EAP business partners as appropriate.		X	X
Offer tools and education: a. Self-care guidelines b. Self-care books c. On line Healthwise Knowledgebase. d. On line Chronic Care Modules. e. On line Lifestyle Management programs. f. On line Lifestyle behavior change tools. g. Telephonic lifestyle behavior change programs. h. Educational mailings. i. Information on accessing the Contractor via 800#.	X	X	X
Welcome mailing with self care guide.	X	X	X
Quarterly Disease Management newsletters.	X	X	X
Semi-annual Vitality Magazine distributed to home.	X	X	X
Quarterly age/sex related preventive health reminder postcards distributed to home.	X	X	X
Successful engagement (i.e., contact via phone between a Health Coach and the participant)	Minimum 4 calls/year	Minimum 5 calls/year	Minimum 12 calls/year

- 10.3 Health Coach Assignment. Each participant shall be assigned a primary Health Coach who shall be a registered nurse (RN). The RN Health Coach shall be responsible for relationship building, leading the care management team for the participant, providing the majority of the counseling and coaching to the participant, and coordinating specialized counsel from other members of the care management team. Supplemental coaching provided by primary Health Coaches shall be other clinicians representing a variety of disciplines including, but not limited to Registered Dietitians; Physical and Occupational Therapists; Licensed Social Workers; Certified Diabetes Educators; nutritionists; smoking cessation experts; exercise physiologist; psychologists; pharmacists; and physicians.
- 10.4 Health Coaching. All participants shall be provided a variety of support services that apply principles of behavior modification and education to optimize participant self-management skills. Services shall be provided telephonically, on-line and by mail. Primary Health Coaches assigned to each participant shall:
- Help participants overcome barriers that are impeding them from living the healthiest lifestyle possible.
  - Assess health status including symptoms, biometric measures, and other physical findings.
  - Develop plans of care, in conjunction with treating physicians.
  - Assess, plan, implement, and evaluate participants' health education needs and educate participants about their disease state(s).
  - Apply behavior modification counseling methods to help participants comply with plans of care and adopt healthy self-care practices.
  - Monitor participant compliance with recommendations and intervene when non-compliance is identified, including but not limited to medication compliance monitoring.
  - Facilitate proactive planning for sick day and emergency preparedness;
  - Coordinate local resources that improve compliance with the provider's treatment plan;
  - Facilitate improved relationships and communications between the participant, their provider(s) and pharmacist.
  - Provide support and affirmation of progress made towards goals.
- 10.5 Guidelines. Health Coaches and other members of the Care Management Teams shall utilize behavior modification methodologies and clinical guidelines based upon current evidence-based practice standards.
- 10.6 Disease-Specific Educational Information. Participants shall be provided with disease-specific education materials on-line and in print.
- 10.7 Inbound Support Services. All participants shall be provided inbound access to the Contractor's Call Center 24 hours per day, 7 days per week. In addition, all participants shall be provided on-line access to The Contractor's Web-based health portal 24 hours per day, 7 days per week with the exception of scheduled maintenance periods.
- 10.8 Post-Active Engagement. The Contractor shall provide ongoing education, support and guidance until the member has adopted successful self-management skills to properly manage their condition, made the appropriate healthy lifestyle changes, and achieved an optimal level of health. Once a member has reached clinical stability and attained their set goals, based on their unique plan of care, they shall be placed in a "maintenance level" of care. Members who are at the maintenance level shall have the ability to speak with a Health Coach or Outreach Coordinator if the need arises, and they continue to receive periodic educational mailings. They also undergo "watchful monitoring"; in which each time the Contractor refreshes the claims data it receives from the client, the individual's claims are reviewed and if their condition changes, meaning they are re-identified as being at-risk, they are returned to active status and the appropriate health management initiatives are employed. During post-active engagement in the DM program, the member shall continue to receive periodic outreach by the Health Coach to "check in," in addition to postcard reminders and newsletters mailed to the home.

- 10.9 Physician Outreach. The Contractor shall commit medical leadership and other resources aimed at educating treating physicians about the disease management program and collaborating with them in the management of their consenting patients who participate in the Program. For moderate- and high-risk participants who have consented, the following communications shall be provided to treating physicians of disease management participants:
- A Program introductory letter in conjunction with notification of the Eligible Member's participation.
  - Periodic reports of the participant's clinical status.
  - Notification of urgent/emergent situations.
  - Requests for confirmation of participant's plan of care.
- Information regarding other medical and social services accessed by the participant.
- 10.10 Physician Engagement and Support Services. For moderate and high risk participants who have consented, in an effort to promote participant understanding and compliance with treatment plans, the Contractor shall make best efforts to:
- Seek physician participation in the development of individualized participant care plans.
  - Assist physicians in monitoring participants.
  - Interface with treating physicians with respect to non-compliance.
  - Work with physicians to develop more acceptable plans of care.
- 10.11 Other Physician Support Services. For moderate and high risk participants who have consented, Health Coaches shall also:
- Provide participants with reminders of critical medical appointments, reducing physicians' no-show rates, and improving health outcomes for participants.
  - Serve as the single point of coordination of healthcare needs for participants who take a disproportionate share of the physician's time.

11. Health Decision Support and Health Action Programs.

The Contractor shall provide tools and resources to empower Eligible Members to improve their decision-making skills in the appropriate use of health care services and to increase their understanding and subsequent adoption of healthy self-care practices. These health decision support services shall include nurse advice line, health action programs, Web-based health information and tools, and in-person services provided by the Contractor's Outreach Coordinators.

- 11.1 Nurse Advice Line. Eligible Members shall have telephone and on-line access 24 hours a day, seven (7) days a week to experienced registered nurses who shall provide the following services:

Triage guidance, support, general health information, and self-care instructions to help Eligible Members make informed decisions regarding health issues and questions that otherwise might lead to unnecessary medical or emergency room visits or delays in needed medical services. Nurse advisors shall utilize clinical algorithms that are based upon current, nationally recognized evidenced-based medical guidelines.

Education regarding a specific health concern/issue, and confirmation of the Eligible Member's understanding of such health concern/issue.

Assistance in helping Eligible Members better understand instructions provided by their physician(s) or other health care provider(s) and evaluate possible benefits and risks of tests, treatments and medications recommended or prescribed by their physician.

Assistance in preparing questions for physician office visits and similar encounters with other health care professionals.

Assistance in locating health care facilities and physicians.

Referrals to community resources.

Referrals to state of Ohio-sponsored health-related resources and services including, but not limited to: lifestyle management coaching; disease management; and case management.

Access to nurse advisors who are fluent in both English and Spanish. Translation services for other non-English speaking callers.

Ensure, as a minimum, that follow-up calls are made to Eligible Members who were triaged to emergency care (911) and offered to other Eligible Members who present with symptom-related concerns.

Provide 24/7 access to Audio Health Library providing access to over 1,000 health topics and announcements.

- 11.2 Health Action Programs The Contractor shall work collaboratively with the State to develop and deliver tailored health action programs, including but not limited to the following:

Ergonomics to address back and other musculoskeletal issues

Walking or fitness program

Weight reduction program

Such health action programs may include various features such as Brown Bag educational presentations, employee challenges and competitions, logs and other tools, and educational information related to topic.

- 11.3 Web-Based Health Information and Tools. Eligible Members shall have access to on-line support tools and resources which serve to support the Eligible Member in developing their plan for wellness. On-line tools and resources shall include:

Healthwise Knowledgebase. A collection of decision-focused information about conditions and available treatments.

Interactive medical library through A.D.A.M. A source of on-line health education resources, including health issues and chronic conditions. This encyclopedia of medical information shall serve as a support to the behavior interventions by enhancing the education of the participant.

Exercise and Stretching Libraries. A collection of on-line video lessons shall be provided in order to offer participants appropriate exercises with a full demonstration of proper technique.

Cookbook. Library of recipes for healthy meal selections.

Portion Control Tool. Tool to compare Member's knowledge of portion sizes with accepted recommendations.

Food Tradeoffs Tool. Tool to identify "best choices" within a food category.

Health Links. On-line referrals to additional health resources

Refill Reminder. Tool to enable Member to establish reminders for specific prescription refills.

BMI Calculator. Tool for determining one's BMI and information on the metric.

Fat Calculator. Tool for recording food eaten, serving sizes, calories, and fat grams.

Smoke-U-Lator. Tool for calculating the cost of one's cigarette habit.

"Do the Math" Smoking Assessment. Readiness to quit tool.

- 11.4 Self-Care Handbooks. The Contractor shall provide condition-specific and lifestyle behavior change-specific handbooks for the following subjects for Eligible Members participating in Health Coaching:

How Adults Can Manage Asthma  
Living Your Life With Diabetes  
Taking Care of Your Back  
Learning to Live with COPD  
Learning to Live with Heart Failure  
Healing Your Heart  
Taking Control of Your Weight  
Relaxation for Better Health  
Stress Management  
Creating Personal Eating and Exercise Plans

12. Incentive Management. It is the intention of the State to offer financial incentives to Eligible Members to encourage participation in the PHM program, including the Health Risk Assessment and other program components. The State may choose to incent one (1) or more behaviors including but not limited to: HRA participation, biometric screenings, health coaching program participation or completion, worksite health screening participation, well adult preventive care services, or others. This incentive, subject to funding and labor/management approval, may take the form of either premium reduction or cash payment.
- 12.1. Incentive Structure. The Contractor shall support the State in the development of incentive rules, processes, and administration guide for use by both the State and the Contractor.
- 12.2. Incentive Administration. The Contractor shall administer the incentive program. Administration of the incentive program shall include:
- In a collaborative effort with the State, develop an invitation, program description materials, and confirmation information for Eligible Members.
- The Contractor shall print and mail incentive information to Participants, at a minimum once a year.
- The Contractor shall produce, print and mail accurate confirmation statements to participants' home addresses at no additional cost to the State.
- The Contractor shall provide designated call center services staff located within The Contractor's Columbus Ohio Service Center who shall be trained on the State's incentive program. These designated contractor representatives shall be responsible for responding to incentive-related telephone calls, e-mails, letters, and other inquiries by Eligible Members, resolving disputes, answering questions, checking incentive program eligibility, confirming participation and completion of activities eligible for incentives, and providing potential referrals as necessary. Telephone support shall be available during normal business hours, 8:00 a.m. to 5:00 p.m. Eastern Standard Time, with voice mail available to Eligible Members during non-business hours.
- Provide on-going support to Eligible Members and those who elect participation after the initial implementation period and as Eligible Members complete the required incentive activities.
- Provide subsequent-year services to confirm Eligible Members' program eligibility and completion for subsequent years' incentive participation and ongoing program administration.
- As directed by the State, the Contractor shall track and administer incentives in conjunction with the following activities completed by Eligible Members such as:
- Completion of HRA.
  - Participation in any of the Contractor's component PHM programs including telephonic or on-line LM program or disease management.
  - Receiving preventive health care services as identified through claims.
  - Biometric values captured via worksite health screenings or other sources.
  - Achievement of specific goals or metrics (e.g., reducing cholesterol, weight loss, etc.)
  - Attendance at the Contractor's on-site educational program.
- The Contractor shall accept documentation of above submitted by multiple means including, but not limited to claims, HRA laboratory results, and documentation supplied by Eligible Members.
- The Contractor shall track individual members' activities, report incentive amounts to the State, reconcile reported data with the amounts applied by the State. Incentive amounts reported to the State shall not exceed the individual's maximum annual allowable award amount.

13. Management Reporting and Outcomes. The Contractor shall provide integrated, consolidated, timely, and accurate reporting of regular program activities, performance, and results.
  - 13.1 Risk and Condition Reporting. The Contractor shall provide reports of unique member participation in each risk or condition-specific program
    - Asthma
    - Chronic Obstructive Pulmonary Disease (COPD)
    - Coronary Artery Disease
    - Congestive Heart Failure
    - Diabetes
  
    - Nutrition
    - Weight management
    - Stress management
    - Tobacco/smoking cessation
    - Back care
    - Depression
    - Insomnia
  - 13.2 Executive Summaries. Quarterly and annual reports shall include executive summaries that outline highlights of the reporting period, opportunities for improvement, and specific recommendations.
  - 13.3 Dashboard Report. Quarterly and annual reports shall include a dashboard of key metrics
  - 13.3 Timeliness of Reporting. Monthly reports shall be provided within 20 calendar days following the month's end. Quarterly reports shall be provided within 45 days after a quarter's end. Annual reports shall be provided within 120 days following the end of the respective Contract year.
  - 13.4 Year to Date Reporting. The Contractor shall provide fiscal year to date reporting (i.e., statistics reflecting accumulated activity) with all monthly and quarterly reports.
  - 13.5 Benchmark Comparisons. For all results as noted in chart below, the Contractor shall compare the State's results to industry benchmarks, such as HEDIS or other commonly accepted benchmarks.
  - 13.6 Reporting by Agency. At the State's request, the Contractor shall capture and report on all agreed metrics at the agency level.

13.7 Report Content and Frequency. Report content and frequency shall include the following: Index No.

REPORT	BOOK OF BUSINESS COMPARISON	MONTHLY	QUARTERLY	ANNUALLY
Demographics	X	X	X	X
Participation rates for:	X	X	X	X
HRA	X	X	X	X
On-line LM programs, by program	X	X	X	X
Health & wellness phone coaching, by program	X	X	X	X
DM, by condition	X	X	X	X
Biometric health screenings	X	X	X	X
Nurse advice line	X	X	X	X
Completion rates for:	X	X	X	X
On-line LM programs	X	X	X	X
Health & wellness phone coaching	X	X	X	X
HRA outcomes including but not limited to:	X		X	X
Health status	X		X	X
Disease prevalence	X		X	X
Stratification of risks	X		X	X
Engagement:	X	X	X	X
Number of identified candidates for each DM condition and each lifestyle program	X	X	X	X
Number of participants engaged with a health coach by each DM condition and lifestyle program	X	X	X	X
Outreach details	X	X	X	X
Unable to reach details	X	X	X	X
Duration in program	X	X	X	X
Web portal utilization	X	X	X	X
Number of hits	X	X	X	X
Number of unique users	X	X	X	X
Risk status and outcomes	X	X	X	X
Stratification of the population by risk level	X	X	X	X
Prevalence of health risks by risk level	X	X	X	X
Biometric clinical results of those completing health screenings	X	X	X	X
Number of participants who improved health score	X	X	X	X
Risk reduction and elimination by risk area	X	X	X	X
Clinical outcomes	X	X	X	X
Participant improvement in functional status and quality of life	X	X	X	X
Estimated costs of risks and projected savings from risk reduction				X
Customer service	X	X	X	X
Average speed of answer	X	X	X	X
Call abandonment rate	X	X	X	X
Number of calls	X	X	X	X
During business hours	X	X	X	X
After business hours	X	X	X	X
Nurse Advice Line utilization	X	X	X	X
Call statistics	X	X	X	X
Results of health decision making	X	X	X	X
Participant satisfaction				X
Changes in utilization (e.g., ER, office visits, inpatient, Rx, etc.)				X
ROI				X
Time over time comparisons				X

14. Performance Metrics.

14.1 The Contractor shall meet agreed upon performance guarantees, with fees at risk for performance targets not met according to the chart below:

Component	Description of Metric	Measurement Specifications	Fees at Risk
Success of Implementation	A detailed work plan is created for the State to track progress at each phase of implementation	Measured at end of Year 1, the Contractor shall achieve 90% of all implementation milestones on time according to our mutually agreed upon implementation and work plans. This assumes no delays that are out of the control of the Contractor created by the State or other State vendor partners.	5% of total fees
Client Satisfaction with Account Management	90% satisfaction	Measured annually, the Contractor shall achieve 90% satisfaction (i.e., satisfied or very satisfied) using a mutually agreed upon account management satisfaction survey tool.	5% of total fees
Participant Satisfaction	90% satisfaction	Measured annually, the Contractor shall achieve 90% satisfaction (i.e., satisfied or very satisfied) using the Disease Management Association of America (DMAA) survey tool (See RFP Exhibit S).	1% of total fees
Participation rates			
HRA	45% participation of Eligible Members	Measured annually, the Contractor shall achieve a 45% participation rate and shall calculate the percent participation by dividing the number of completers by the number of Eligible Members.	1% of Web and Print HRA fees
LM	25% participation	Measured annually, the Contractor shall achieve a 25% participation rate and shall calculate the percent participation by dividing the number of participants in the LM program by the number of people who complete an HRA.	1% of Lifestyle Management and On-line Program fees
DM	75% participation	Measured annually, the Contractor shall achieve a 75% participation. The Contractor shall calculate the percent participation by dividing the number of members who choose not to opt-out by the total number of Eligible Members identified for the Program.	1% of DM fees
HDS (Nurse Advice Line)	2% utilization	Measured annually, the Contractor shall achieve a 2% utilization rate, and calculate the utilization rate by dividing the number of calls received for individual needs by the number of eligible employees and spouses.	1% of Nurse Advice Line fees

Clinical Outcomes			
Component	Description of Metric	Measurement Specifications	Fees at Risk
Asthma	% of Members with Script for Appropriate Medications	Measured annually, 5% improvement in percentage of members identified with Asthma who have claims evidence of a script for appropriate Asthma medication during the Measurement Period vs. previous year. "Members identified" are those members Identified with Asthma and still plan eligible at end of the Measurement Period.	1% of Core Asthma DM Fees
Diabetes	% of Members Identified with Diabetes that completed HgbA1c during the Measurement Period	Measured annually, 5% improvement in percentage of members identified with Diabetes who have claims evidence of HgbA1c screening during the Measurement Period vs. previous year. "Members identified" are those members identified with Diabetes and still plan eligible at end of the Measurement Period.	1% of Core Diabetes DM Fees
CAD	% of Members with CAD with completed Lipid Test during the Measurement Period	Measured annually, 5% improvement in percentage of members identified with CAD who have claims evidence of Lipid screening during the Measurement Period vs. previous year. "Members identified" are those members identified with CAD and still plan eligible at end of the Measurement Period.	.5% of Core CAD DM Fees
CAD	% of Members with Script for Statin Medication	Measured annually, 5% improvement in percentage of members identified with CAD who have claims evidence of a script for Statin medication during the Measurement Period vs. previous year. "Members identified" are those identified with CAD and still plan eligible at end of the Measurement Period.	.5% of Core CAD DM Fees
CHF	% of Members with CHF with LVF evaluation during the Measurement Period	Measured annually, 5% improvement in percentage of members identified* with CHF who had a left ventricular function (LVF) assessment done during the Measurement Period vs. the previous year. "Members identified" are those identified with CHF and still plan eligible at end of the Measurement Period.	1% of Core CHF DM Fees
COPD	% of Members on a Bronchodilator	Measured annually, 5% improvement in percentage of members identified with COPD who have claims evidence of filling a script for a Bronchodilator during the Measurement Period vs. previous year. "Members identified" are those identified with CHF and still plan eligible at end of the Measurement Period.	1% of Core COPD DM Fees
Return on Investment			
ROI	Programs shall demonstrate a 1.5:1 ROI after Year 1 based on valid methodology	Measured annually, the Contractor shall achieve a 1.5:1 ROI after Year 1 based on the mutually agreed upon measurement methodology as calculated by the Contractor's actuarial staff.	5% of total fees

14.1 Clinical Outcomes Notes.

For each measurement specification, the percentage improvement listed is a relative percentage improvement. A cap on levels of performance achievement will be set for each metric based on current national achievement standards and agreed upon at the beginning of each contract year. These cap achievement target ranges will be set at an absolute target of 90% or 105% of the commercial HEDIS 90th percentile threshold whichever is lower. No fees will be at risk if metrics achieved are at or above agreed upon achievement standards even if listed percentage improvement metrics are not met. If metrics are below the caps, measurement specifications apply, as outlined in the table above.

Fees at risk are proportional to achievements demonstrated (i.e., if a 5% improvement is required and a 4% metric is achieved, fee penalties will be 20% of 1%).

Program fees at risk for each disease state/condition are fees at risk for each disease state/condition being tracked and not fees for the total of all DM programs combined.

14.2 Additional Metrics.

Additional metrics that are measured and reported to the State without fees at risk.

Diabetes	% of participants with 2 or more HgbA1C per year % of participants with HgbA1C result 10 or > % of participants with HgbA1C 7.1 to 9.9 % of participants with LDL-C completed within 1 year % of participants with annual foot exam % of participants with annual dilated retinal eye exam ER visits/1000 Inpatient days/1000
CHF	% of participants on ACE/ARB % of participants on beta blocker Inpatient days/1000
CAD	% of post MI participants on ACE/ARB ER visits/1000 Inpatient days/1000
COPD	% of members with Spirometry results % of members who quit smoking or are in a smoking cessation program % of members Stage 1 on short-acting Bronchodilator & % of members Stage II, III, and IV on Long-acting Bronchodilator % of members with Stage III and IV on Glucocorticosteroids % of members in Pulmonary Rehab for exercise training ER visits/1000 Inpatient days/1000
Asthma	# of Asthma Members on Rescue Inhaler Number of members with Persistent Asthma on Inhaled Corticosteroids Inpatient days/1000

15. Methodology for Return on Investment (ROI) Calculations. For each Measurement Period of the Contract period, the Contractor shall measure and report the ROI for all PHM Program elements in aggregate. To TTTTo oo To determine ROI, the Contractor shall conduct the analysis as indicated below.

As a starting point, the Contractor uses assumptions to organize and prepare the membership and claims financial data:

- a. Establish a Baseline Period: The 12 or 24 month period immediately preceding the effective date.
- b. Establish a Target Trend: The mutually agreed upon claims trend for the period immediately preceding the effective date, calculated using actual group data for the three-year period immediately preceding the effective date, or other basis as mutually agreed.
- c. Define the Measurement Period: The period commencing on the effective date or after a mutually agreed upon ramp-up period, and ending at the end of the Contract or a mutually agreed upon interim date.
- d. The Measurement Group is the population of Eligible Members less the Excluded Members.
- e. Eligible Members must be enrolled in the client health plan for at least three (3) months in both the Baseline and Measurement Periods, and also must be participating in one of the management programs for at least three (3) months in the Measurement Period
- f. Exclusions:
  - 1) Costs for members with combined medical and pharmacy claims in excess of \$100,000 in either the baseline or the Measurement Period will be capped at \$100,000 for purposes of the measure. For smaller group sizes, a lower cap may be required.
  - 2) Members with HIV/AIDS, malignant cancer, transplants, end state renal disease and infertility are Excluded Members
- g. Other adjustments for items such as benefit changes and changes to reimbursement levels may be made if applicable, and mutually agreeable to the State and the Contractor.

Once the data preparation is completed, the Contractor shall then compute the return on investment:

- |            |   |
|------------|---|
| Step One   | Calculate the Measurement Group incurred claims PMPM for the baseline period, and apply the Target Trend to the midpoint of the Measurement Period to develop the Unmanaged PMPM. |
| Step Two   | Calculate the incurred claims PMPM for the Measurement Period. This is the Managed PMPM.  |
| Step Three | Subtract the Managed PMPM from the Unmanaged PMPM to determine the PMPM Savings.  |
| Step Four  | Multiply the PMPM Savings by the total member months during the Measurement Period for all members participating in any of the management programs. This is the Total Savings.    |
| Step Five  | Divide the Total Savings by the total associated program fees for the corresponding Measurement Period to determine the ROI.  |

16. Pricing and Fees.

- 16.1 The Contractor's Firm Fixed Price. Fees paid to the Contractor from the State shall be based upon the number of lives covered, on a per employee, per month (PEPM) pricing model. Exceptions to the firm fixed pricing are contained in paragraphs 16.5 and 16.6 below (All pricing and costs shall be reflected in U.S. dollars).
- 16.2 Final Pricing. Final pricing is represented as presented in the Best and Final Offer submitted by the Contractor on February 2, 2009 and supplemental clarification provided on February 17, 2009.
- 16.2 Number of Employees. The estimated annual PHM program cost component projections below are based upon an estimate of 51,895 employees. The actual number of employees will vary each month.
- 16.3 Per Employee Per Month (PEPM) Fee. The State shall pay PEPM fees set forth in the table below for each Eligible Employee, for . This fee structure reflects the 2-part implementation process, for Year 1:

Beginning date	PEPM Fee	Covered Employees
7/1/2009	\$ 5.99	For Aetna and United Healthcare enrolled employees.
10/1/2009	\$ 5.99	For all enrolled employees (Aetna, United Healthcare, Medical Mutual, Paramount, and The Health Plan).

- 16.4 Total Cost. The actual total cost of the PHM Program shall be calculated using the rates in the table in 16.3 which shall be calculated monthly based on the actual number of employees. Annual cost projections are based on the PEPM pricing model multiplied by a 12 month year.
- 16.5 Adjustment in the Event Assumptions. Should actual performance differ by more than +20% or -10% in any one assumption or combination of assumptions in Attachment 12 of the RFP, the Contractor and the State reserve the right to negotiate in good faith changes to fees, but in no event shall the State's fees increase more than 10% of the total cost for any Contract year.
- 16.6 Economic Price Adjustment. In the event that the State and the Contractor elect to renew this Contract beyond the initial three (3) year term, fees in Year 4 and Year 5 shall not exceed the Consumer Price Index for All Urban Consumers (CPI-U) to a maximum of 3%.
- 16.7 Invoices. Within 15 days of the start of each month during the Term of the Contract, commencing with the month in which falls the Commencement Date, the Contractor shall invoice the State the fees for the current month, based on the number of Eligible Members enrolled in the previous month. Changes in fees due to changes in member eligibility shall be represented as an adjustment on the succeeding month's invoice. The Contractor shall submit a proper itemized invoice in accordance with ORC Section 125.01 (B).
- 16.8 Payment of Fees. Payments to the Contractor shall be remitted by check within 30 days after receipt of a valid invoice at the following or at such other address as may be specified to the State in writing or via electronic deposit in an account specified to the State in writing:

Innovative Resource Group  
 PO Box 890903  
 Charlotte, NC 28289-0903

16.9 Fee Reconciliation. The Contractor shall provide a return of a percentage of the fees in partial proportion to the actual levels of participation. The State will refer to this process for calculating a return of fees as a Fees Reconciliation.

a. Fees will be reconciled as follows for the Disease Management program:

Set DM Participation Number Targets Using Best and Final Pricing Grid: Core DM projection was 2,848 participants.

For each Measurement Period, the Contractor shall pay back 1% of Core DM Fees for every 5% reduction in the number of participants compared to the 2,848 projected participant count.

For purposes of this reconciliation, Participants shall be defined as members who have completed as least one (1) telephonic assessment or coaching call during the Measurement Period where completed means that member discussed health information with Health Coach.

Example:

At the end of Measurement Period 1, the Contractor reports that 2,200 participants completed at least one (1) assessment or coaching call.

Participation is 23% less than projected

The Contractor would owe back 4% of Core DM fees (23%/5%)

b. Lifestyle Behavior Coaching (LBC):

Set LBC Participation Number Targets Using Best and Final Pricing Grid: Projection was 5,000 members.

For each Measurement Period, the Contractor shall payback 1% of LBC Fees for every 5% reduction in the number of participants compared to the 5,000 projected participant count.

For purposes of this reconciliation, Participants shall be defined as members who have completed as least one (1) coaching call during the Measurement Period where completed means that member discussed health information with nurse or coach.

Example:

At the end of Measurement Period 1, the Contractor reports that 4,000 participants completed at least one (1) coaching call.

Participation is 20% less than projected

The Contractor would owe back 4% of Lifestyle fees (20%/5%)

c. Nurse Advice Line (HDS) - 5% Utilization is the target

For every one (1) percentage point reduction in the utilization rate below 5%, Nurse Advice Fees should be reduced by 5%

Example:

The Contractor reports 4% utilization for Measurement Period 1

The Contractor would owe back 5% of Nurse Fees

16.10 Fees.

UNSPSC Code: 85000000 (Healthcare Services)  
 OAKS Line Item Number: 15816

Rates are identified as follows (Year 1: July 1, 2009 – June 30, 2010):

PHM Program Fees Pricing Methodology:			
PROGRAM AREA	PEPM	PEPM Total	Program Annual Totals (based on 51,895 employees per month)
a. General Contractor		\$0.79	\$492,483
b. Disease Management		\$2.70	\$1,679,296
1). COPD	\$0.33		\$205,840
2). Coronary Artery Disease	\$0.47		\$290,356
3). Congestive Heart Failure	\$0.26		\$159,468
4). Diabetes	\$0.99		\$617,159
5). Asthma	\$0.65		\$406,473
c. Health Decision Support		\$0.41	\$258,437
d. HRA		\$0.27	\$169,385
e. LM (phone)		\$0.45	\$282,724
f. LM (Web portal/on-line programs)		\$0.14	\$87,184
g. Incentive Management		\$0.16	\$99,638
h. Worksite Health Screenings		\$0.43	\$268,557
i. Communication		\$0.41	\$252,550
j. Health Action Plan		\$0.23	\$143,703
Total Projected Fees for all PHM Services (Year One Pricing) and subject to ROI calculation		\$5.99	\$3,733,957

Rates are identified as follows (Year 2: July 1, 2010 – June 30, 2011):

PHM Program Fees Pricing Methodology:			
PROGRAM AREA	PEPM	PEPM Total	Program Annual Totals (based on 51,895 employees per month)
a. General Contractor		\$0.81	\$507,257
b. Disease Management		\$2.78	\$1,729,675
1). COPD	\$0.34		\$212,015
2). Coronary Artery Disease	\$0.48		\$299,067
3). Congestive Heart Failure	\$0.26		\$164,252
4). Diabetes	\$1.02		\$635,674
5). Asthma	\$0.67		\$418,667
c. Health Decision Support		\$0.43	\$266,190
d. HRA		\$0.28	\$174,467
e. LM (phone)		\$0.47	\$291,206
f. LM (Web portal/on-line programs)		\$0.14	\$89,799
g. Incentive Management		\$0.16	\$102,628
h. Worksite Health Screenings		\$0.44	\$276,614
i. Communication		\$0.42	\$260,127
j. Health Action Plan		\$0.24	\$148,014
Total Projected Fees for all PHM Services (Year Two Pricing) and subject to ROI calculation		\$6.18	\$3,845,977

Rates are identified as follows (Year 3: July 1, 2011 – June 30, 2012):

PHM Program Fees Pricing Methodology:			
PROGRAM AREA	PEPM	PEPM Total	Program Annual Totals (based on 51,895 employees per month)
a. General Contractor		\$0.84	\$522,475
b. Disease Management		\$2.86	\$1,781,565
1). COPD	\$0.35		\$218,376
2). Coronary Artery Disease	\$0.49		\$308,039
3). Congestive Heart Failure	\$0.27		\$169,179
4). Diabetes	\$1.05		\$654,744
5). Asthma	\$0.69		\$431,227
c. Health Decision Support		\$0.44	\$274,176
d. HRA		\$0.29	\$179,701
e. LM (phone)		\$0.48	\$299,942
f. LM (Web portal/on-line programs)		\$0.15	\$92,493
g. Incentive Management		\$0.17	\$105,706
h. Worksite Health Screenings		\$0.46	\$284,912
i. Communication		\$0.43	\$267,930
j. Health Action Plan		\$0.25	\$152,455
Total Projected Fees for all PHM Services (Year Three Pricing) and subject to ROI calculation		\$6.37	\$3,961,355

16. The Contractor shall complete the Business Associate Agreement included in Supplement One of the RFP.

CONTRACTOR INDEX

CONTRACTOR AND TERMS:

CONTRACT NO.: CSP902609 (06/30/12)

OAKS Vendor ID No.: 139748

Innovative Resource Group, LLC  
dba APS Healthcare Midwest  
44 South Broadway, 12<sup>th</sup> floor  
White Plains, NY 10601

TERMS: Net 30 Days

CONTRACTOR'S CONTACT:

Primary:  
Verdene Thompson, RNC, CCM, MSHA  
Executive Director, Ohio Service Center  
751 Northwest Blvd., Suite 301  
Columbus, OH 43212

Telephone: (800) 305-3720 x 5660

FAX: (614) 255-0763

E-mail: vthompson@apshealthcare.com

Secondary:  
Julie Fisher  
Sr Vice President, Business & Product Development  
Westchester One  
44 South Broadway, Suite 1200  
White Plains, NY 10601

Telephone: (914)288-4798

FAX: (914) 288-4605

E-mail: jfisher@apshealthcare.com

PAYMENT ADDRESS:

Innovative Resource Group  
PO Box 890903  
Charlotte, NC 28289-0903  
Attn: Accounts Receivable

To remit by means of Wire/ACH, contact the Contractor's Primary Contact for account information.