Quantum Employer Population Health Benchmarks

Quantum provides a quick best-practices benchmark list to evaluate your population health metrics. Should your self-funded organization be looking at a medical management? Expert Medical 2nd Opinion? If your plan meets any ONE of the items on the list below, then you need to contact me, and let me help you do a more thorough evaluation of the group.

- Admits/1000 > 47.85
- ALOS (Average Length of Stay) > 4.23
- Days/1000 > 202.15
- Group ER utilization higher than 18% of members (member lives times 0.18 or higher)
- 50% of spec report shows # of patients greater than 1% employee lives (more than 1 person per 100 ee lives shows up on the 50% spec report)
- <20% of patients engaged in Case Management (fewer than 20 people per 100 ee lives are getting case management)
- Patients with RX cost >$500 who are not in case management
- Patients with hospitalization >5d LOS who did not get case management
- Patients with 2+ inpatient hospitalizations in the last year who did not get case management
- Patients with 3+ ER visits in the last year who did not get case management
- Patients with >$25,000 in claims in the last year who did not/are not getting case management
- Patients with more than 3 doctors submitting claims in the last 12 months who did not/are not getting case management
- Pregnant members not engaged in maternity management program
- Patients on dialysis for whom renal repricing has not been deployed
- Patients with a diagnosis on the SIIA ICD-10 list who are not in case management
- Patients with Chronic Kidney Disease (CKD) or at High-Risk (potentially undiagnosed CKD) not engaged in case management
- Patients with “pre-transplant” conditions
- Patients with imaging > 2 times in the past 12 months
- PEPY >$7,500 (medical & RX before SL reimbursement)
- Predictive Modeling report (via claims data mining) for any of the above

Quantum UM/CM Analysis

When Quantum Services Group reviews your Self-Funded claims data, our strategic opportunity analysis delivers actionable results. Define how employee accountability, consumer advocacy, utilization management and case management can improve financial stability within your healthcare spend. Here are just a few examples of our findings:

- A self-funded major medical health plan getting a 56.1% PPO discount from their carrier for in network hospitalization. They could leave the carrier, start paying full national average retail rate for hospitalization, moderately manage their inpatient utilization, and save $2,942,767.00 *and that's only looking at the expense category. What if we reviewed attribution and helped manage misdiagnosis and unnecessary procedures?*

- 302 people experienced 701 ER visits, only 86 of which were truly emergent. The group paid over $290,000 for those ER visits. By putting in place a 24/7 Nurse On Call coupled with a telehealth solution we believe it would be reasonable to avert those unnecessary ER visits. Let's do the math. We suggest the group invest $53,000 so they can offer their members a FREE telehealth MD service. Average ER costs $400...the group only has to avert 131 unnecessary ER visits to "break even" on their investment. Given that they had 615 unnecessary ER visits, there's plenty of room/opportunity for improvement!

- A self-funded plan who has ***one*** patient getting chemotherapy due to an inflated charge master situation. AFTER the PPO discount the group is *over paying* RCC rates by $18,310 per dose! This patient has already had 15 doses of this medication, and will continue to get this medication until it stops working and the cancer advances (statistical average of 2 years at least). If this group chooses to add medical management with Quantum Services Group for their plan population, the cost savings of just 6 doses of chemotherapy cost mitigation would pay for the service every year. (Also, this group has MANY cancer patients in their population).

- A self-funded plan who is covering Psychiatric Treatment facilities is experiencing over billing. On just ONE patient in their plan, they overpaid by more than $42,000. Their medical management vendor didn't catch the facility type (not uncommon) and their PPO discount is a percent off billed charges. The carrier didn't apply R&C verbiage from the plan design before paying the claim (and medical management didn't give claims a heads up, or if they did it was disregarded). They've got 111 patients receiving this care. If cost were better controlled on *just* ***three*** of these patients, this group could have paid for Quantum UM/CM services.

This analysis and strategy session all occurred within JUST ONE SELF-FUNDED HEALTH PLAN. That's right, just in those 4 issues this group could save over $3,000,000 in claims spend and essentially have Quantum partner's team of health care concierge partners helping their members to get the *right* care at the *right* time in the *right* place for the *right* price - all without spending one single penny more than they spent last year!

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