STATE OF NORTH CAROLINA
Department of State Treasurer
NC State Health Plan for Teachers and State Employees

REQUEST FOR INFORMATION NO. 270-20240419GLP

RESPONSE FROM:

SWITCHBRIDGE, LLC

May 29, 2024

EXECUTION

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THE ENCLOSED FLASH DRIVE IS ENCRYPTED BUT CONTAINS NO CONFIDENTIAL OR PROTECTED HEALTH INFORMATION.

THE CASE-SENSITIVE PASSWORD IS: NCSHPabc123

OVERVIEW

The phenomenon recently experienced by the North Carolina State Health Plan for Teachers and State Employees (NCSHP) related to the dramatic increase and further projected increase in utilization and cost for glucagon-like peptides (GLP-1s) and gastric inhibitory polypeptide (GIP) agonists for weight loss is occurring nationally in similar healthplans and presents a unique opportunity for the State of North Carolina to construct a data-driven, responsive strategy, as well as, a platform for managing this and other similar sorts of challenges which are bound to present in the future.

Therefore, the purpose of the Switchbridge[1] RFI responses is intended to provide the Department of State Treasurer with the requested information, recommendations, and potential solutions that will enable the coverage of these types of weight loss medications (e.g. GLP-1, GIP-GLP-1 agonists, other similar new molecular entities, etc.) for those NCSHP members who need them the most, in both a clinically and fiscally responsible manner over the near-term and long-term by integrating their usage within the context of an overall efficacious and clinically sound medical weight management program.

In addition to clinical soundness, another key feature of our proposal is the assurance of technological agility to enable the bi-directional integration of innovations to address and solve this and similar issues. While the challenge of these GLP-1s/GIP-GLP-1s is certain to endure for years – especially as new treatment indications are discovered for this sub-class of drugs – healthplans nationally will continue to be confronted with this same challenge as expensive, novel medications flood the market and require similar value assessments and creative coverage approaches for a wide range of treatment modalities. By leveraging the Switchbridge platform across NCSHP's existing data warehouse, we will not only focus on the RFI but will also have the ability to review clinical and fiscal opportunities across the entire benefit plan.

In order to achieve the objectives presented in the RFI, our proposal endeavors to illustrate various approaches to:

1. Enable NCSHP to provide benefit coverage to Plan members to use GLP-1, GIP-GLP-1 agonists, and other similar new molecular entities, for the purpose of weight loss.
2. Permit the Plan to provide this coverage in a fiscally responsible and sustainable manner through such strategies as:
    a. Paying for specific patients based on BMI thresholds. This will allow costs to be controlled and the plan will not be at the mercy of the manufacturer and/or Pharmacy Benefit Manager (PBM).
    b. Structuring the AOM GLP1/GIP benefit in a way that takes advantage of Eli Lilly and Novo Nordisk's cash pay program. This will allow the net cost to be $550 and/or $650 respectively for the product. Setting a reasonable co-pay and/or reimbursement from the State will help to control the cost of the medications for the appropriate patients.

    c. Auditing claims, rebates, and prior authorizations for accuracy and compliance with applicable laws and regulations.
3. Establish a program outlining specific eligibility requirements, parameters, or other prerequisites for Plan members to follow in order to receive benefit coverage of these and similar drugs for weight loss which may include:
    a. Requirement that an approved weight loss program or nutrition classes be completed before approval of payment for the medication.
    b. Development of step therapies involving lower cost medications.
    c. Requirement that medications be prescribed by a practitioner with appropriate levels of expertise (i.e. narrowing the provider network).
    d. Prohibition of Body Mass Index (BMI) measurements from being estimated via telehealth visit to ensure accuracy and accountability, while enabling a data collection process that supports the successful implementation of the benefit.
4. Provide the potential for establishing a program wherein the Plan has the flexibility to establish parameters for utilization management of these and other similar weight loss drugs which may include considerations such as (but not limited to):
    a. Body Mass Index (BMI);
    b. Current and achieved weight;
    c. Documented history of lifestyle modifications including reduced calorie intake and increased physical activity;
    d. Documented enrollment and measurable participation in nutritional and/or dietary programs;
    e. Consideration of evidence for and impact of one or more co-morbid conditions or other obesity-related medical conditions;
    f. Data analytics and reporting tools supporting successful member targeting, claims adjudication, member participation and achievement, program evaluation, etc.;
    g. Requirements for in-person treatment visits to verify efficacy of specific medications for participants; and
    h. Other parameters supporting the achievement of the Plan's objectives of serving members who need these medications the most and offering alternative programs for obese members deemed not to be in the highest risk category.
5. Provide pricing structures, cost estimates and other relevant expense information related to the recommendations and potential solutions submitted.

Obviously, the veracity of this and other proposals will improve dramatically after a focused period of discovery with the State and during a formal Request for Proposal (RFP) process. Access to specific data will inform and improve specific recommendations, program designs, patient parameters, cost projections, etc.

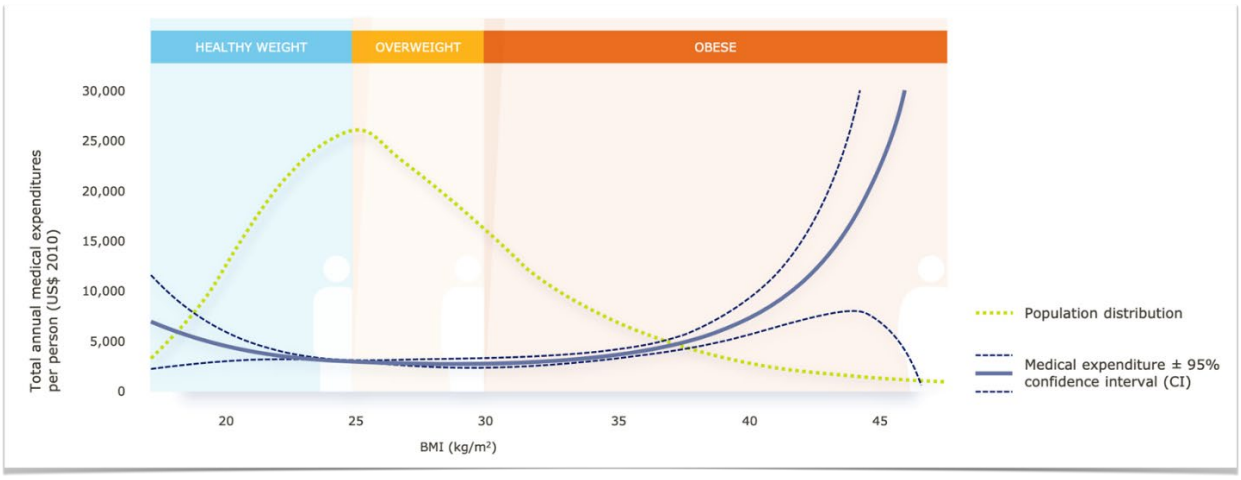
It is also important to note that our proposal considers the health of family members as well as the health of the employee. Through education about healthier approaches to daily

living, professional support to implement and achieve new and sustainable habits, etc. the sentinel effect will positively permeate families and individual communities throughout the entire State of North Carolina to offer a path to wellness and the avoidance of obesity and the large number of related co-morbidities that are wreaking personal and financial havoc on employees, other citizens and healthplans across the State.

As requested, this proposal represents a high-level set of vetted ideas representing the current state of thought and best practices in this rapidly evolving area of benefits coverage based on a clinically sound, patient-centric, carved-out weight management solution. As alluded to earlier, this proposal is meant to encourage further exploration and discussion.

Our primary goal has been to provide the Department of State Treasurer with sufficient evidence of our desire, proven expertise, and ability to advise, collaborate with, and support the Department in solving the current NCSHP GLP-1/GIP-GLP-1 agonist problem to be invited to participate in a comprehensive, specific Request for Proposal (RFP) process to further detail, explain and develop the solution with the input and feedback of Department's staff.

Throughout this proposal, we are recommending the initial use of these drugs (GLP-1/GIP-GLP-1 agonists) for those members with a Body Mass Index (BMI) greater than or equal to 40. As illustrated below, medical costs increase dramatically once a person's BMI exceeds 40. We believe that this population of NCSHP members represents the most obvious cohort for targeting, inclusion, and study, as well as, the greatest opportunity for predicted cost savings throughout the healthplan.



In addition, it is our strong recommendation that all patients must successfully complete a nutrition and behavioral therapy program for six (6) months prior to being approved for GLP-1/GIP-GLP-1 agonists therapy.

Lastly, it is also our strong recommendation that NCSHP adopt a very narrow prescribing network for these medications such that only approved ABOM and bariatric physicians are able to prescribe for NCSHP members under this program.

We would like to thank and highlight the professionals who have collaborated to architect this approach, solution, and proposal and who, most importantly, will participate in the final development, deployment, and management of any specific solution the State may choose to pursue, including: Mary Ellen Gervais, PhD, RN, CCM; Kelly Chillingworth, RPh, MHA-Ed; Ronald DeVizia, Jr., PharmD; Jason Williams; Ryan Resnick; and Aaron Davis.

We sincerely thank you for considering our response. We welcome the opportunity to meet with the Department of State Treasurer staff to answer any questions you might have and/or discuss any items of particular interest.

USE OF DATA AND ANALYTICS

An essential feature of our response relates to the need to capture and fully integrate NCSHP data from claims and other sources. This function would be performed by Switchbridge[1] and can be operationalized from the NCSHP data warehouse or directly from the data sources (e.g. carriers, PBMs, labs, wellness companies, biometric firms, on-site/near-site clinics, etc.).

As an independent data activation platform, Switchbridge is also designed to integrate with an unlimited number of data analytics, programs, point solutions, etc. – the kinds of tools that will be either helpful or essential to the success of this project – such that only the top-performing tools will be selected and deployed for NCSHP.

Furthermore, Switchbridge now has a number of clients who are using multiple analytics against the same data to help meet complex needs. This phenomenon is likely to increase over the next few years as more and more specialized analytics are developed and the cost of each continues to drop. This capability will enable NCSHP to stay on the cutting edge of analytics and not be subject to technological obsolescence if and when superior tools are available.

Switchbridge is currently working with or vetting, through an extensive RFI process, approximately 100 data analytics and point solutions that address nearly all aspects of healthcare quality and cost-containment – with many focused on pharmaceuticals. Each analytic and point solution is reviewed clinically, technically, financially, and administratively in order to assess their soundness and efficacy before being offered to clients.

But Switchbridge doesn't stop at the point of activating analytics and point solutions. Uniquely, Switchbridge is a bi-directional data activation platform where outputs, insights and findings from all connected analytics and point solutions are ingested back to the member level within the data warehouse. Every data element ingested by Switchbridge can be transferred for storage and/or use to the NCSHP's own data warehouse.

Of course, integrating multiple tools adds complexity and can be hard to track. Last year, Switchbridge deployed a first-of-its-kind dashboard which combines key performance indicators and other information from all deployed analytics and point solutions in one place for a clear view into the outcomes of the entire solution.

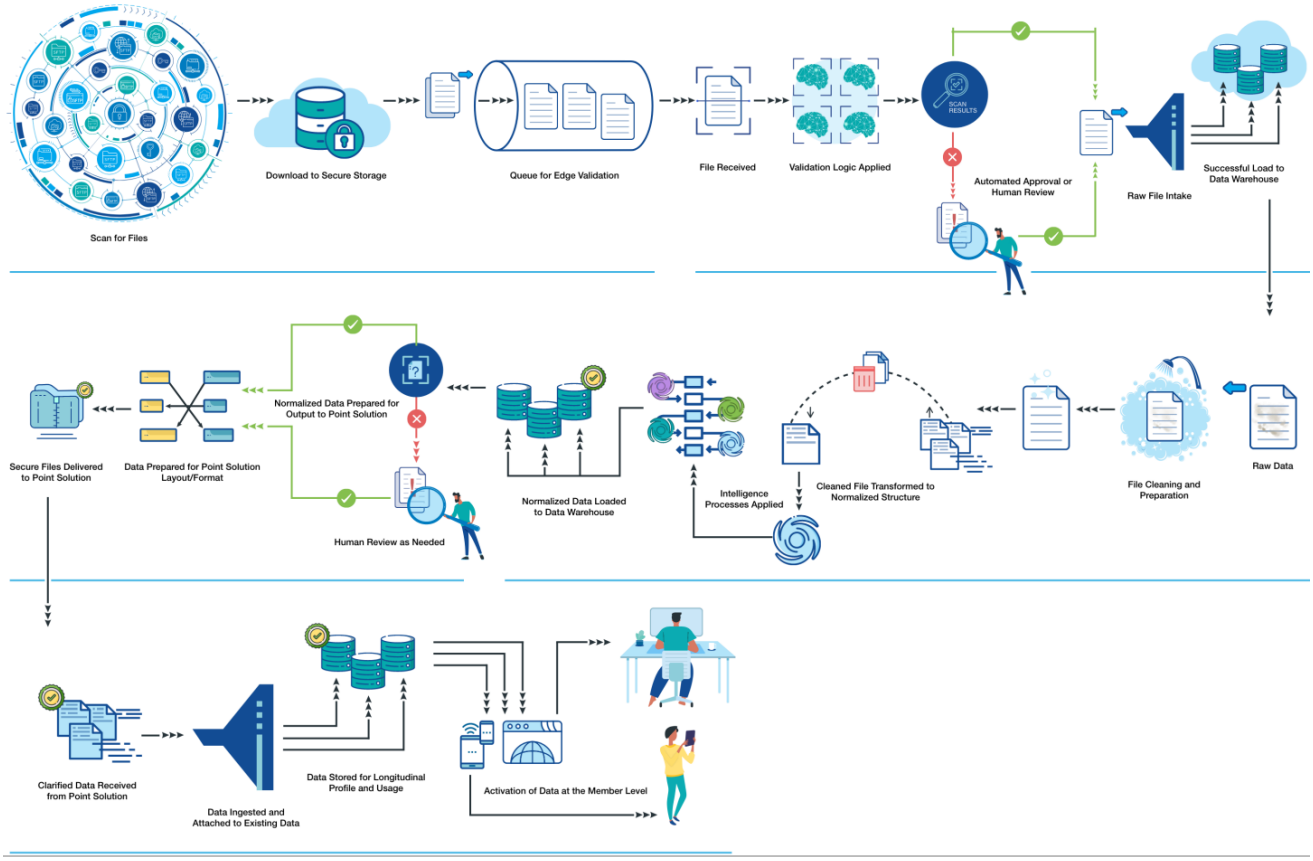
When needed, Switchbridge also has extensive member engagement tools. Specifically, our Wellth mobile app and WellthCloud portal would enable Switchbridge to present any NCSHP-approved data, information, programs, etc. directly to individual plan members, cohorts, divisions, etc. We developed an extensive cards system which supports an

endless array of member communications that can be built as authorized by the Department of State Treasurer, plan vendors, advisors, point solutions, etc. Also, any information entered into the mobile app or portal can be collected at the member level within the data warehouse for future analysis and use.

To improve and enhance member experience and engagement, Switchbridge can automate the provision of these data, messages, offers, etc. to members by programming sophisticated surveillance algorithms that constantly run through the data looking for opportunities to meet specific member needs such as extending an invitation to participate in a weight management program, offering the ability to chat with a nurse/patient advocate, guiding to select and/or preferred providers, etc.

Lastly, all data ingested by Switchbridge will be contractually owned by NCSHP and the State of North Carolina. If NCSHP were to ever choose to leave Switchbridge, all data would be transferred to the designated, HIPAA-secure data warehouse.

Switchbridge Data Flow Process Illustration



To support any program option and to provide appropriate outcomes reporting, Switchbridge recommends the deployment of the analytic tool Innovu[2]. In addition to

being one of the most powerful health benefits data analytics tools on the market, Innovu is about to release a generative AI model that is purported to have a 70%-plus probability of predicting which healthplan members will be on GLP-1 drugs within the next 12 months. Obviously, this analysis could be tremendously helpful to our teams in estimating costs, targeting programs, driving engagement, etc.

Of course, complete online and on-demand ad hoc reporting will be available to NCSHP and its advisors. The Switchbridge team will work with Innovu to construct all necessary reports to ensure that the implemented program is producing desired results. Because Innovu will ingest all claims (e.g. Medical, Rx, etc.), it will also enable the team to calculate medical offsets from the use of GLP-1/GIP agonists.

A list of standard reports is provided as an attachment to this response. Sample reports and/or an online demonstration of the system can be provided upon request.

Furthermore, NCSHP might choose to avail itself of additional Rx and/or PBM analytics to further identify savings opportunities and/or instances where the PBM(s) did not properly apply the terms of the contract. Tools such as Xevant, Ringmaster, etc. are inexpensive and deliver strong Returns-on-Investment (ROIs).

Switchbridge consulting and data management including Innovu data analytics is core to each of the following programs at a cost of approximately: $0.68 PMPM. This fee is separate from and in addition to the fees associated with each of the following programs.

PROGRAM OVERVIEW

This program has been designed and will be coordinated by Switchbridge and Piedmont Pharmaceutical Care Network (PPCN)[3] to provide a solution that has been proven successful throughout the State of North Carolina.

CONSIDERATIONS

1. Multiple, thoughtful layers will exist to best steward the State's benefit dollars.
2. From PPCN's experience, five County customers have seen grade 3 overweight (BMI ≥40) of seventeen percent (17%) based on biometric screening participation. This is higher than the national average of nine percent (9%)[4]. Fifty percent (50%) of grade 3 overweight (BMI ≥40) have a diagnosis of pre-diabetes with an average hemoglobin A1c of 6.1. The average cost savings for prolonging the diagnosis of diabetes for members that participant in the Medical Weight Management Program (MWMP) is $12,111/year.
3. Prescription drugs are just one tool available in the challenge to treat obesity. MWMP has a collaborative effort of regularly scheduled care management sessions (one-on-one, group support sessions, weekly survey check-ins, and weekly weigh-ins) in which participants will engage in intensive behavioral therapy, lifestyle modifications, nutritional education/support, and accountability designed to achieve clinical goals with long term success. After 6-months of MWMP, participants will receive Anti-Obesity Medications (AOMs) at $0 cost share (recommendation carve-out solution for non-coverage anti-obesity medications through the NC State health plan).
4. Risks and side effects need to be considered prior to prescribing. MWMP has shown AOMs medication possession ratio of 82.3% vs. regular medical care of 40.7%. Also, 90.5% achieved AOMs maintenance dosing. Pharmacist Care Managers provide support, education and strategies that help minimize side effects that are associated with medication non-adherence.
5. MWMP is designed to compare medical and pharmacy claims for participants vs. non-participants. Switchbridge and Innovu analytics will filter data to create a non-participant cohort with the following criteria: Adult health plan members with ICD-10 medical code for grade 3 Overweight, No ICD-10 diagnosis of Diabetes, and not having a pharmacy claim for Anti-Obesity Medications (Wegovy, Zepbound, Saxenda, Phentermine, Contrave, or Qsymia) in the past 6-months. Switchbridge will update cohort comparisons monthly once data feeds are provided from TPA and PBM.
6. Identified Intervention MWMP Population:
    a. Active and Eligible Health Benefit Members: 483,493.
    b. Approximate number of members with BMI ≥40: 82,194.
    c. Projected Enrollment (10%): 8,219
    d. Suggested Pilot Enrollment: 2,054 (4%)
7. Suggested customers to target for MWMP intervention:
    a. Twenty (20) Mark III Employee benefits customers. This partnership will allow program success to promote at open enrollment meetings, health

fairs, employee appreciation events, new hire orientation, healthcare onsite clinic, etc. Using this strategy, PPCN has seen 30-40% enrollment.

8. MWMP Budget Projections:
    a. Medical Weight Management Program Fees: $2.5-$3.0 million. This range depends upon participation of the pilot program (4%).
    b. Patient Reimbursement costs will vary depending upon member success and the percentage selected.
9. Cost Savings Projections:
    a. Prevention of the Diagnosis of Diabetes:
        i. Pre-diabetes (50%): 1,027

Diabetes Prevention (20%)	**Prevention Savings** ($12,111 x 205)	**Program Savings** (2,054 x $115 x 12)
205	$2,482,755	$2,834,520

    b. Average medical and pharmacy spend trending comparison between participants and non-participants. This can be variable, but PPCN has demonstrated a average cost savings difference up to $10,000 per member per year (PMPY).

Partnership Entities:

North Carolina State Health Plan (NCSHP): The largest healthplan in North Carolina consists of teachers, state employees, retirees, and their dependents and provides coverage to nearly 740,000 members.

Pharmaceutical Care Network (PPCN) and HealthMap Rx®: Ronald DeVizia, Jr., PharmD and his team of professionals have a strong track record of achieving optimal patient outcomes in North Carolina in obesity management and much more. PPCN is an excellent in-person option for patients who can access the available locations. PPCN is an independent third-party contractor that provides chronic condition care management services. HealthMapRx® programs are designed to manage costs by reducing financial and clinical risk of chronic conditions.

Switchbridge: A data activation platform solution with data analyses, reporting, and engagement tools derived from multiple sources. This platform combines data from medical, pharmacy, and biometric clinical data.

Mark III Employee Benefits[5]: An independent benefit consultant for public sector clients in the Southeast representing over 500,000 public servants. Mark III is currently providing consulting service to twenty-five NC State Health Plan members.

Program Criteria:

NC State Health Plan benefits members meeting the following criteria:

1. Adult health plan benefit members with a body mass index (BMI) of ≥40 kg/m2 or greater.

2. Not having a diagnosis of diabetes.
3. 12-month program commitment.

Phase 1: Promotion
Purpose: To promote medical weight management services to eligible health plan benefit members**.**
Process:
Email and Flier Communication: Provide Promotional email template with flier.
Internal Events Promotion: Medical weight management services will be promoted at open enrollment meetings, health fairs, employee appreciation events, new hire orientation, healthcare resources (on-site clinic), text messaging, social media, emails/mailings, and program information/testimonial videos (see sample at https://bcove.video/3Bz7Poj).

Phase 2: Eligibility Determination and Enrollment
Purpose: Each potential health plan benefits participant will complete an online screener to determine eligibility and if eligible, will complete Step 1 and Step 2 enrollment.
Process: Typically, Medical Weight Management programming is offered twice annually. Screening to determine program eligibility is open for a 3–4-week interval prior to the start of the programing. If the health plan benefits participant meets the eligibility criteria, then HealthMapRx Program Support will communicate Step 1 online enrollment. Once Step 1 enrollment is completed, then HealthMapRx Program Policy and Procedures are communicated and then participants are asked to complete Step 2 online enrollment:

1. Consent to Participate and Medical Release
2. Program Policy and Participation Acknowledgement.

Phase 3: Virtual Kick Off Session and Pharmacist Care Manager Assignment
Purpose: Program introduction group virtual session and initial visit schedule.
Process: Once step 2 enrollment is completed, participants will register for virtual kick off that works best for their schedule and HealthMapRx program support will schedule one-on-one live visit with pharmacist care manager. Each appointment will receive three appointment reminders and participants will receive a text message asking for confirmation 1 week prior to their appointment.

Phase 4: Intervention
Purpose: Medical weight management services will consist of pharmacist care manager sessions, monthly virtual support group sessions, and weekly survey check-ins. Through a collaborative effort of regularly scheduled care management sessions (one-on-one and group support sessions), participants will engage in intensive behavioral therapy, lifestyle modifications, and nutritional education/support designed to achieve clinical goals with long term success. Incentives will be provided to eligible plan members meeting participation protocols.

Process:

1. **Visits with Pharmacist Care Manager**: A licensed Pharmacist Care Manager with advanced expertise in chronic condition and medication management will meet with you six times per year, typically during work hours for convenience. Communication also occurs between visits when reviewing weekly check-ins and the priority of interventions will be determined from the weekly survey responses.
2. **Group Sessions with Health Coach**: National Board-Certified Health Coach will meet with you, along with other program participants, once per month for the first six months of the program, then twice every other month for a total of eight sessions. These virtual small group sessions will provide education, motivation, and peer support with a focus on behavior modifications associated with weight loss and healthy lifestyle habits. Participants may attend anonymously if desired. There will be multiple options per month and if a session is missed, then the participants will have the option to watch the recorded session and submit an attestation.
3. **Weekly Check-Ins**: A brief survey will be delivered weekly via email or text to participants. The data collected from the check-in will serve to report aggregate progress and assist the program team in providing individualized support to participants. Participants will be able to complete the weekly check-ins from Friday to Tuesday of each week.
4. **Weekly Weigh-ins:** Participants will receive a digital scale that has Bluetooth® capabilities with an app to track weekly weigh-ins. Pharmacist Care Manager and Health Coach will have remote access to the weekly weigh-in data and can communicate with platform/App.

Medical Weight Management Services Timeline:

	Month											
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Care Mgr.	X	X	X			X			X			X
Group	X	X	X	X	X	X		X		X		

Initial Care Management Assessment (Months 1-3):

1. Weight Assessment: Body Mass Index and Waist Circumference
2. Review & Discuss Medical History
3. Physical Activity and Goal Setting
4. Nutrition Education (plate method, reading food labels, portion control strategies, etc.)
5. General Wellness Assessments (Anxiety, Sleep, Quality of Life, Pain, Presenteeism)
6. Medication Adherence Review and Assessment (Morisky)
7. Prioritize Needs and Develop a Mutual Plan and determine self-management goals.
8. Communication: share progress notes and recommendations to PCP as appropriate
9. Document visit in PPCN proprietary, web---based care management platform for guiding adherence to protocols, as well as tracking and management of participant care, progress and compliance with program requirements.

Subsequent Care Management Visits (Months 6, 9, 12):

1. Weight and Goal Determination (e.g. 10% decrease from previous years weight)
2. Review lab Values and Trending (A1C, Lipids (LDL, Non-HDL), Kidney Function, etc.)
3. Medication Review: New Therapy Assessment, Formulary Review, Adherence Assessment
4. Self-Management Goal Assessment (achieved, partially achieved, regressed, no progress)
5. Communication: share progress notes, communicate recommendations to PCP as appropriate
6. Document visit in PPCN web---based care management platform.

Support Group Session Topics (months 1-6, 8, 10)

Year 1	Year 2
1. Program Introduction	Weight-Loss Plateaus
2. Habit Loop	Non-Scale Victories
3. Healthy Eating 101	Seasonal Affective Disorder/Self-Care
4. Physical Activity 101	Sleep & Weight-Management
5. Challenges to Your Healthy Routine	Seasonal Nutrition (Summer)
6. Essential Guide to Sugar	Reflection/Next Steps
7. Eliminating Critical Self-Talk	
8. Maintenance & Strategies	

Pilot Project Intervention:

Purpose: By starting with a pilot project, this project will provide NC State Health Plan the confidence in partnering with these entities to provide Medical Weight Management program, pharmacy dispensing, and data management that will result in positive clinical and financial outcomes.

Process: Mark III Employee Benefits provides consulting services to NC State Health Plan customers and this relationship will help expedite implementation and engagement. Below is the list of customers that the Medial Weight Management program would be offered (Bold: Medical Weight Management Program was provided from March 2023 to April 2024).

1. Alexander County Schools
2. Cabarrus County Schools
3. **Caldwell County**
4. Cleveland County Schools
5. Columbus County
6. Davidson County Schools
7. **Durham Public Schools**

8. Forsyth Technical Community College
9. Franklin County Schools
10. Guilford County Schools
11. Harnett County Schools
12. Kannapolis City Schools
13. Martin County
14. **Nash County**
15. New Hanover County Schools
16. Onslow Water and Sewer Authority
17. Pitt County Schools
18. Polk County
19. Robeson Community College
20. Surry County Schools
21. Winston-Salem/Forsyth County Schools

Phase 5: Program Participant Monitoring
Purpose: Program participation is monitored for all components of the intervention (pharmacist care manger visits, monthly virtual sessions, weekly surveys, and weekly weigh-ins).
Process: Weekly reports are shared with HealthMapRx Program Support Team and discussed during weekly team call. If participants are non-compliant then additional outreach is provided to re-engage participants prior to starting the process to make them inactive. Multiple contact attempts are made before making participants inactive.

Phase 6: Program Incentives
Purpose: Incentives encourage enrollment and engagement for members that have pre-diabetes, and/or multiple chronic conditions associated with phase 3 obesity (BMI of ≥40).
Process: After 6-months of the Medical Weight Management program participation and if program participation is >80% of program activities, participants will receive Anti-Obesity Medications (AOMs) at $0 cost share. Program pharmacy will dispense AOMs using Manufacture Savings Card Programs. NC State Health Plan will reimburse Program Pharmacy for each program participant cost on a monthly basis (Example: $550 for Zepbound (original cost after PBM rebate: $735), $650 for Wegovy (original cost after PBM rebate: $945), etc.).

Phase 7: Cohort Comparison
Purpose: Comparison average medical and pharmacy cost per member per year (PMPY) vs. non-program participants.
Process: Switchbridge platform will provide cohort comparisons providing aggregate data comparisons for participants vs non-participants. Non-participants cohort will be determined from medical and pharmacy claims data combined for each individual with the following criteria:

1. Adult health plan benefit members
2. ICD-10 Medical Code for Grade 3 Overweight

3. No ICD-10 diagnosis of Diabetes
4. No pharmacy claims fill history of Anti-Obesity Medications (Wegovy, Zepbound, Saxenda, Phentermine, Contrave, Qsymia) in the past 6-months.

Phase 8: Outcomes & Analysis
Purpose: Promote and determine eligibility for medical weight management (MWM) services.
Evaluate program effects on clinical outcomes. Comparisons will include weight, waist circumference, body mass index, blood pressure, and cholesterol (LDL, HDL, triglycerides, and total cholesterol).
Process:

1. Evaluate clinical outcomes (weight, BMI, blood pressure, cholesterol, FBG/Hemoglobin A1c) comparing MWM services prescribed AOMs.
2. Evaluate pharmacy and medical cost (PMPY) comparing MWM services prescribed AOMs vs. standard medical care.
3. Anti-Obesity Medications Medication adherence (portion of days covered or medication procession ratio)

Phase 9: Budget Projection
Purpose: Determine budget projections for Medical Weight Management Program, Pharmacy Costs and Data management.
Fees and Terms:
Medical Weight Management Program

Base Price	$105.00
Bluetooth® Scale Technology w/ Remote Monitoring	$10.00
Total	$115.00

Monthly Fees: Pricing is based upon a monthly fee per participant (PPPM).

Identified Population

a. Active Health Benefit Members: **483,493**
b. Approximately 17% have BMI ≥40 (5-County data): **82,194**

Budget Projections

a. Projected Enrollment (10% engagement): **8,219**
b. Pilot Project with Mark III Employee Benefits Customers: **2,054**
c. Medical Weight Management Program Fees: **$2,588,040**

Again, we thank you for your time and consideration of our response to this RFI. We welcome the opportunity to answer any questions you may have and/or discuss any elements of this proposal for which further explanation or elucidation is desired.

FOOTNOTES

[1] https://switchbridge.com/

[2] https://www.innovu.com/

[3] https://ppcn.org/

[4] https://www.medpagetoday.com/primarycare/obesity/90142

[5] https://markiiieb.com/

ADDITIONAL MATERIALS

Innovu Standard Reports

Executive Overviews
- Executive Summary
- Cost Per Month
- Enrollment
- Financial
- High-Cost Claimants
- Medical
- Pharmacy
- Potential Savings Opportunities
- Risk
- Workers Compensation

ER
- Average ER Visit Count Per Month
- Emergency Room Visits Overview
- Members with 10 or more ER Visits in Last 12 Months
- Members with 5 or more ER Visits in Last 12 Months (de-identified)
- Members with 5 or more ER Visits in Last 12 Months

Providers
- Top 10 Inpatient Providers by Amount Paid
- Top 10 Outpatient Providers by Amount Paid
- Top 10 Pharmacy Providers by Amount Paid
- Top 10 Professional Providers by Amount Paid

Potential Payment Errors
- Unenrolled Members with Claims
- Overage Enrolled Dependents with Claims
- Overage Enrolled Dependents Regardless of Claims
- Medically Unlikely Events
- Inappropriate Services
- Duplicate Claims
- Ambulance Ride w/o Medical Claims
- Hep C Treatment in Overdose

Financial
- New Member Above Cost Amount Paid in Plan Year
- High Cost Out-of-Network Medical Claims
- ESRD > 30 Months
- ER Site of Care
- Wasteful Spending Rx Drugs
- Brand with Generic Available
- AUVI-Q Rx Use
- Implant Site of Care
- Improve Rx Discounts
- Imaging and Injectable Site of Care
- Lab Site of Care
- Chronic Condition Site of Care
- Medical Pharmacy Site of Care
- Specialty Pharmacy Coupon Savings
- Year over Year Financial Report

- Financial - Plan Year 2020
- Financial - Unenrolled Claims
- Fully Insured Financial Report
- Financial Reporting Package
- Financial - Potential High-Cost Claimants
- Financial - Plan Year Comparisons
- Financial - Last 12 Months Summary
- Financial - Claim Lag Reports

Plan Utilization
- Plan Utilization by Age Range
- Plan Utilization by Gender
- Plan Utilization by Relationship

COVID-19
- COVID-19 - Potential Employer Impact
- COVID-19 Testing Payment Errors

Medical/Rx
- Medical & Rx - Plan Year 2020
- Medical - Plan Year 2020
- Rx - Plan Year 2020
- Specialty Rx Analysis
- Medical - Emergency Room and Inpatient Utilization
- Medical - Emergency Room Utilization
- Plan Year Medical Financials
- Plan Year Rx Financials
- Plan Year Medical/Rx Financials
- Rx - 2018 Price Increase Drugs to Watch
- Medical & Rx - Specialty Drugs
- Top 10 Drugs by Paid Amount
- Preventive Medicine Utilization
- Rx – Opioids
- Rx - Rx Specialty Drugs

- Medical - Medical Specialty Drugs
- Medical - Out of Network Claims
- Medical - Plan Year Comparisons
- Calculated Value Examples, Rx - Plan Year Comparisons

National Benchmark
- Brand Rx Analysis
- Generic Rx Analysis
- Emergency Room Cost & Utilization
- Emergency Room & Urgent Care Visits per 1000
- Average Member Age
- Allowed per Days Supply
- Pharmacy Program Cost & Utilization PMPM
- Per Member Per Year Allowed Amount
- Inpatient Visits and Days per 1,000 Members

Benefits Convergence
- Members Exceeding Deductible / OOP Max
- HDHP Health Outcome Analysis
- Reference Based Pricing Tool
- Onsite Clinical Analysis
- Worker's Comp Review
- WC Claimant Risk Scores
- WC Claimant PMPM
- WC Claim Detail
- WC Open Claims
- Workers Comp Overview

Enrollment
- Enrollment - Plan Year 2020
- Enrollment - Average Age
- Contract Count per Coverage Tier

- Enrollment - Plan Year Comparisons
- Enrollment – Current

Other
- Member Heat Map
- Overage Dependents with Claims
- Member Count by Relationship - Last 12 Months
- Mail Order Utilization
- Percent of Total Amount Paid by Claim Type
- Top Diagnoses Categories by Paid Amount
- Retail Utilization
- Average Contract Size
- Average Contract Size per Coverage Tier
- Claim Distribution by Claim Type
- Total Amount Paid Distribution by Claim Type

Risk Score
- Average Risk Score by Gender
- Risk - High Risk Members (Global)
- Global Risk
- Global Risk Distribution
- Average Risk Score by Age Range
- Average Risk Score by Relationship
- Chronic Condition Strategic Dashboard

Health & Safety Risk
- $0 Medical Claimants
- $0 Medical / Rx Claimants
- Obese Individuals with Diabetes
- High ER Use
- High Opioid Users
- Narcotics in Children

- Increase Cost in Asthma Patients
- Over-use of Controlled Substances
- Opioid use in Members with Substance Abuse
- Individuals with Diabetes without Pro Claims
- Managing Diabetes
- Diabetes Gaps in Care
- Chronic Kidney Disease / ESRD
- Musculoskeletal Disease
- Metabolic Syndrome
- Biometric Analysis

Childhood
- IPV Immunization Utilization
- Hep A Immunization Utilization
- Hep B Immunization Utilization
- MMR/MMRV Immunization Utilization