



Dan Hinderliter
Commonwealth of Virginia
Department of Human Resource Management
101 N. 14th Street
Richmond, VA 23219

Dear Mr. Hinderliter,

We are pleased to submit our analysis of your historical claims data in response to your request. We found the assignment to be helpful in understanding your population and we are now even more excited and confident about the money we can save the Commonwealth and the satisfaction we can create for your employees and their families. We're also excited about our ability to make a real difference in the lives of your employees, because as we looked at the data, many real stories of real people came into focus:

- The 49 year-old diabetic who repeatedly goes to the ER for chest pains although he has no cardiac diagnosis.
- The 54 year-old woman who has joint surgery and whose home care is so inadequate that she develops malnutrition and dehydration and serious infection which precipitates a string of readmissions.
- The 53 year-old who was put on medicine for hyperthyroidism, developed fatigue, chest pains, and dehydration only to be re-diagnosed with hypothyroidism and put on medicines for that.
- A 59 year-old woman who contracts viral meningitis which leads to a stupor, coma, and a craniotomy leading to intermittent periods of confusion and delirium, yet she or her family must deal with a claims situation so complicated that two years later she still appears to be sorting them out based on the reversals and resubmissions in the data.
- The 52 year-old floridly psychotic female with cerebral palsy with multiple psychiatric readmissions who gets home care for the cerebral palsy but only sporadic outpatient care for her bipolar disorder, which could be done at the same time.
- The 60 year-old man who has a coronary bypass with no outpatient follow-up for 18 months and appears to stop taking his medication after six months and requires additional bypass surgery a year later.

There are many more, with needs both big and small. These are the people that we built Accolade to help. Accolade's people work here because they know the satisfaction they will get from helping these people comply with their physician's instructions, choose the right diagnostic and treatment option, access the right provider and setting, learn how to respond appropriately to their symptoms and how to manage their chronic disease, and how to stay healthy. We don't expect to keep all of your employees from getting sick. Nor do we treat them when they do – that is the realm of their physicians. And we know that there will still be unmet needs we don't identify or resolve. But we

know that we can help so many of them make better choices – and help them help their doctors make better choices – that we will make a huge difference in the lives of many families.

And those last four words may sum up our difference – “lives of many families”. In our effort to respond to your core question – “What do you do for our people that will make a difference?” – we have summarized patients health care decision processes, shown how our activities relate to proven savings levers, and inserted a rather long table to show the similarities and differences between today’s best practices and Accolade’s approach. We are excited to have been able to start our company with a “clean sheet of paper” – it has allowed us to pick and choose from the very best practices, tools, and approaches and integrate them into our unique model. But we are concerned that our biggest differences may get clouded in that long list. But “lives of many families” catches the big points:

- We impact many more families than anyone else:
 - We’ve designed an attractive service that our research shows consumers want – “a Personal Health Assistant that can help me with all my health care and benefit needs” – to drive more engagement
 - By creating Accolade as the single point of contact for all health and benefit questions, we will simplify things for the member, driving more engagement
 - Unlike competitors that may offer some training to existing customer service agents to help them refer some calls to care coaches, our Personal Health Assistants are selected, trained, measured, and equipped (with built-for-purpose technology) from the start to engage members, solve their problems, and build a relationship, driving even more engagement
- We work to address every member’s health care issues in the context of their life:
 - Addressing all of their conditions together, not one disease at a time
 - Understanding how well they can navigate the health system, how motivated they are to change and learn, how they like to communicate, and how they perceive their health so we can build a productive relationship with each one
 - Understanding the person’s life and family situation, and helping them overcome financial, social, and logistical barriers to getting the right care in the right place at the right time
 - Understanding the goals that motivate them, allowing us to help them create meaningful plans to overcome all the barriers to making good health care choices.

We are convinced that the key to making a significant difference is creating one number to call for all of a member’s health benefit needs, seizing the opportunity those calls create by providing excellent service, building a relationship with each member, and then working to understand and solve the real needs that member has in getting the right care at the right place at the right time. We think this submission, using your data, provides further evidence that our model works and why it is the only approach that will drive significant savings. We should also note that while your questions and our response largely focus on savings, there are other important tangible (if more difficult to measure) benefits to the Commonwealth including better employee productivity from less absenteeism,

“presenteeism”, and less time spent navigating the hassles of the health care and health benefits systems. We are confident that your employees will appreciate the Commonwealth’s leadership in providing this great new service to them and their families.

And we are so confident that we can create significant savings while driving member satisfaction, that we are providing this service to the Commonwealth in a totally at-risk proposition. We are only paid out of savings and only then if we have satisfied members.

We also want to take this opportunity to update you on the progress of our business.

- While we are meeting with a number of prospective clients interested in initiating service over the next two years, we have received executive approval and are entering into contract negotiations with a Fortune 100 company with 100,000 eligible employees. They would like to start operations in the second half of 2009 in our Virginia center and are willing to work with you on the timing of their launch. This is evidence of our acceptance in the marketplace and of the economic development opportunity our proposal represents for Virginia.
- We have substantially completed evaluating the capabilities of Northrop Grumman in Virginia to provide secure hosting and IT infrastructure services for us. Given the significant benefits to the Commonwealth of Accolade selecting Northrop Grumman for this capability, we are completing our evaluation and commencing pricing discussions with them. In addition to the known quality and security of this operation for the Commonwealth, we understand there are direct contractual financial benefits to the Commonwealth of moving our systems and related jobs (in service of all of our clients) into Northrop Grumman’s operations in Virginia, in addition to the economic development benefits. We look forward to understanding your perspective on this option.
- We have met with top executives at a number of provider organizations in Virginia, including HCA Virginia, VCU Medical Center, Sentara Medical Group, the Virginia Medical Society, and the Virginia Hospital and Healthcare Association. We were energized by the spirit of collaboration we found in meeting with each group – these organizations view the Commonwealth and their employees as an important constituency and were willing to cooperate to make our program successful for the Commonwealth. We came away confident that providers and health plans in Virginia will be very supportive of the Commonwealth in making our program successful.
- We continue to progress well on all other business building fronts, including continued enhancement of our Member Relationship Management system, continued development of our training courses, and continued enhancement of our member marketing and communications tactics and materials.

We did hit one interesting speed bump. Just prior to receiving your request to analyze your claims data, Resolution Health informed us that they would no longer work with us for the Commonwealth of Virginia. They were instructed not to do so by the corporation that had acquired them earlier in the year, Anthem (WellPoint). They made this decision despite a signed teaming agreement and

repeated assurances from WellPoint before and after the acquisition months earlier that the change in ownership would not affect our relationship. We appreciate Anthem's competitive spirit, but the fact that they have offered to continue to work with us at other clients makes a clear statement about the priority they put on improving the health and welfare of the Commonwealth's employees.

The good news is that Anthem's decision forced us to re-evaluate other options in the evidence-based medicine rules and consumer messaging market. We have selected DiagnosisOne, who for the last nine years has offered a high-quality and very flexible, scalable, and interoperable product. Their clients include the Centers for Disease Control and Prevention, Partners HealthCare, Blue Cross Blue Shield of Massachusetts, and Google Health. DiagnosisOne was able to load and process your data quickly and they produced the alert information referenced in this submission. As they use published guidelines from the same places and update using similar processes to Resolution Health, there is no other change to our proposal in the area of our rules engine and alerts capability.

We hope you can tell from our response that we remain very excited about serving the Commonwealth of Virginia and your employees. Clearly our analytic capabilities are only a small part of our proposition to you and this response is only a fraction of what we will provide when all of our capabilities are in place and we have our analysis team dedicated to the Commonwealth. That said, our analysis of your data makes us even more confident about the opportunity that exists to deliver the savings and satisfaction we promise. And from each of your employee's point-of-view, it is not an opportunity as much as it is a need. Needs that we can see in case after case in your claims data. It would be a shame to try to meet those needs with the same old solutions – they have proven themselves to help too few. We are willing to invest a huge amount of our time and money to make a real difference and change health care in Virginia forever.

Very Truly Yours,

Thomas K. Spann
Chief Executive Officer
Accolade LLC

Part A: Financial Analysis

We have enclosed the Financial Analysis Workbook as a separate file. The savings projections in that workbook are consistent with our previous submissions and our claims analysis in Part B. For clarity, we have added a tab that shows the 2009 numbers without trend and another one that shows savings by cost category.

Part B: Claims Analysis

As requested, this section contains:

- Our analysis of the claims data you sent to us
- A description of how our services would specifically help the COVA employee population based on that analysis

Interventions Overview

Since our approach for helping and serving your members is consistent across various sub-populations, we will describe our overall service approach to provide context for our later descriptions of how we help and drive savings in different specific member populations. As described in our original Conceptual Proposal, our goal is to reduce unproductive health care utilization by helping members and their physician/providers make better decisions and choices. Taking responsibility for helping members with routine claims, coverage and eligibility questions gives us many, many opportunities to learn more about your members, and to use proven techniques for helping members in their health care decision processes. This adds up to more confident, health-literate members, more productive employees, higher member satisfaction and significant cost savings.

As we described in our original proposal, patients and physicians face many challenges in making good decisions across the entire spectrum of decision-making in health care:

The Challenge of Making Good Decisions in a Complex System

Healthcare Decisions	Patients	Providers
Staying healthy	√	
Reacting to symptoms	√	
Diagnosing	√	√
Choosing treatments	√	√
Complying with treatments	√	

Little capability and support to find and understand good healthcare choices

Often unable to understand available information

Poorly individualized incentives to make good choices

Frustrated by poor customer service and fragmentation

Overwhelmed with system complexity

Responsible for increasing share of escalating costs

Want to deliver high-quality healthcare

Understand that lack of coordination is an important issue resulting in excess costs and serious errors

Have no economic incentive or tools to coordinate care

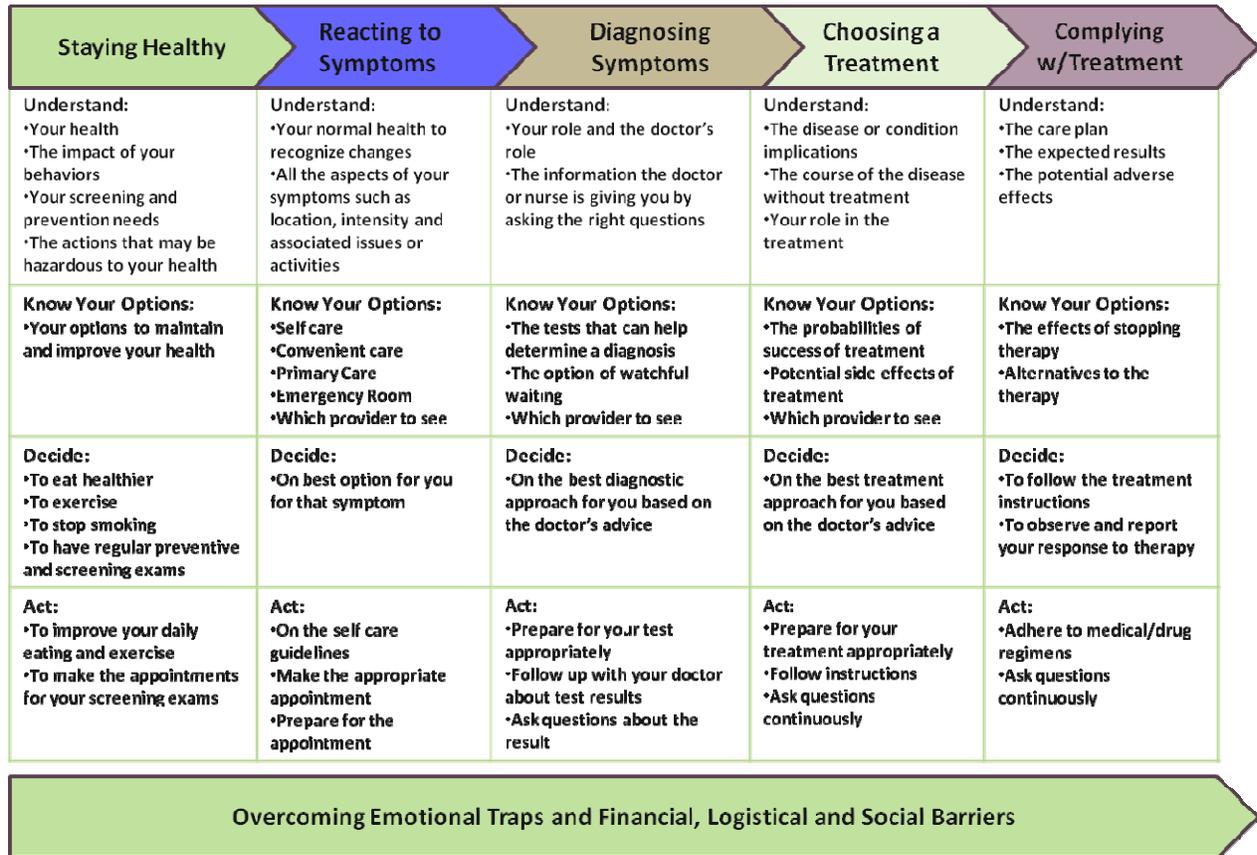
Are challenged to keep current with ever expanding medical knowledge

Beginning with these key patient healthcare decisions, we have further subdivided each process. Since our role is to help members (and their providers) during these decision processes, it is important to understand what a member is actually experiencing and what the desired outcomes are at each step. Each cell in the chart below identifies key outcomes we are striving for in each part of the decision process. To help your members we engage with as many of them as possible at the time when they are making these decisions and in a manner that is personalized to be relevant to them at that moment. Many of the opportunities to help members involve providing information or describing their choices -- closing the “knowledge gaps” that patients have -- whether those gaps are about their options for care, the workings of the healthcare system and their benefits, or the options for overcoming financial, logistical, or social barriers to getting the right care at the right time. According to the Institute of Medicine, 50% of Americans have low health literacy¹ and according to a study published in the American Journal of Medicine, total health costs for those with low health literacy are twice as high as for those with adequate

¹ Institute of Medicine: [Health Literacy: A Prescription to End Confusion](#) 2004

health literacy.² In the right context, helping patients to understand their options and make well informed decisions will reduce unproductive utilization and save money.

Patient Processes in Healthcare – Targets for Improvement



As noted at the bottom of the chart above, throughout a member's decision process we will also strive to reduce the "emotional traps" which further frustrate members and interfere with good decisions. Emotional traps are the feelings or reactions that interfere with one's ability to absorb information and make optimal decisions. Behavioral Economists have repeatedly found that people simply do not make consistently rational decisions about purchases and investments – and this is particularly true in stressful situations. The emotions and stresses associated with health care decisions certainly fall in this category. For example, a study in the Journal of Occupational and Environmental Medicine showed that anxious employees are 46% more expensive than those that are not anxious³.

² David Howard, et.al. American Journal of Medicine 2005

³ Ron Geotzel, et. al. Journal of Occupational and Environmental Medicine, April 2002