Geoff Brown, IW Chair, will convene a public meeting of the Innovation Workgroup on October 15 2019 at 1:15 p.m. The meeting will be held in the boardroom of the Health Licensing Office at 1430 Tandem Ave., Ne, Suite 180, Salem, Oregon.

Innovation Workgroup Agenda
October 15, 2019

I.	1:15 p.m. – 1:20p.m. Attachment 1	**Welcome, Introductions & Approval of September 17, 2019 Synopsis** *Geoff Brown, Chair*
II.	1:20 p.m. – 2:45 p.m. Attachment 2, 2a	**Cost Driver Analyses and Recommended Renewal Actions** *Consultants from Willis Towers Watson and Mercer will continue the presentation started at the September 17, 2019 meeting, providing detailed analyses of cost drivers related to Musculoskeletal conditions and Cancer along with recommendations the Innovation Workgroup may wish to consider for benefit plan renewals.*
	2:45 p.m. – 3:00 p.m.	**BREAK**
III.	3:00 p.m. – 4:00 p.m. Attachment 3	**Cost Benchmarking and Practical Applications** *Consultants from Mercer and Willis Towers Watson will present preliminary data comparing PEBB and OEBB payments for health care services to the amount Medicare pays for these services and discuss considerations for PEBB and OEBB programs.*
	4:00 p.m. – 4:10 p.m.	**Public Comment**
IV.	4:10 p.m. – 4:15 p.m.	**Wrap Up & Adjourn**

OEBB/PEBB Innovation Workgroup
Meeting Minutes
September 17, 2019

The OEBB/PEBB Innovation Workgroup held a regular meeting on September 17, 2019, at the Health Licensing Office, 1430 Tandem Ave. NE, Suite 180, Salem, Oregon. Geoff Brown, IW Chair called the meeting to order at 1:00 p.m.

Attendees

Workgroup Members:
Geoff Brown
Shaun Parkman (arrived at 2:30 p.m.)
JJ Scofield
Dana Hargunani
Representative Rob Nosse (non-voting member)

Workgroup Members Absent:
Senator Betsy Johnson (non-voting member)

OEBB/PEBB Staff:
Ali Hassoun, Director
Rose Mann, Board Policy and Program Coordinator
Margaret Smith-Isa, PEBB Program Development Coordinator

Consultants:
Emery Chen, Mercer Health & Benefits, LLC
James Matthisen, Mercer Health & Benefits, LLC
Robert Valdez, Mercer Health & Benefits, LLC
Michael Garrett, Mercer Health & Benefits, LLC
Nick Albert, Mercer Health & Licensing LLC
Jenny Marks, Willis Towers Watson
Brad Lawson, Willis Towers Watson
Dr. Louis Dickey, Willis Towers Watson

I. Call to order and approval of June 18, 2019 Meeting Minutes.

Chair Geoff Brown called the meeting to order at 1:00 p.m.

MOTION - JJ Scofield moved to approve the meeting synopsis of the June 18, 2019 Innovation Workgroup meeting. Dana Hargunani seconded the motion. The motion carried 2 – 0 (Shaun Parkman was not present at this time).

II. Legislative Update

Glenn Baly provided a brief legislative update.

III. IW Workplan Review

Margaret Smith-Isa reviewed the draft IW Workplan.

IV. Cost Driver Analysis and Recommended Renewal Actions

Jenny Marks, Brad Lawson, and Dr. Louis Dickey, Willis Towers Watson, reviewed analyses of PEBB and OEBB cost drivers to inform workgroup strategy development and areas of future focus.

There being no public comment nor further business to come before the Workgroup, Chair Geoff Brown adjourned the meeting at 4:00 p.m.

Innovation Workgroup

Condition Specific Strategies for OEBB/PEBB

Musculoskeletal and Cancer

September 17, 2019 & October 15, 2019

Willis Towers Watson

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Content

- Background
- Executive summary
- Musculoskeletal
  - Back/neck/spine
  - Hip/knee/major joint replacements
- Cancer
- Next steps
- Appendix

Meeting objectives:

- Define and scale current cost and utilization experience by specific condition (including OEBB and PEBB populations)
- Identify best practices and compare market scan to OEBB and PEBB — understand what others in the marketplace have done and explore what interventions and innovations are possible
- Identify potential tailored solutions to address cost, quality and outcomes associated with the largest areas of OEBB/PEBB spend

Background

- In March and April 2019, key cost drivers within OEBB/PEBB medical and pharmacy programs were evaluated
- Based on data from these reports, OEBB/PEBB would like to pursue interventions with the following key conditions:
  - Back and spine
  - Hip/knee/major joint replacements
  - Cancer
  - Site neutral services
  - Pharmacy
- In subsequent slides of this presentation a deep dive into data, interventions and potential opportunities have been evaluated for the first three conditions listed above (back and spine, arthritis/hip/knee/major joints and cancer)

Executive summary

Musculoskeletal Conditions (MSK)

- When combined, Hip/Knee/Back/Spine procedures represent the highest category of care at $99M for OEBB and PEBB combined
  - Of this, 57% ($57M), is surgery/procedure related
- While there is a lot of historical variation in cost per episode for most procedures, this is expected to be mitigated through SB 1067 200% of Medicare Hospital payment cap
  - Opportunity monitor non-facility costs and explore bundled payments
- Generally, surgeries are being performed at higher quality facilities
  - Still opportunity to address low quality facility performance
  - Significant variation for individual provider quality scores within a given facility
- Additional opportunities for decision support, expert medical opinion and virtual treatment to avoid surgery

Executive Summary (Continued)

Cancer

- After musculoskeletal conditions, cancer represents the highest cost condition for OEBB and PEBB at $93M
  - Unlike MSK, only 33% ($31M) is associated with facility costs
  - Pharmacy drives over $42M of cost, with radiology following facility at $16M
- Breast, leukemia, lymphoma, lung, prostate and colon cancer are the top conditions for OEBB/PEBB
- Unlike MSK, facility quality is a smaller part of the quality story
  - Many OEBB/PEBB facilities struggle with quality ratings
  - Lower quality facilities can still have high quality individual providers
- Cancer treatment is advancing at a rapid rate and providers have indicated they have a hard time keeping up
- Given the complexities and variation of cancer conditions, getting the right treatment at the right place at the right time is the primary focus
- Opportunities for infusion management/site of care, expert opinion, decision support and care navigation for member support

Musculoskeletal

Key Data Findings

Why Back and Spine Conditions Matter to OEBB/PEBB

- Musculoskeletal procedures for back/spine and hip/knee replacement represent a significant area of spend and prevalence for both OEBB and PEBB

Top Conditions by Allowed*

Condition	Rank	Allowed	Patients	OEBB Rank	PEBB Rank
Cancer	1	$93,196,470	4,564	1	1
Hip/knee/major joints	2	$52,475,490	7,709	2	3
Infections	3	$49,849,797	79,434	3	4
Diabetes	4	$47,384,673	9,249	4	5
Spinal/Back	5	$45,968,411	35,206	7	2

*Note: this chart excludes the category of preventive/administrative health encounters. Time period: October 2017 – September 2018. Arthritis/hip/knee/major joints does not include claims related to rheumatoid arthritis. Infections include: body sites, eye, gastrointestinal, gynecological, multisystem, musculoskeletal, nervous system, respiratory, urinary and NEC. Spinal/back includes: low back and back disorders.

Importance of Focus on Musculoskeletal Conditions

Complication 3% – 12%
Reoperation 1% – 9%

rates for back surgery vary significantly by surgeon

Significant Cost Variation

$22k – $112k range for spinal surgery

Efficacy

For spinal fusion, outcomes are similar for patients treated surgically compared to those treated non-surgically

6% annual trend for joint replacement surgery

10% annual trend for spine surgery

Appropriateness of Care

One in five patients have a major change in recommended treatment plan if they obtain a second opinion regarding orthopaedic or spine procedures

30 – 50% of spine fusions are not evidence-based

Note: see appendix page 52 for reference sources

Back/Spine Place of Spend — OEBB and PEBB Combined

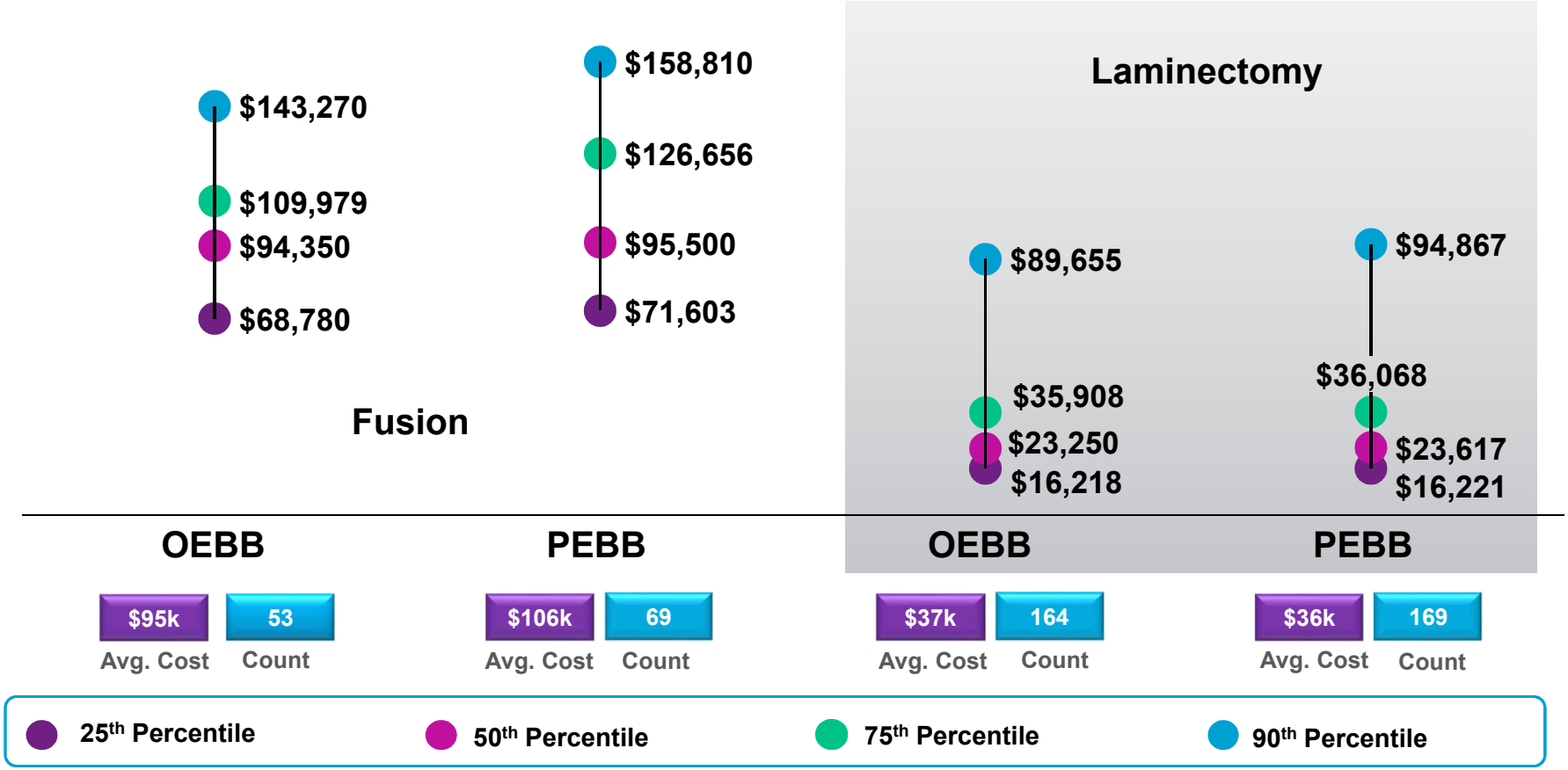
2018 Spine Fusion Inpatient	2018 Spine Fusion Outpatient	2018 Spine Fusion Ambulatory	2018 Spine Laminectomy Inpatient	2018 Spine Laminectomy Outpatient	2018 Spine Laminectomy Ambulatory
$12.0M	$214k	$193k	$6.9M	$3.8M	$1.4M
110	7	5	85	152	95
96%	2%	2%	57%	31%	12%

2018 Neck Fusion Inpatient	2018 Neck Fusion Outpatient	2018 Neck Fusion Ambulatory	2018 Neck Laminectomy Inpatient	2018 Neck Laminectomy Outpatient	2018 Neck Laminectomy Ambulatory
$4.6M	$1.9M	$385k	$901k	$203k	$85k
65	48	14	14	9	5
67%	27%	6%	76%	17%	7%

Episode defined as allowed claims incurred 10 days prior to surgery and up to 30 days after surgery. All allowed claims for an episode are grouped in the procedure's place of service.

Spine Fusion/Laminectomy Surgery Cost Variation By Group

A Deeper Dive into Back and Spine Cost and Prevalence



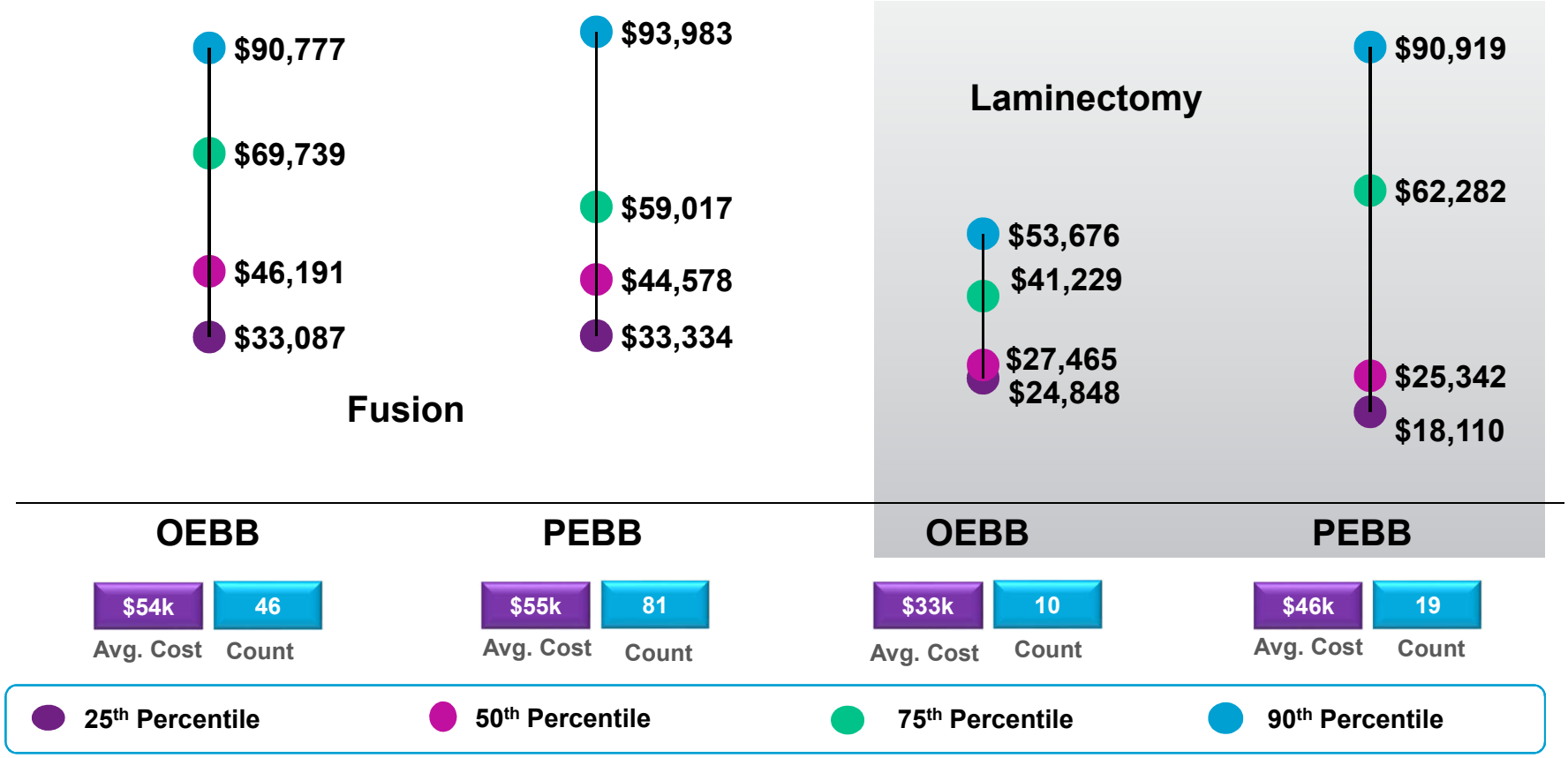
Observations

- SB 1067 hospital facility cap is expected to reduce cost variance between facilities and between OEBB/PEBB
- Reassess variance after cap has been implemented and focus on non-facility portion of the variance
- Monitor shift of care to facilities that are not subject to SB 1067 cap

Note: Cost variation is due to geography and provider billing and is not based on complex vs. simple procedures/services. A procedure episode includes all allowed claims incurred 10 days prior to surgery and up to 30 days after surgery.

Neck Fusion/Laminectomy Surgery Cost Variation By Group

A Deeper Dive into Back and Spine Cost and Prevalence



Observations

- SB 1067 hospital facility cap will reduce variance between facilities and between OEBB/PEBB
- Reassess variance after cap has been implemented and focus on non-facility portion of the variance
- Monitor shift of care to facilities that are not subject to SB 1067 cap

Note: Cost variation is due to geography and provider billing and is not based on complex vs. simple procedures/services. A procedure episode includes all allowed claims incurred 10 days prior to surgery and up to 30 days after surgery.

Are Procedures Being Performed at Hospitals with Demonstrated Outcomes?

Fusion and Laminectomy Procedures

Quality Key:

- 90th percentile or above
- 75th – 89.9th percentile
- 25th – 74.9th percentile
- 10th – 24.9th percentile
- Less than 10th percentile

Currently, 76% of services are being done at facilities with quality score above 75%

OEBB And PEBB Combined: Top Facilities Utilized By Spend Back/Neck/Spine

#	Facility	Subject to HRC	Location	Total Allowed	Total Surgery Count	Quality Score Composite
1	Salem Hospital	✓	Salem, OR	$3,762,729	77	
2	PeaceHealth Sacred Heart Medical Center at RiverBend	✓	Springfield, OR	$2,721,248	45	
3	OHSU	✓	Portland, OR	$1,974,458	25	
4	McKenzie-Willamette Medical Center	✓	Springfield, OR	$1,608,354	15	
5	Providence St. Mary Medical Center		Walla Walla, WA	$1,390,778	13	
6	Providence St. Vincent Medical Center	✓	Portland, OR	$1,273,858	38	
9	St. Charles Health System — Redmond and Bend	Bend	Redmond/Bend, OR	$1,215,477	40	
7	Asante Rogue Regional Medical Center	✓	Medford, OR	$1,124,359	22	
8	Providence Medford Medical Center	✓	Medford, OR	$1,096,119	14	
10	Providence Portland Medical Center	✓	Portland, OR	$880,088	32	

Episode defined as allowed claims incurred 10 days prior to surgery and up to 30 days after surgery. All claims for an episode are attributed to the procedure's primary facility
Quality Analytics provided by Quantros, Inc.

Which Hospitals in the Area Have the Highest Overall Quality Scores for these Procedures?

Spine Fusion and Laminectomy Procedures

Quality Key:

- 90th percentile or above
- 75th – 89.9th percentile
- 25th – 74.9th percentile
- 10th – 24.9th percentile
- Less than 10th percentile

Highest Quality Scores for Hospitals in PEBB/OEBB Service Areas for Spine Surgeries:

#	Facility	Subject to HRC	Location	OEBB/PEBB Top 10 Facility?	Surgery Quality Score*	Fusion Quality Score*
1	Providence St. Mary Medical Center		Walla Walla, WA	Y	99.9	99.9
2	Asante Rogue Regional Medical Center	✓	Medford, OR	Y	99.5	99.4
3	Sacred Heart Medical Center — Riverbend	✓	Springfield, OR	Y	98	94.2
4	Providence Medford Medical Center	✓	Medford, OR	Y	96.7	98.3
5	SW Washington Medical Center		Vancouver, WA	N	94.7	90.8
6	Salem Hospital	✓	Salem, OR	Y	92.8	89.1
7	Providence St. Vincent Medical Center	✓	Portland, OR	Y	92.6	93.3
8	Sky Lakes Medical Center		Klamath Falls, OR	N	80.7	77.8
9	McKenzie-Willamette Medical Center	✓	Springfield, OR	Y	80.3	77.8
10	Bay Area Hospital		Coos Bay, OR	N	76.9	73.9
11	Adventist Medical Center	✓	Portland, OR	N	75.8	62.2

*Surgery quality score includes fusion and laminectomy surgeries. Data and quality analytics provided by Quantros, Inc.

Quality Data is Available at the Individual Provider Level

Individual Provider Quality Scores for Spinal Surgery

Clinically Adjusted Cost

OHSU Hospital and Clinics

380009 | Portland, OR

Overview | Physicians | DRGs

Clinical Category: Spinal Surgery

Performance Period: Q4 2015 - Q3 2018

Average Cost Per Physician

$38,157 ↑**

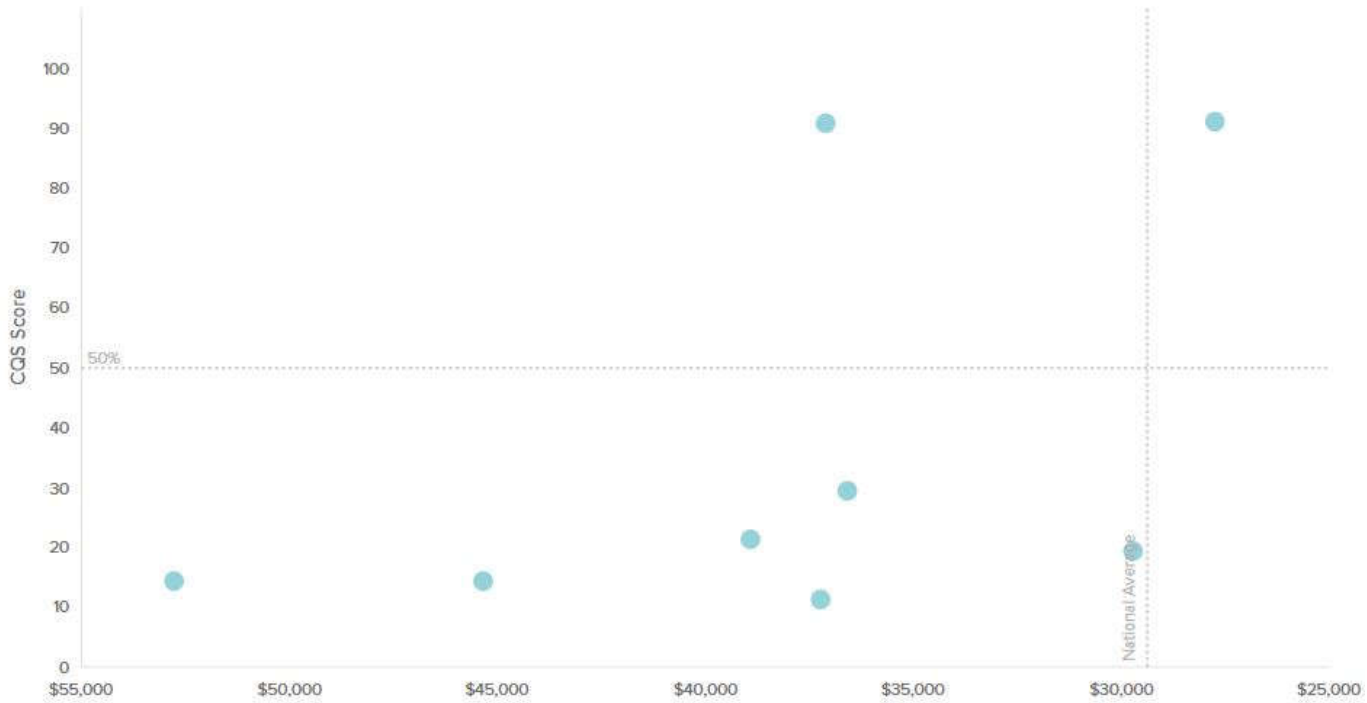
National Average

$29,380

Percent Average Per Physician

129.9%

Physician Cost vs. CQS Score



Note: data and quality analytics provided by Quantros, Inc.

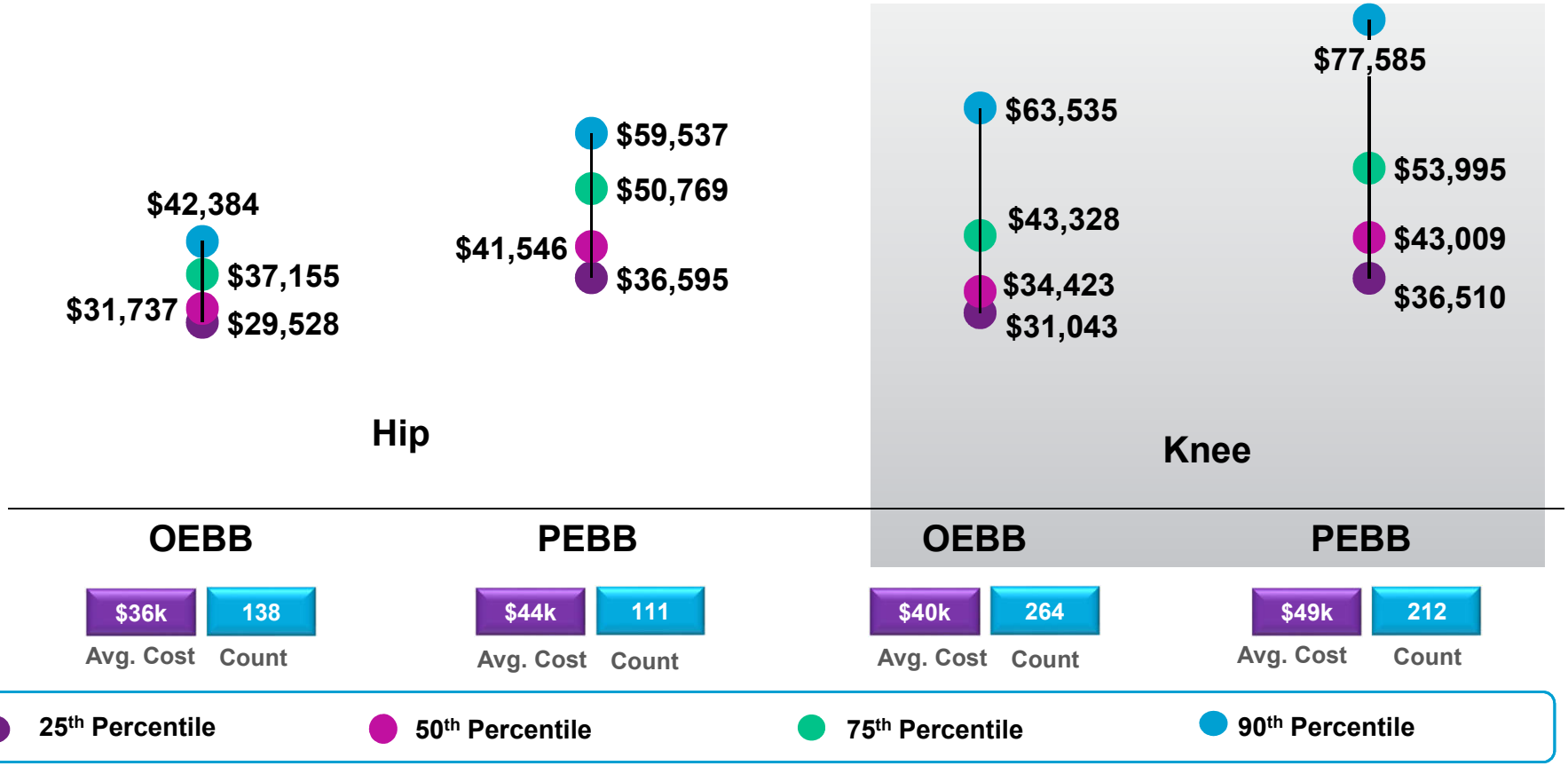
Hip/Knee Place of Spend — OEBB and PEBB Combined

2018 Hip Replacement Inpatient	2018 Hip Replacement Outpatient	2018 Hip Replacement Ambulatory	2018 Knee Replacement Inpatient	2018 Knee Replacement Outpatient	2018 Knee Replacement Ambulatory
$8.2M	$110k	$1.6M	$15.9M	$2.3M	$2.8M
197	3	49	336	49	91
83%	1%	16%	76%	11%	13%

Episode defined as allowed claims incurred 10 days prior to surgery and up to 30 days after surgery. All allowed claims for an episode are grouped in the procedure's place of service.

Hip/Knee Replacement Surgery Cost

Procedure Cost Variation for OEBB/PEBB



Observations

- SB 1067 hospital facility cap will reduce variance between facilities and between OEBB/PEBB
- Reassess variance after cap has been implemented and focus on non-facility portion of the variance
- Monitor shift of care to facilities that are not subject to SB 1067 cap

Note: Cost variation is due to geography and provider billing and is not based on complex vs. simple procedures/services
A procedure episode includes all allowed claims incurred 10 days prior to surgery and up to 30 days after surgery.

Are Procedures Being Performed at Hospitals with Demonstrated Outcomes?

Hip Replacements

Quality Key:

- 90th percentile or above
- 75th – 89.9th percentile
- 25th – 74.9th percentile
- 10th – 24.9th percentile
- Less than 10th percentile

Currently, 62% of services are being done at facilities with quality score above 75%

OEBB and PEBB Combined: Top Facilities Utilized by Spend

#	Facility	Subject to HRC	Location	Total Allowed	Total Surgeries	Quality Score: Composite
1	Salem Hospital	✓	Salem, OR	$884,423	26	
2	PeaceHealth Sacred Heart Medical Center at RiverBend	✓	Springfield, OR	$783,500	20	
3	St. Charles Health System — Bend	✓	Bend, OR	$467,726	15	
4	Willamette Surgery Center PC		Salem, OR	$467,153	18	Data not available for outpatient facilities
5	Providence St Vincent Medical Center	✓	Portland, OR	$430,920	13	
6	Legacy Silverton Medical Center		Silverton, OR	$407,981	15	
7	Legacy Meridian Park Medical Center	✓	Tualatin, OR	$313,085	16	
8	OHSU	✓	Portland, OR	$308,398	12	
9	McKenzie-Willamette Medical Center	✓	Springfield, OR	$306,084	7	
10	Grants Pass Surgery Center		Grants Pass, OR	$297,000	10	Date not available for outpatient facilities

Episode defined as allowed claims incurred 10 days prior to surgery and up to 30 days after surgery. All claims for an episode are attributed to the procedure's primary facility.
Quality data and analytics provided by Quantros, Inc.

Are Procedures Being Performed at Hospitals with Demonstrated Outcomes?

Knee Replacement Surgery

Currently, 69% of services are being done at facilities with quality score above 75%

Quality Key:

- 90th percentile or above
- 75th – 89.9th percentile
- 25th – 74.9th percentile
- 10th – 24.9th percentile
- Less than 10th percentile

OEBB and PEBB Combined: Top Facilities Utilized by Spend

#	Facility	Subject to HRC	Location	Total Allowed	Total Surgeries	Quality Score: Composite
1	St. Charles Health System — Bend	✓	Bend, OR	$1,861,406	57	
2	PeaceHealth Sacred Heart Medical Center at RiverBend	✓	Springfield, OR	$1,847,221	45	
3	Salem Hospital	✓	Salem, OR	$1,681,629	56	
4	Willamette Surgery Center PC		Salem, OR	$721,139	33	Data not available for outpatient facilities
5	Legacy Silverton Medical Center	✓	Silverton, OR	$703,716	21	
6	Samaritan Albany General Hospital	✓	Albany, OR	$533,084	13	
7	McKenzie-Willamette Medical Center	✓	Springfield, OR	$529,291	16	
8	Providence Portland Medical Center	✓	Portland, OR	$520,242	22	
9	Providence St. Vincent Medical Center	✓	Portland, OR	$496,945	21	
10	Grants Pass Surgery Center		Grants Pass, OR	$464,985	16	Date not available for outpatient facilities

Episode defined as allowed claims incurred 10 days prior to surgery and up to 30 days after surgery. All claims for an episode are attributed to the procedure's primary facility.
Quality data and analytics provided by Quantros, Inc.

Which Hospitals in the Area have the Highest Overall Quality Scores for these Procedures?

Quality Key:

- 90th percentile or above
- 75th – 89.9th percentile
- 25th – 74.9th percentile
- 10th – 24.9th percentile
- Less than 10th percentile

Highest Quality Hospitals in PEBB/OEBB Service Areas

#	Facility	Subject to HRC	Location	OEBB/PEBB Top 10 Facility?		Quality Score*
				Hip	Knee	
1	Salem Hospital	✓	Salem, OR	Y	Y	98.9
2	Asante Three Rivers Medical Center	✓	Grants Pass, OR	N	N	97.7
3	Asante Rogue Regional Medical Center	✓	Medford, OR	N	N	96.9
4	St Charles Bend	✓	Bend, OR	Y	Y	96.7
5	Sacred Heart Medical Center — Riverbend	✓	Springfield, OR	Y	Y	96.2
6	Providence Medford Medical Center	✓	Medford, OR	N	N	86.7
7	Legacy Salmon Creek Medical Center		Vancouver, WA	N	N	86.2
8	Legacy Meridian Park Medical Center	✓	Tualatin, OR	Y	N	83.0
9	Good Samaritan Regional Medical Center	✓	Corvallis, OR	N	N	80.7
10	S W Washington Medical Center		Vancouver, WA	N	N	80.3
11	Samaritan Albany General Hospital	✓	Albany, OR	N	Y	78.0
12	Providence St. Vincent Medical Center	✓	Portland, OR	Y	Y	77.3

*Data and quality analytics provided by Quantros, Inc.

Recommended Framework

Best Practice Approach for Addressing Musculoskeletal Conditions

Prevention

Member does not have any significant back/spine or joint issues:

- **Weight management**
- **Exercise**
- **Education**
- **Ergonomics**

How do OEBB and PEBB assist members in avoiding significant back/spine conditions?

Steerage/Decision Support

Member is beginning to develop a musculoskeletal condition:

- **Conservative treatment**
- **Physical therapy**
- **Treatment decision support**

How does OEBB/PEBB support members in understanding and navigating the optimal care path when they begin to experience back or spine problems?

Surgery Support

When surgery or a complex procedure is the best course of treatment:

- **Spinal fusions or laminectomies**
- **Neck fusions or laminectomies**
- **Knee replacement**
- **Hip replacement**

How does OEBB/PEBB support members in accessing the best quality and lowest cost treatment option?

Best Practices

Musculoskeletal Conditions

Framework	Best practice approach	Kaiser	Moda	Providence
Prevention	▪ Lifestyle management programs (e.g., weight management, smoking cessation, lifestyle coaching, yoga program, etc.)	Y	Y	Y
Steerage/ Treatment Decision Support	▪ Advanced radiology management vendor to prevent premature imaging (PA with denials)	Y	Y	Y
	▪ Steerage to physical therapy, chiropractic, and acupuncture benefits (consider virtual solutions)	Y	Y	Y
	▪ Require treatment decision support/expert medical opinion services	N	N	N
	▪ Provide and promote cost and quality transparency tools to members	Y (cost only)	N	N
Surgery Support	▪ Reimburse providers through value-based contracts, or bundles, in place of fee for service	Y	Y (OEBB) N (PEBB)	Y (Prov. facilities only)
	▪ Centers of excellence and/or specialty condition carve-out network for high cost procedures (including evaluation of facilities and providers)	Y (internal only)	N	Y (Prov. facilities only)
	▪ Ensure coordination among vendor partners	NA	N	N
	▪ Ensure proper prior authorization/utilization management approaches are in place for spine/joint replacement surgery	Y	N	Y (Prov. facilities only)

Current OEBB/PEBB Carrier Programs and Initiatives

Framework	Kaiser	Moda	Providence
Prevention	▪ All carriers offer weight management, nutrition counseling and smoking cessation programs		
Steerage/ Treatment Decision Support	▪ Shared decision model ▪ Steerage to physical therapy ▪ Virtual physical therapy ▪ Internal PA process embedded in Clinical Practice Guidelines	▪ Evicore PA for high-tech imaging ▪ Provider-led steerage/decision support ▪ Second opinion from OHSU as needed	▪ AIM PA for high-tech imaging ▪ Provider-led steerage/decision support
Surgery Support	▪ Internal COE program for joint replacement and spine care ▪ Total Joint Replacement Registry	▪ Reference price for hip/knee replacements ▪ Additional cost tier for additional back/spine procedures	▪ Steerage to select providers ▪ Bundled payment for joint replacements at Providence facility

- Opportunities:
  - Formal, aligned second opinion and treatment decision support
  - Virtual physical therapy support
  - Steerage to high quality specialists and facilities

Key:
- Prevention
- Steerage/Decision Support
- Surgery/Complex Case Support

Market Leading Employer Interventions

Employer Description	Primary Intervention	Results
Technology plan sponsor with approximately 52k U.S. employees	Primary focus — surgical management and analytics: Preventive screening initiative Use of claims analytics to identify those at risk for surgery Targeted member outreach **Offer decision support for spine and joint** **Non-engagement penalty of $1k before surgery** **Focus on surgical alternatives, clinical decision support and steerage by leveraging vendor partner**	▪ Significant savings (over $6M over three years) ▪ Engagement rose to 3.5X with penalty ▪ 51% of stratified and engaged members avoided surgery ▪ Measuring high satisfaction with program
Consumer good employer with approximately 250k employees	**Primary focus — surgical management and mandated use of COE:** Wellness and incentive programs Onsite support Concierge support **COEs with regional health systems** Clinical decision support Surgical alternatives **Mandated travel to regional center for spine surgery (includes travel benefit with companion)**	▪ Significant program ROI (5:1) ▪ 33 – 40% of surgery avoidance ▪ Improved surgical outcomes ▪ Extended COE care with back-at-home physicians ▪ High patient and family satisfaction ▪ Much redirected care success
Consumer goods employer with 25k employees	Primary focus — prevention, digital engagement and connectivity to resources: Weight loss program **Virtual physical therapy coaching through vendor partnership** Care advocates Transparency tool through vendor partnership Second opinion vendor partnership COE	▪ 9% engagement through digital solution ▪ NPS of 72 ▪ Measuring: 70% pain reduction, push out in intent to have surgery, 48% reduction in behavioral therapy screenings

Marketplace Solutions

Expert Medical (2nd) Opinion (EMO) and Treatment Decision Vendors

2nd.MD
advance|medical
Best Doctors
consumermedical
GRAND ROUNDS

Member Advocacy; Navigator Carve–Out Vendors

Accolade
COMPASS Healthcare Redefined
Health Advocate
Quantum HEALTH

Musculoskeletal Solutions

HingeHealth
SimpleTherapy
PHYSERA

Centers of Excellence Vendors

BridgeHealth
Aetna
Anthem
carrum health
SurgeryPlus By EmployerDirect Healthcare
Cigna
UnitedHealthcare

Transparency Vendors

castlight HEALTH
CHANGE HEALTHCARE
Healthcare Bluebook

Recommendations

Continuum of Suggested Interventions

Light	Medium	Robust
▪ Educate members on treatment options (offer treatment decision support/expert medical opinion — i.e., Best Doctors/Grand Rounds) ▪ Virtual physical therapy (vendor solution) ▪ Implement medical necessity denials for high-tech imaging	▪ Identify high performing specialists and providers ▪ Require members obtain a treatment decision support/expert medical opinion (EMO) consult prior to coverage of a procedure or tie to higher Additional Cost Tier	▪ Establish high performing network of high quality specialists with plan design steerage ▪ COE: establish direct contracting with high quality facilities ▪ Bundled payment for provider and facilities

Cancer

Key Data Findings

- Cancer procedures represent a significant area of spend and prevalence for both OEBB and PEBB

Top Conditions by Allowed*

Condition	Rank	Allowed	Patients	OEBB Rank	PEBB Rank
Cancer	1	$93,196,470	4,564	1	1
Arthritis/hip/knee/major joints	2	$52,475,490	7,709	2	3
Infections	3	$49,849,797	79,434	3	4
Diabetes	4	$47,384,673	9,249	4	5
Spinal/Back	5	$45,968,411	35,206	7	2

*Note: this chart excludes the category of preventive/administrative health encounters. Time period: October 2017 – September 2018. Arthritis/hip/knee/major joints does not include claims related to rheumatoid arthritis. Infections include: body sites, eye, gastrointestinal, gynecological, multisystem, musculoskeletal, nervous system, respiratory, urinary and NEC. Spinal/Back includes: low back and back disorders. Cancer excludes skin cancers.

Cancer Care

84% of medical oncologists surveyed acknowledge a lack of confidence when delivering precision medicine

FDA approved a record 18 new cancer therapies and 13 new uses of cancer therapies between November 2016 – October 2017

CAR-T Cell Therapy

Has the potential for total cost per patient of ~$1.5M

$375k – $1.5M per patient poses unique challenges for Gene Therapy

Up to 28% of cancer cases are misdiagnosed or mis-staged, yet this rate is underestimated by many oncologists.

33% – 70% of patients

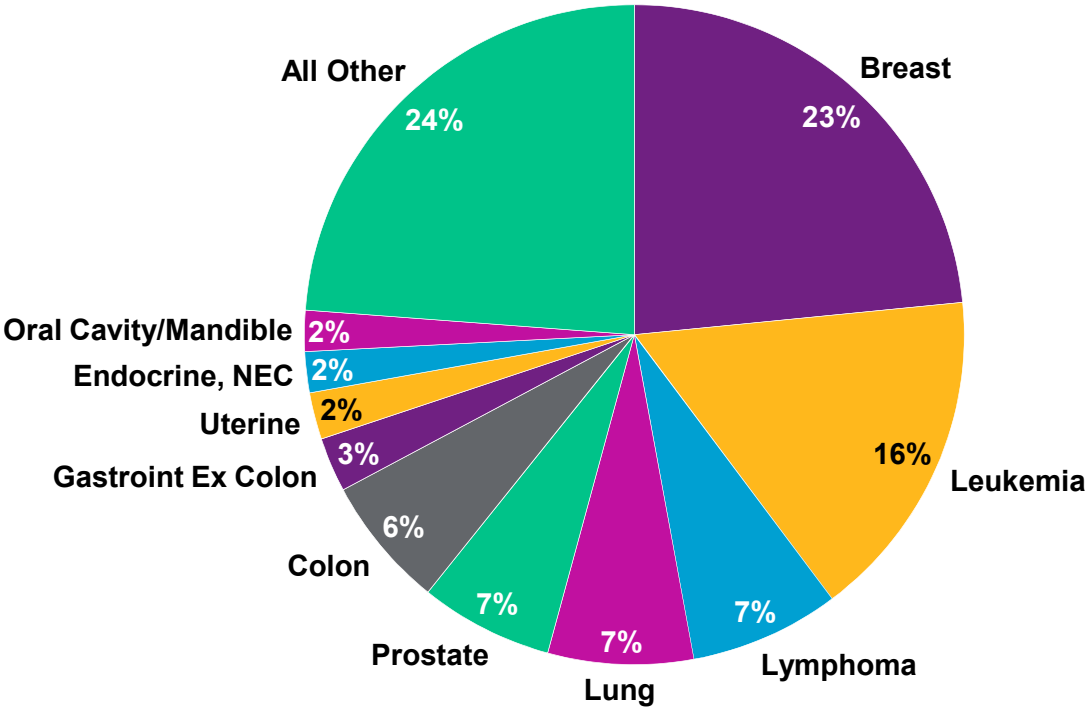
With known treatable mutation receive appropriate targeted therapy

Note: see appendix page 51 for reference sources

Cancer Spend by Type

Targeted

Type of Cancer	Spend ($M)*	Patients**
Breast	$31.6	1,742
Leukemia	$22.0	407
Lymphoma	$9.9	397
Colon	$9.6	250
Prostate	$8.8	842
Lung	$8.7	431
Oral cavity/mandible	$3.6	143
Uterine	$3.1	278
Endocrine, NEC	$2.7	532
Gastroint Ex colon	$2.7	150
All other	$32.1	
Total	**$134.8**	

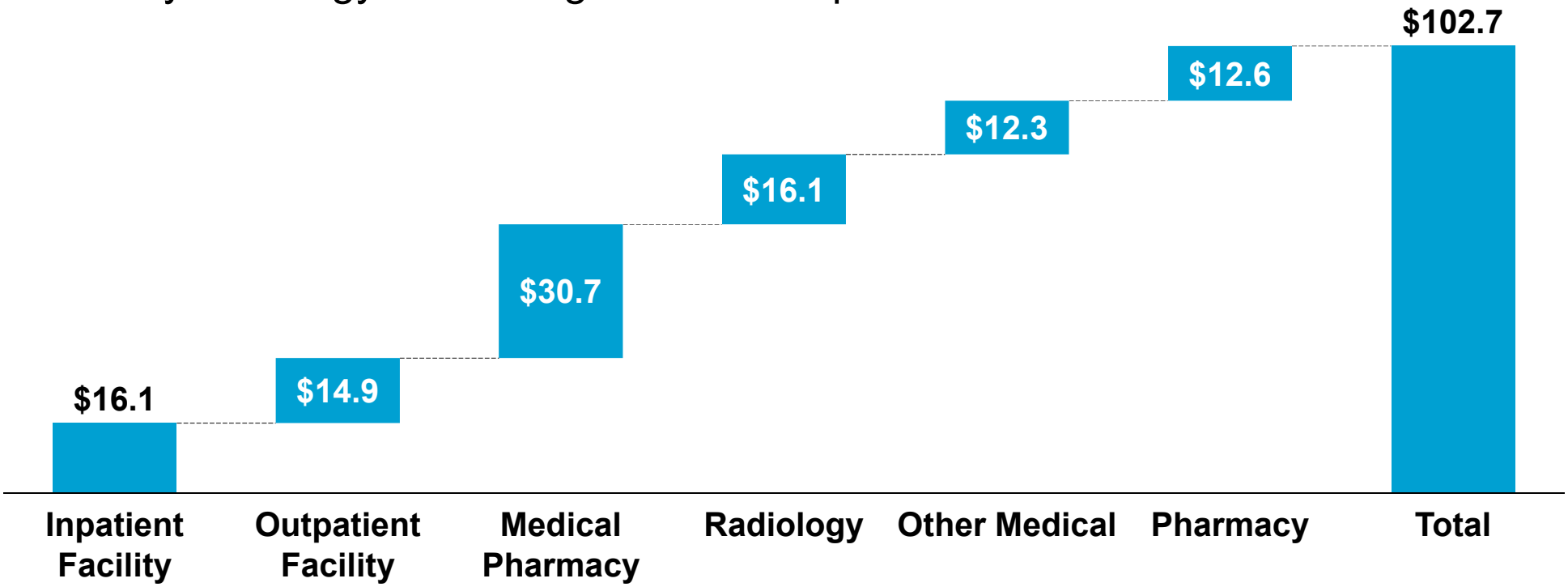


Targeted cancers represent **78%** of OEBB and PEBB's total cancer spend

*An Episode of care is a Medstat grouper for costs associated with a defined period of care; applied here for targeted cancer Episodes.
** Patient counts are unique patients for each specific cancer category

Place of Spend: Targeted Cancer Episodes of Care

Pharmacy/Oncology is the Largest Area of Spend for Cancer



($M)	Inpatient Facility	Outpatient Facility	Medical Pharmacy	Radiology	Other Medical	Pharmacy	Total
Combined	$16.1	$14.9	$30.7	$16.1	$12.3	$12.6	$102.7
OEBB	$9.7	$8.0	$17.3	$8.6	$6.5	$5.2	$55.5
PEBB	$6.3	$6.9	$13.4	$7.5	$5.8	$7.3	$47.2

An Episode of care is a Medstat grouper for costs associated with a defined period of care; applied here for targeted cancer Episodes.

Measuring quality and outcomes for cancer

- Treatment protocol is individualized to the patient, progression of disease, type of cancer
  - One size fits all does not apply
- National Cancer Institute (NCI):
  - Federal agency for cancer research and training
  - NCI recognizes cancer centers that meet rigorous standards for transdisciplinary, state of the art research focused on developing new and better approaches to preventing, diagnosing and treating cancer
  - OR — Knight Cancer Center/OHSU
  - WA — Fred Hutchinson/UW
  - CA — 10 facilities including City of Hope
- National Comprehensive Cancer Network (NCCN)
  - Alliance of leading cancer centers devoted to patient care, research, education
  - Develop guidelines to improve quality and promote efficient/effective cancer care

Top facilities by OEBB/PEBB spend

Facility Med + Professional Med + Rx

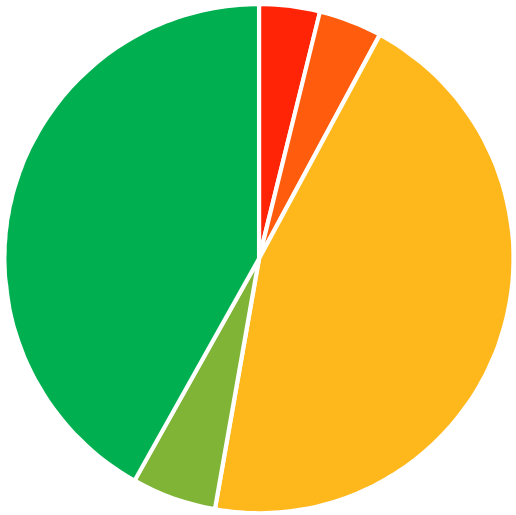
Quality Key:

- 90th percentile or above
- 75th – 89.9th percentile
- 25th – 74.9th percentile
- 10th – 24.9th percentile
- Less than 10th percentile

OEBB and PEBB Combined: Top Facilities Utilized by Spend

#	Facility	Location	Total Allowed ($M)	Total Patients	Inpatient Cancer Care Quality Score* Composite 36 Months	Inpatient Cancer Care Quality Score* Composite 18 Months
1	OHSU	Portland	$12.1	679		
2	Providence Portland Medical Center	Portland	$5.0	351		
3	Salem Hospital	Salem	$5.5	484		
4	Providence St. Vincent Medical Center	Portland	$2.0	258		
5	Good Samaritan Regional	Corvallis	$1.9	156		
6	St. Lukes Boise Medical Center	Boise	$1.9	75		
7	Bay Area Hospital	Coos Bay	$1.5	66		
8	St. Charles Health System — Redmond	Redmond	$1.4	26		
9	St. Charles Health System — Bend	Bend	$1.3	144		
10	Columbia Memorial Hospital	Astoria	$1.2	35		
11	Legacy Good Samaritan Medical Center	Portland	$1.2	82		
12	Providence Medford Medical Center	Medford	$1.2	63		

Quality Distribution Prior 18 months



Observations:

- Quality scores are shown only for the top 12 cancer inpatient facilities
  - Quality scores specific to cancer are not available for outpatient facilities
  - Includes only targeted cancer types, but all claims (not just inpatient) associated with the cancer care
- For the top 12 inpatient cancer facilities, 47% are performing at or above the 75th percentile in quality ranking in the last 18 months
- In general, quality scores have been improving over the last 36 months, notably for OHSU which has moved from middle to highest ranking

* Quality score provided by Quantros, Inc. 18 month national average

Note: an episode of care is a Medstat grouper for costs associated with a defined period of care. All allowed claims for targeted cancer Episodes are attributed to the episode's primary facility.

Quality Data is Available at the Individual Provider Level

Quantros Snapshot — Individual Provider Quality Scores for Cancer at OHSU

Clinically Adjusted Cost

OHSU Hospital and Clinics

380009 | Portland, OR

Clinical Category: Cancer Care

Performance Period: Q4 2015 - Q3 2018

Overview | Physicians | DRGs

Average Cost Per Physician

$18,097 ↑**

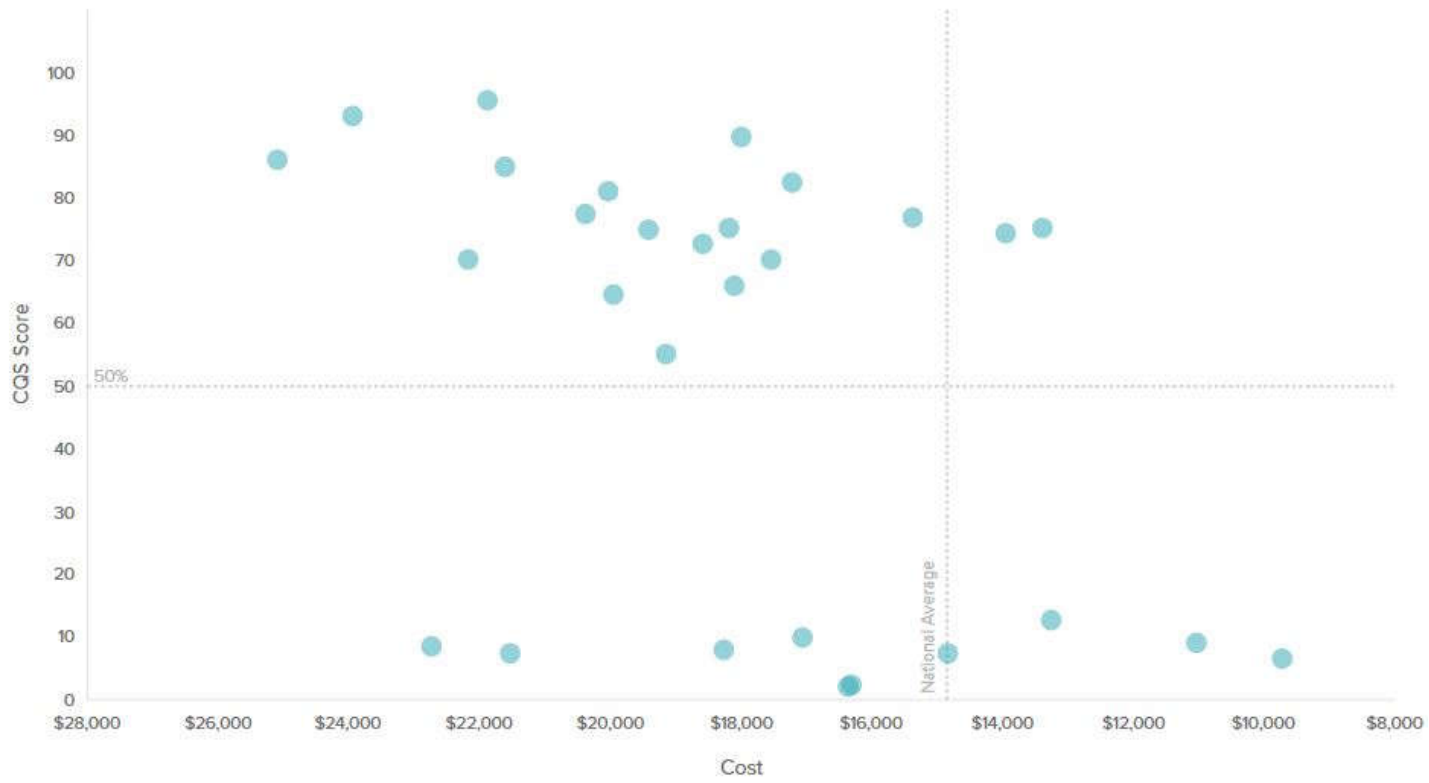
National Average

$14,850

Percent Average Per Physician

121.9%

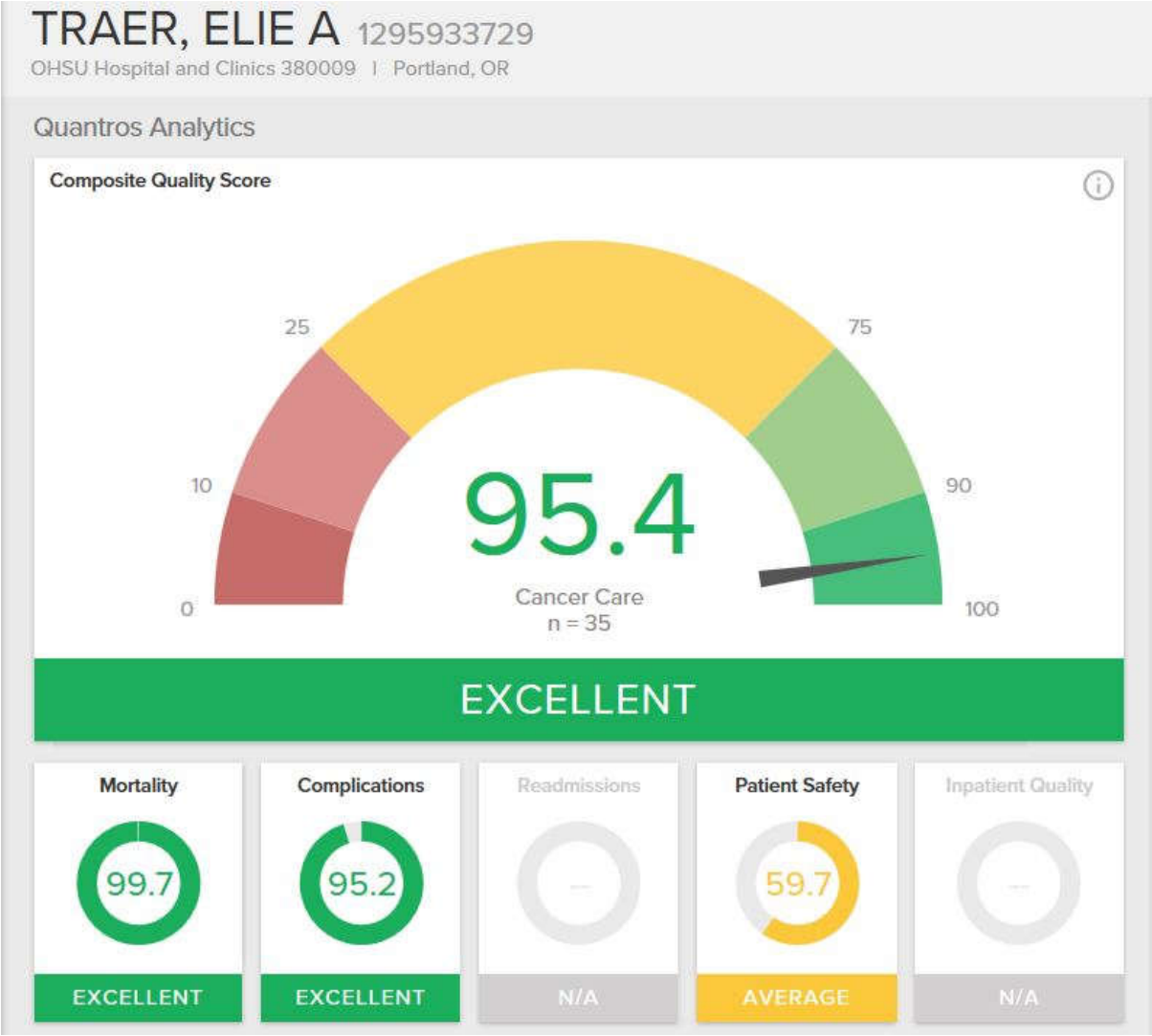
Physician Cost vs. CQS Score



Note: data and quality analytics provided by Quantros, Inc.

Quality Data is Available at the Individual Provider Level (Continued)

Quantros Snapshot — Detailed Quality Scores by Provider for Cancer at OHSU



Infusions: Variation In cost

Breast Cancer Infused Medications — Top Three by Place of Service

Drug Name	Total Spend	Place of Service	Cost per Patient
Herceptin	$3,915,287	Office	$40,076
		Outpatient Hospital	$66,847
Perjeta	$1,501,720	Office	$36,289
		Outpatient Hospital	$57,990
Neulasta	$1,238,557	Office	$11,114
		Inpatient Hospital	$19,400
		Outpatient Hospital	$19,379

- Generally, the office setting is the lowest cost venue for medical pharmacy cancer spend
- Opportunity exists to steer infused medications at office setting or designated COE

Recommended Framework

Best Practice Approach to Cancer Care

- Breast cancer screening
- Colon cancer screening

How does OEBB/PEBB educate members on the best ways to prevent cancer or encourage early detection?

- Expert opinion treatment plan
  - NCCN guidelines
  - NCI accredited facilities

How does OEBB/PEBB support members and their families obtain accurate diagnosis and optimal treatment protocol?

- Member follows personalized pathway which may require additional benefit support and care coordination
  - Avoid unnecessary admissions/complications

How does OEBB/PEBB support members and their families navigate their treatment protocol, seek optimal care and stay compliant with treatment?

Best Practices

Cancer

Framework	Best practice approach	Kaiser	Moda	Providence
Screening/Early Detection	▪ Encourage ongoing preventive screening: mammography, colonoscopy	Y	Y	Y
	▪ Help providers remind patients about getting screened	Y	Y	Y
Correct Diagnosis and Treatment Plan	▪ Correct diagnosis and optimal treatment protocol (specialized second opinion)	N (internal only)	N	N (can support)
	▪ Cover genomic testing of cancer tissue	Y (blood cancer only)	N	N
	▪ Require precertification for oncology and chemo-therapy	N (meet internal CPGs)	N (limited)	Y (if not meet NCCN)
Ongoing Treatment/ Member Support	▪ NCCN guidelines and NCI accredited facilities	Y	N	Y
	▪ Steerage to specialists with demonstrated quality scores specific to cancer	N (internal only)	N	N
	▪ Site of service steerage for infused chemotherapy and radiology	Y	N (evaluating)	Y (soft steerage)
	▪ Gene therapy drug coverage/management and precision oncology	N	N	N
	▪ Integrated care team (i.e., dietician, pharmacist, social worker, BH, etc.)	Y	N	N
	▪ Cancer specific advocacy program	Y	N	N

Current OEBB/PEBB Carrier Programs and Initiatives

Framework	Kaiser	Moda	Providence
Screening/ Early Detection	▪ OEBB and PEBB carriers are in 75th percentile for breast cancer and colon cancer screening rates		
Early Intervention/ Diagnosis	▪ Second opinion within Kaiser ▪ NCCN Guidelines inform KP Clinical Practice Guidelines ▪ Cover Genetic testing	▪ NCCN Guidelines are one source of information in PA ▪ Genetic testing subject to PA	▪ NCCN Guidelines are primary basis of PA ▪ Genetic testing subject to PA
Ongoing Treatment/ Support	▪ Dedicated infusion center ▪ PA for proton beam and Car-T ▪ Precision medicine program is under development ▪ Nurse navigators provide member support	▪ PA for proton beam and Car-T	▪ Coverage of genetic testing ▪ PA for proton beam and Car-T ▪ Site of service requests are reviewed case by case

- Opportunities:
  - Robust PA processes
  - Formal second opinion program and steerage to high quality specialists and facilities
  - Site neutral or site of care steerage for chemotherapy infusions
  - Precision medicine assistance
  - Care advocacy team for member

Key:
- Prevention/Screenings
- Early Intervention/Diagnosis
- Ongoing Treatment/Support

Market leading employer interventions

Employer Description	Primary Intervention	Results
Pharmaceutical company with 14k U.S. employees	**Comprehensive strategy with center-of-excellence model:** Incentivized screenings Coverage for genetic testing Precision medicine (personalized) treatment support and nurse case manager Steerage for high quality national and pediatric oncology COE Navigation strategy and support resources Benefit coverage alignment for supporting medical care and resources Post-care plan based on patient need	▪ New program
Global commerce and technology company with 15k employees	**Primary focus — treatment support program with Johns Hopkins Comprehensive Cancer Center:** Managing Cancer at Work program Targeted web-based education modules to cancer patients, caregivers, and managers Oncology nurses (some onsite) who navigate members through cancer services and care Steerage to COE and quality-based network resources Assess treatment plan in conjunction with return to work planning Nurses will provide coordination with managers (subject to patient agreement)	▪ Increasing engagement in program since 2017 launch ▪ High satisfaction ▪ High rate of successful return to work ▪ Expansion of nurse support services
▪ **Approx. 20k U.S. employees** ▪ **Loyalty and marketing services**	**Primary focus — navigation and center-of-excellence model with virtual support:** Screening and education High touch navigation model with care management and outreach for cancer diagnoses Nurse case management and referral to expert/2nd opinion program and personalized cancer plan with City of Hope Steerage to COE or virtual support/coordination with local providers	▪ New program

Cancer-Related Marketplace Solutions

Centers of Excellence

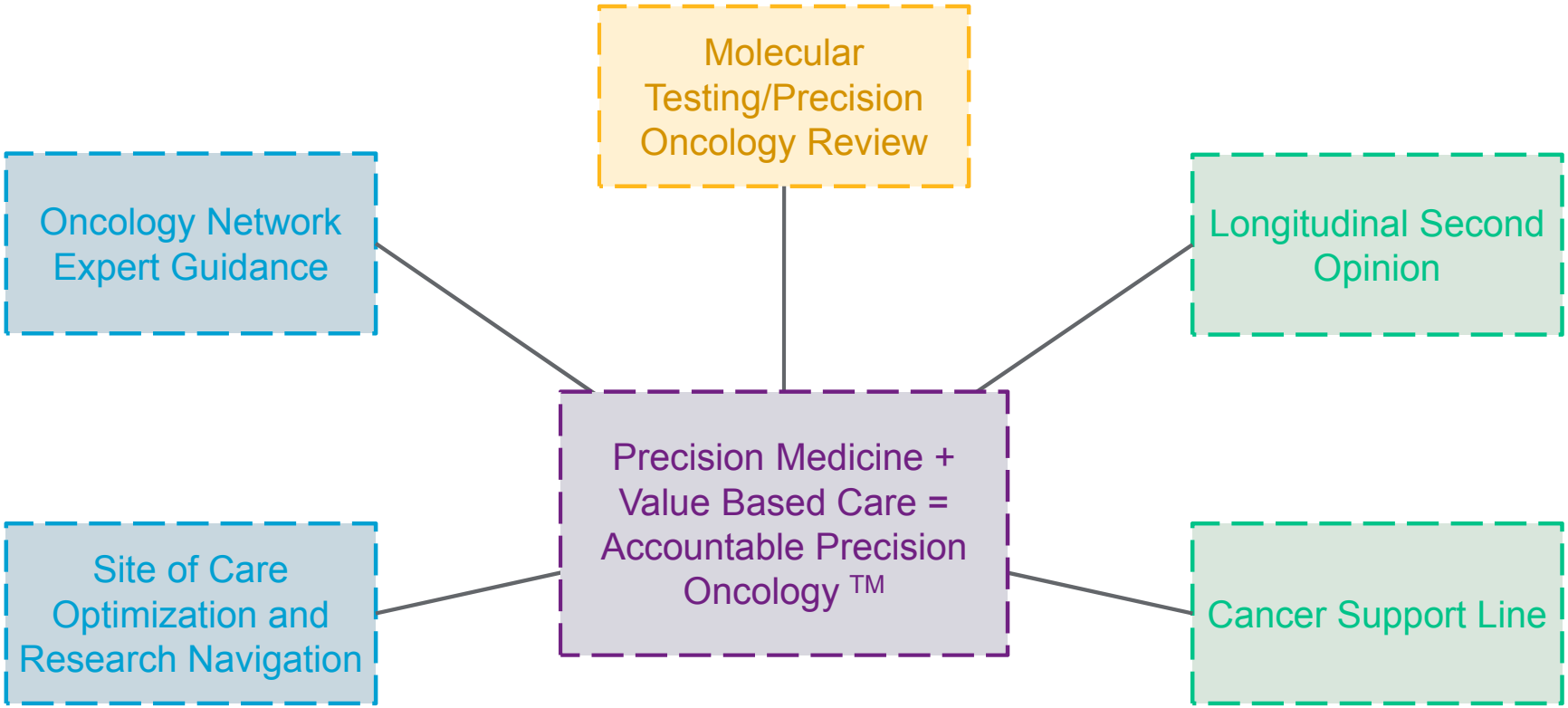
Expert Medical (2nd) Opinion and Treatment Decision Vendors

NCI-Designated Cancer Centers

Member Advocacy/Navigator Carve–Out Vendors

Oncology Second Opinion Partnership Example

EMO/SO Vendor provides advice, consultation, expert opinion to patients and the local provider to optimize care



Closing the gap between best care and typical care

the MIRACLE of SCIENCE with SOUL City of Hope

Recommendations

Continuum of Suggested Interventions

Light	Medium	Robust
▪ Align PA process toward NCCN guidelines	▪ Carriers to adopt formal site of service or site neutral program for infused medications	▪ Ensure correct diagnosis and treatment protocols by using Expert Medical Opinion vendors ▪ Create specialized workgroup with leading cancer experts for a local second opinion steerage solution for cancer treatment including precision medicine

Next steps

Next Steps

- IWG to select recommendations to pursue: light, medium, robust
- Outline work stream to implement selected recommendations
- Review proposed recommended approaches with each board

Appendix

Average Cost per Inpatient Surgery at Top Facilities

Spine Fusion Procedures

Facility	Composite Quality**	OEBB Avg	OEBB #	PEBB Avg	PEBB #	OEBB/PEBB IP % of Medicare*
Salem Hospital		$90,678	2	$95,097	14	221%
PeaceHealth Sacred Heart Medical Center at RiverBend		$106,311	7	$163,303	6	234%
OHSU		$148,184	4	$108,581	8	230%
McKenzie-Willamette Medical Center		$134,312	1	$114,603	8	228%
Providence St. Mary Medical Center		$100,237	7	$118,519	3	N/A
Providence St. Vincent Medical Center				$115,080	6	226%
St. Charles Health System — Redmond and Bend		$140,894	4	$93,423	1	253%
Asante Rogue Regional Medical Center		$95,889	2	$124,626	3	317%
Providence Medford Medical Center		$111,782	4	$89,135	2	276%
Providence Portland Medical Center		$114,599	2	$126,453	1	224%

Episode defined as claims incurred 10 days prior to surgery and up to 30 days after surgery. All claims for an episode are grouped in the procedure's primary facility spend location.
*OEBB / PEBB combined percent of Medicare as presented in November 2018 IWG
** Data and quality analysis provided by Quantros, Inc.

Average Cost Per Inpatient Surgery at Top Facilities?

IP hip procedures

Facility	Composite Quality**	OEBB Avg	OEBB #	PEBB Avg	PEBB #	OEBB/PEBB IP % of Medicare*
Salem Hospital		$40,901	6	$48,934	16	221%
PeaceHealth Sacred Heart Medical Center at RiverBend		$42,665	13	$54,770	7	234%
St. Charles Health System — Bend		$38,086	12	$53,772	2	253%
Willamette Surgery Center PC	Outpatient Facility					
Providence St. Vincent Medical Center		$51,397	6	$40,664	6	226%
Legacy Silverton Medical Center		$31,429	4	$37,759	9	N/A
Legacy Meridian Park Medical Center		$30,612	13	$29,094	1	207%
OHSU — Marquam Hill Campus		$35,011	8	$34,698	7	230%
McKenzie-Willamette Medical Center		$32,013	2	$58,847	5	228%

IP knee procedures

Facility	Composite Quality**	OEBB Avg	OEBB #	PEBB Avg	PEBB #	OEBB/PEBB IP % of Medicare*
St. Charles Health System — Bend		$40,030	26	$59,234	18	253%
PeaceHealth Sacred Heart Medical Center at RiverBend		$51,504	28	$61,093	14	234%
Salem Hospital		$40,988	29	$48,207	17	221%
Willamette Surgery Center PC	Outpatient facility					
Legacy Silverton Medical Center		$33,943	7	$43,115	13	N/A
Samaritan Albany General Hospital				$59,848	6	251%
McKenzie-Willamette Medical Center		$64,317	6	$57,102	6	228%
Providence Portland Medical Center		$35,442	7	$48,330	8	224%
Providence St. Vincent Medical Center		$41,917	9	$44,354	4	226%

Episode defined as claims incurred 10 days prior to surgery and up to 30 days after surgery. All claims for an episode are grouped in the procedure's primary facility spend location
* OEBB / PEBB combined percent of Medicare as presented in November 2018 IWG
** Data and quality analysis provided by Quantros, Inc.

Quantros Executive Dashboard

Get a composite snapshot of the hospital's quarterly performance using the industry's most clinically reliable and statistically valid approach for evaluating performance.

COMPOSITE QUALITY SCORE®

Integrated, multi-dimensional performance score using national benchmarks across all primary clinical quality measure domains

MORTALITY

Measures the risk of death during a hospital stay using predictive variables including patient's age, sex, DRG cluster, co-morbidities, the presence of any secondary diagnoses (cancer; other major chronic conditions).

RISK-ADJUSTED COMPLICATIONS

Measurements for all categories of medical, post-surgical, and post-obstetrical care.

ALL-SITE READMISSIONS

Profiles and measures the risk of unanticipated readmissions within 30 days of discharge using predictive variables include age, gender, major chronic conditions, and other significant co-morbidities.

PATIENT SAFETY

Percentile performance of AHRQ Patient Safety Indicators (PSI) including Pressure Ulcers, Postoperative Sepsis, Central Line-Associated Bloodstream Infection and Postoperative Respiratory Failure.

PHYSICIAN PERFORMANCE

Drill down capability into individual physician performance.

UTILIZATION DASHBOARDS

Snapshot of clinically-adjusted cost per case (CPC) and length of stay (LOS) across all procedures and areas of treatment.

INPATIENT QUALITY

Percentile performance of AHRQ inpatient quality measures including AMI, CABG and PTCA.

Quantros Risk Model Methodology

Beyond Standard Components of Number of Chronic Conditions, Age, Gender and Co-morbidities

Quantros uses the Risk-Adjusted Indices (RAMI, RACI and RARI) to develop benchmarks that allow hospitals and providers the opportunity to compare their performance to others to **empower them to improve their quality of care**.

SEPARATE RISK-ADJUSTED INDICES MEASURE THREE IMPORTANT QUALITY INDICATORS

Risk-Adjusted Mortality Index **(RAMI)**	Risk-Adjusted Complications Index **(RACI)**	Risk-Adjusted Readmissions Index **(RARI)**

These measures are unique because they compensate for clinical demographics.

References

- MSK
  - Hospital and Surgeon Variation in Complications and Repeat Surgery Following Incident Lumbar Fusion for Common Degenerative Diagnoses
  - Anecdotal % of orthopaedic spend based on client results; Note, we've seen costs as high costs as $200K; MarketScan data shows 3.9% with 30 million commercial lives, claims incurred 1/1/2014 through 12/31/2014. Episodes were bundled to include inpatient facility, professional and ancillary charges incurred for the procedure. Data captures all inpatient charges five days pre and post date of procedure. Range represents the 10% to 90%ile claim cost
  - MarketScan data incurred 1/1/2013 and paid through 3/3/12014. Episodes were bundled to include inpatient facility, professional and ancillary charges incurred for the procedure. Data captures all inpatient charges five days pre and post date of procedure; https://www.ncbi.nlm.nih.gov/pubmed/24831503
  - Cleveland Clinic mySecond Opinion Consult Statistics: Based on review of MyConsult Second Opinion cases from 2003 to 2015
  - WTW HBUS_Musculoskeletal_Point-of-View; https://www.hcup-us.ahrq.gov/reports/statbriefs/sb171-Operating-Room-Procedure-Trends.pdf; By The Numbers Musculoskeletal Conditions
  - 2005. Spine.Long-Term Outcomes of Surgical and nonsurgical management of lumbar spinal stenosis: 8 to 10 year results from the Maine lumbarspine study
  - NIMH,2010; Disability_IBI_2015_IndustryReport_LTD; Disability_IBI_2015_IndustryReport_STD; IBI: Health and Productivity Impact of Chronic Conditions: July 2017
- Cancer
  - Medscape, https://www.Medscape.com/slideshow/genomics-and-oncology-report-6008655;
  - American Society of Clinical Oncology: Clinical Cancer Advances 2018
  - Kaiser Health News, Kaiser Health News, https://endpts.com/cascade-of-costs-could-push-new-gene-therapy-above-1-million-per-patient/
  - National Business Group on Health, Innovative Approaches to Cancer Care Delivery
  - BMJ Quality and Safety Journal
  - JAMA

Data

- IBM Watson Health Data Warehouse
  - OEBB and PEBB data was extracted from the IBM data warehouse using the following parameters:
    - Claims are on an incurred/allowed basis
    - OEBB data is for the OEBB plan year October 2017 through October 2018
    - PEBB data is for the PEBB plan year January 2018 through December 2018
    - MSK related data includes claims incurred 10 days before and 30 days after the defined procedures
    - Cancer related data is based on Medstat episode grouper methodology for costs associated with a defined period of care
- Quality data
  - Data and quality analysis provided by Quantros, Inc.

IW Attachment 2a
October 15, 2019

Innovation Workgroup

Condition Specific Strategies for OEBB/PEBB — Musculoskeletal Recommendations

Supplement to presentation delivered on September 17, 2019

October 15, 2019

Willis Towers Watson

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Musculoskeletal recommendations

Continuum of suggested interventions presented on September 17, 2019

Light	Medium	Robust
▪ Educate members on treatment options (offer treatment decision support/expert medical opinion — i.e., Best Doctors/Grand Rounds) ▪ Virtual physical therapy (vendor solution) ▪ Implement medical necessity denials for high-tech imaging	▪ Identify high performing specialists and providers ▪ Require members obtain a treatment decision support/expert medical opinion (EMO) consult prior to coverage of a procedure or tie to higher Additional Cost Tier	▪ Establish high performing network of high quality specialists with plan design steerage ▪ COE: establish direct contracting with high quality facilities ▪ Bundled payment for provider and facilities

EMO member experience

#1 Member has a condition that could benefit from an EMO consult (for example, newly diagnosed with cancer).

#2 Member is referred to or contacts EMO vendor (this could be from company communication material, referral from heath plan care management unit, member services, HR, or word of mouth from fellow employee).

#3 Member goes through intake process at EMO (this is usually a nurse or physician that discusses member's issue, condition and identifies their questions/objectives to answer from the consult).

#4 EMO vendor collects clinical data/information from providers which could include tissue sample of cancer, imaging tests and other clinical tests and notes.

#5 EMO vendor selects appropriate specialist based on members condition to review material, prepares his/her summary and recommendations, and returns to EMO vendor.

#6 EMO vendor physician reviews specialist report to ensure it addresses all pertinent issues and member questions.

#7 EMO vendor sends report to member and schedules a time for either EMO physician or specialist that reviewed the case to discuss with the member.

#8 Member can take report to their physician and/or request they discuss it with their treating physician.

#9 For some conditions, such as cancer, member would have access to EMO vendor for follow-up questions on an ongoing basis.

Key milestones

Sample project plan

	2020				2021				2022			
EMO with required consultations												
Confirm scope of services (second opinion support/advocacy spectrum)			■									
Conduct and deliver gap assessment of current carrier partnerships			■									
Work with carriers to explore marketplace solutions, as needed				■	■	■						
Implementation and Go Live 10/1/2021						■	■	■				
Ongoing support and tracking								■	■	■	■	■
Virtual physical therapy — point solution												
Conduct vendor innovation day	■											
Conduct reverse request for proposal (RFP)		■										
Select point solution		■										
Implementation and Go Live 1/1/2021			■					■				
Ongoing support and tracking			■	■	■	■	■	■	■	■	■	■
Quality based steerage												
Evaluate network contracting arrangements with current carriers	■	■										
Conduct detailed request for information (RFI) with current carriers			■	■								
Identify and implement high quality network(s) and integrate across carriers for 1/1/2022 Go Live					■	■	■	■	■			
Ongoing support and tracking									■	■	■	■
Medical necessity denials for high-tech imaging												
Evaluate and identify opportunities of current programs (Evicore, AIM and CPGs)	■											
Harmonize carrier programs across carriers and with market best practices		■										

COEs to be revisited once above recommendations have been evaluated and/or established (2022 or later)

Next steps framework

#1	Design (including current state analysis)
#2	Evaluation
#3	Making decisions
#4	Implementation
#5	Ongoing support and tracking

Expert medical opinion/treatment decision support with required consultations

#1 **Design (including current state analysis)**	▪ Confirm scope of services
	▪ Evaluate current second opinion partnerships established with Moda, Kaiser and Providence
	▪ Conduct gap assessment of current partnerships that includes:
	  ▪ Comparison to marketplace best practices and define scope of services
	  ▪ Evaluates ability to administer required consultations (including triage process, length of consultation process, connectivity and steerage to facility/provide following consultation, ability to administer alternate plan design structure, etc.)
	  ▪ Evaluates ability to steer members to high quality providers/facilities (including provider lookup tool functionality, member service portal and ability to steer members a designated high performing network and/or COE)
	▪ Evaluate financial impact and ROI analysis

#2 **Evaluation**	▪ If carrier partnerships do not meet program requirements, evaluate marketplace solutions ▪ Work with carrier partners to evaluate the marketplace ▪ Final negotiations and contract review
#3 **Making decisions**	▪ Select expert medical opinion/second opinion partner(s) ▪ Confirm program effective date
#4 **Implementation**	▪ Develop implementation project plan and establish reoccurring check-in calls to ensure key milestones are met ▪ Ensure required consultations, steerage to high quality providers/facilities and connectivity/integrations with current carriers are embedded in key milestones
#5 **Ongoing support and tracking**	▪ Review reoccurring vendor reporting to track engagement, quality and results ▪ Monitor performance guarantees

Virtual physical therapy — point solution

#1 **Design (including current state analysis)**	▪ Identify current carrier partners
#2 **Evaluation**	▪ Evaluate vendor capabilities with presentations to IWG (including any current carrier programs) ▪ Test virtual physical therapy program through pilot population ▪ Conduct Request for Proposal (RFP) for vendor finalists ▪ Final negotiations and contract review
#3 **Making decisions**	▪ Select virtual physical therapy opinion partner(s) ▪ Confirm program effective date
#4 **Implementation**	▪ Develop implementation project plan and establish reoccurring check-in calls to ensure key milestones are met
#5 **Ongoing support and tracking**	▪ Review reoccurring vendor reporting to track engagement and results ▪ Monitor performance guarantees

Quality based steerage

#1 **Design (including current state analysis)**	▪ Define scope of services and objectives
	▪ Identify approach to selecting higher quality network(s)
	▪ Facilitate conversation with current carrier partners to evaluate current provider/facility networking arrangements and identify any established COEs
	  ▪ Confirm if contracting high quality network(s) can be established and carrier can steer toward network
	▪ Evaluate plan design considerations:
	  ▪ Point of enrolment or only option
	  ▪ Broad based network approach
	  ▪ Tiered cost tier approach

#2 **Evaluation**	▪ Conduct deep-dive with current carriers that includes:
	  ▪ Steerage capabilities to high quality providers
	  ▪ Methodology for high quality
	  ▪ Ability to administer design differential
	  ▪ Ability to take-in external date from external sources (especially if contracting does not allow for contracting with high quality network(s) directly)
	▪ Utilize RFI results by carrier for harmonization across program

#3 **Making decisions**	▪ Determine if arrangements through current carriers should be implemented or if additional marketplace programs should be evaluated ▪ Confirm program effective date
#4 **Implementation**	▪ Develop implementation project plan and establish reoccurring check-in calls to ensure key milestones are met
#5 **Ongoing support and tracking**	▪ Review reoccurring vendor reporting to track engagement, quality and results ▪ Monitor performance guarantees

IW Attachment 3
October 15, 2019

PERCENT OF MEDICARE RESULTS AND INSIGHTS

IDEAS FOR TRANSFORMATIVE INNOVATION – CREATING A BENCHMARK HEALTH PLAN

OCTOBER 15, 2019

Emery Chen and James Matthisen

WHY COMPARE TO MEDICARE

WHY USE MEDICARE AS A BENCHMARK

- Medicare provides a well-established, equitable, and reliable benchmark for costs, and is commonly accepted by most providers.
- Largest Single Purchaser in USA
- Refined Standardized Payment Systems
  - Hospital (Inpatient and Outpatient Prospective Payment System – IPPS/OPPS)
  - Physician services
  - Many other fee schedules (DME, ASC,…)
- Well equipped to handle econometric analyses and political pressures
- MedPAC and formal analyses of payment adequacy

MARCH 2019

REPORT TO THE CONGRESS

Medicare Payment Policy

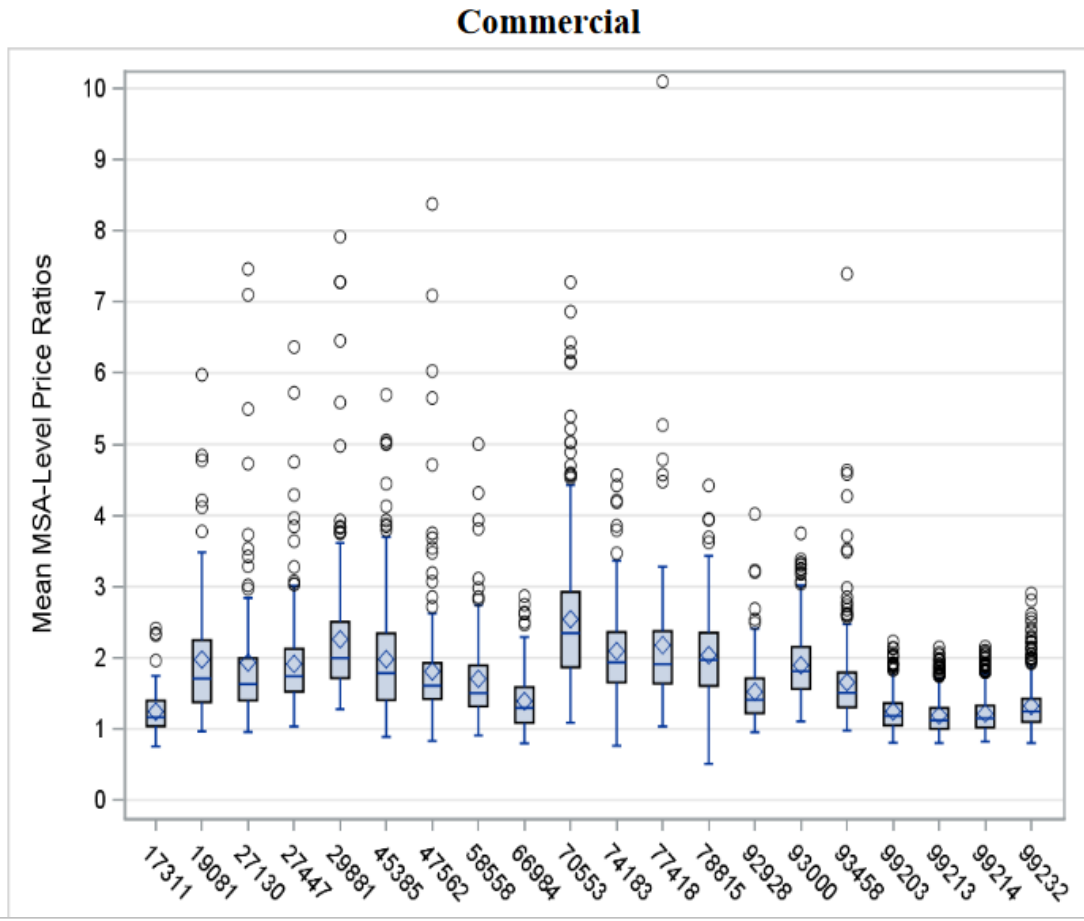
MEDPAC Medicare Payment Advisory Commission

425 I Street, NW • Suite 701 • Washington, DC 20001
(202) 220-3700 • Fax: (202) 220-3759 • www.medpac.gov

MEDPAC MARCH 2019 REPORT TO CONGRESS
MEDICARE PAYMENT POLICY

- Spending under Medicare's FFS payment system is used to set benchmarks for
  - MA plans and for accountable care organizations (ACOs).
  - MA plans' payment rates to hospitals
  - Department of Veterans Affairs
  - Rates that uninsured individuals pay are also often benchmarked to Medicare due to limits on rates charged to low-income uninsured individuals
  - The Medicaid program maximum supplemental "upper payment limit" UPL Medicaid payments
  - Furthermore, Medicare rates can affect rates charged by commercial insurance.
    - Montana's state employee health plan fixed its hospital payment rates to 234 percent of Medicare (Appleby 2018).
    - North Carolina has proposed a similar plan for its state employee health plan

MEDICARE REFERENCED BASED PRICING
MEDICARE VS. COMMERCIAL PAYMENTS



Procedure codes

17311 = Micrographic Surgery	45385 = Colonoscopy	74183 = Abdominal MRI	93458 = Cardiac Catheterization
19081 = Breast Biopsy	47562 = Gall Bladder Surgery	77418 = IMRT	99203 = New Patient Office Visit
27130 = Hip Replacement	58558 = Hysteroscopy	78815 = PET/CT scan	99213 = Estab. Patient Office Visit
27447 = Knee Replacement	66984 = Cataract Surgery	92928 = Stent Placement	99214 = Estab. Patient Office Visit
29881 = Knee Arthroscopy	70553 = Brain MRI	93000 = EKG	99232 = Subsequent Hospital Care

What are we looking at?

There are significant differences in payments for the same services between what Medicare and commercial plans across MSAs

An Analysis of Private-Sector Prices for Physicians' Services
Daria Pelech Congressional Budget Office
daria.pelech@cbo.gov
Working Paper 2018-01
January 2018

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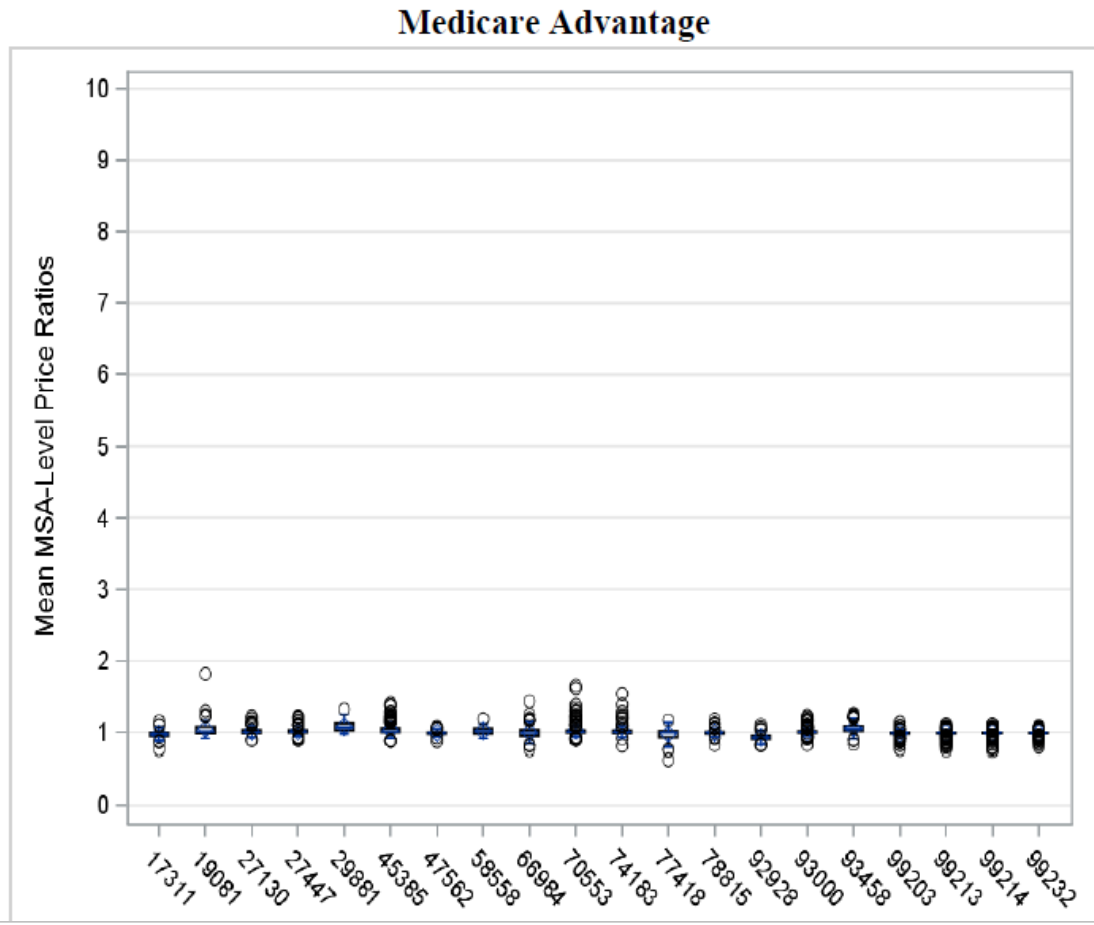

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29881 = Knee Arthroscopy	70553 = Brain MRI	93000 = EKG	99232 = Subsequent Hospital Care

What are we looking at?

Across MSAs, Medicare Advantage payments for the same services are more closely aligned to Medicare than commercial plans

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PEBB AND OEBB ALLOWED AS % OF MEDICARE

CURRENT STATE

Senate Bill 1067 Set maximum in-network hospital reimbursements at 200% of Medicare

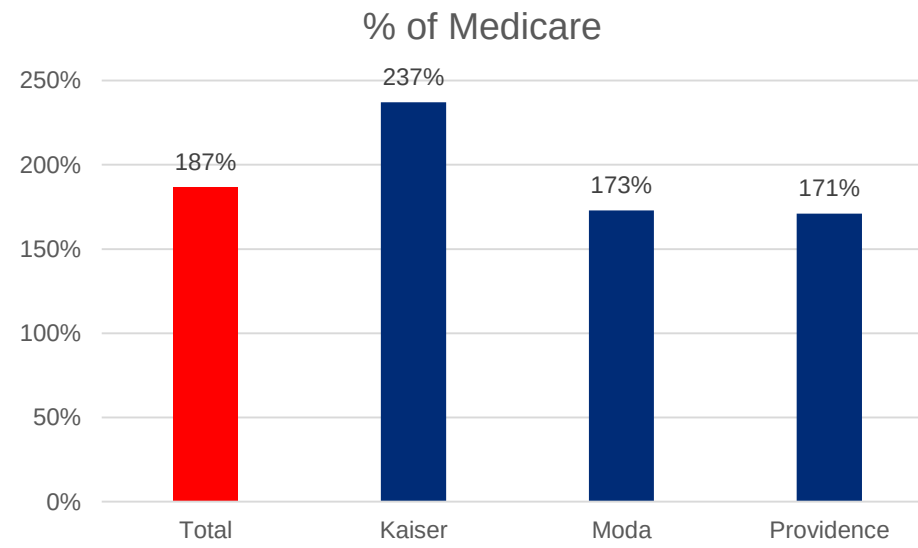
PEBB and OEBB are capped at 3.4% cost growth per year

Previous analysis indicated that Moda and Providence were at 260% of Medicare for IP and OP hospital services in 2017

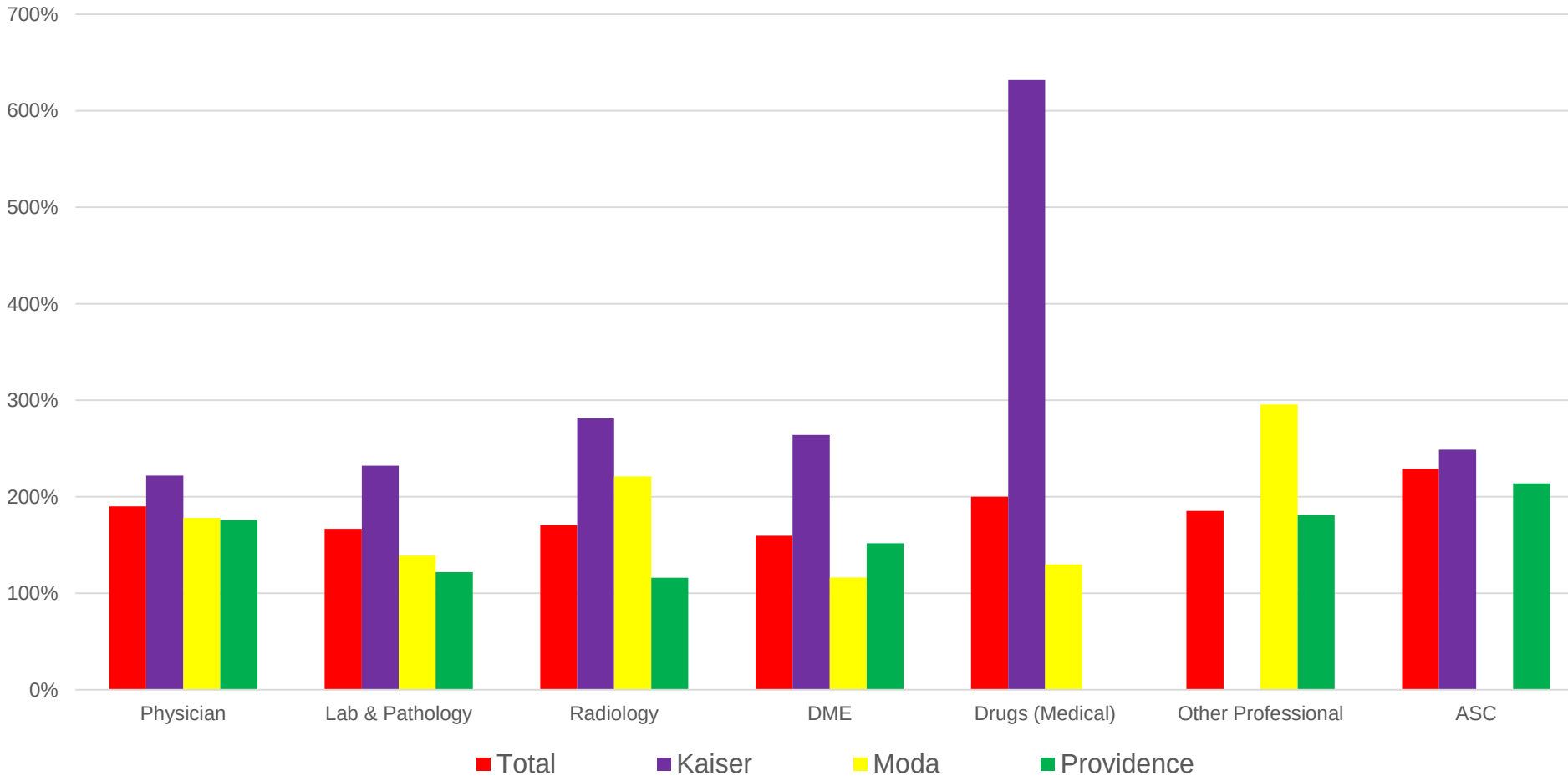
200% of Medicare for Kaiser IP hospital would reduce costs by 8% (2017 data)

NON HOSPITAL AS % OF MEDICARE

- Plans were requested to price 2018 claims on a % of Medicare basis for various categories.
  - IP Hospital, OP Hospital, physician/primary care, physician/specialty, lab, etc.
- If requested categorizations were difficult to price, plans could group into more easily produced categories
- For non-SB 1067 claims, PEBB and OEBB allowed costs are 187% of Medicare
- Moda provided professional claims data
- Providence included ASC and professional
- Kaiser is all non-SB 1067



NON HOSPITAL AS % OF MEDICARE
BY CATEGORY



- Groupings are based on best estimate of service categories

PEBB AND OEBB AS % OF MEDICARE
ADDITIONAL NOTES

- Kaiser and Moda pay surgeons a higher % of Medicare versus primary care
  - Kaiser is at 234% of Medicare for IP professional and 211% for office visits
  - Moda is 214% of Medicare for surgical and 169% for non-surgical
- Behavioral health providers are paid 118% of Medicare by Providence
- Providence reported that drugs provided in a medical setting were paid at approximately 105% of Medicare but these claims were not included in their data
- Moda pays anesthesiologists 296% of Medicare
- Kaiser pays emergency room physicians 370% of Medicare

THE LODESTAR*

*A person or thing that serves as an inspiration or guide

GUIDING PRINCIPLES

- Rationalize Payment ***Method***
- Gain Control of any ***Incentive*** changes
- Gain Control of Payment ***Level***

KEY INGREDIENTS

Advocacy model for member services
– **Concierge**

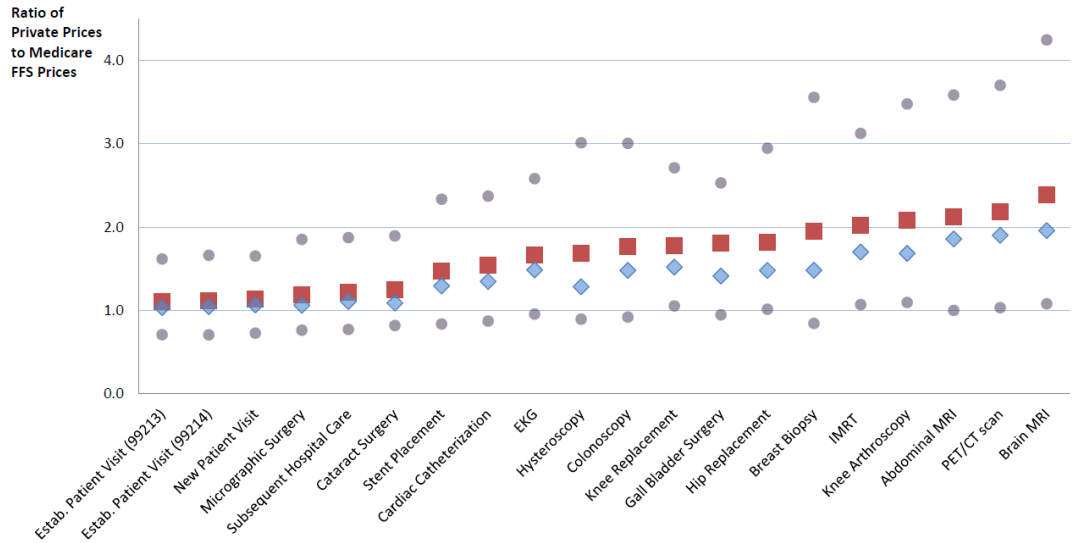
Reference based pricing
– **% of Medicare**

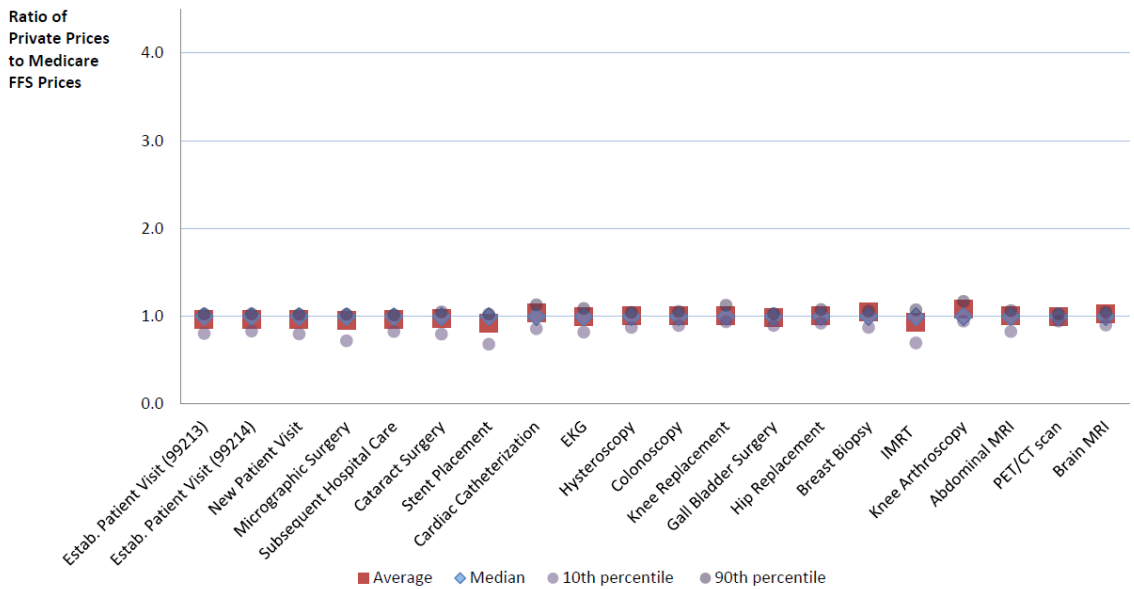
All in-network providers participate in significant quality related VBP
– **Bonus, Shared Savings, Infrastructure**

Global budget adjuster
– **Guarantees 3.4%**

ADVOCACY AND CONCIERGE TO MEET THE GOALS OF THE TRIPLE AIM

% OF MEDICARE SETS THE RATES





2014 Prices for Selected Physicians' Services

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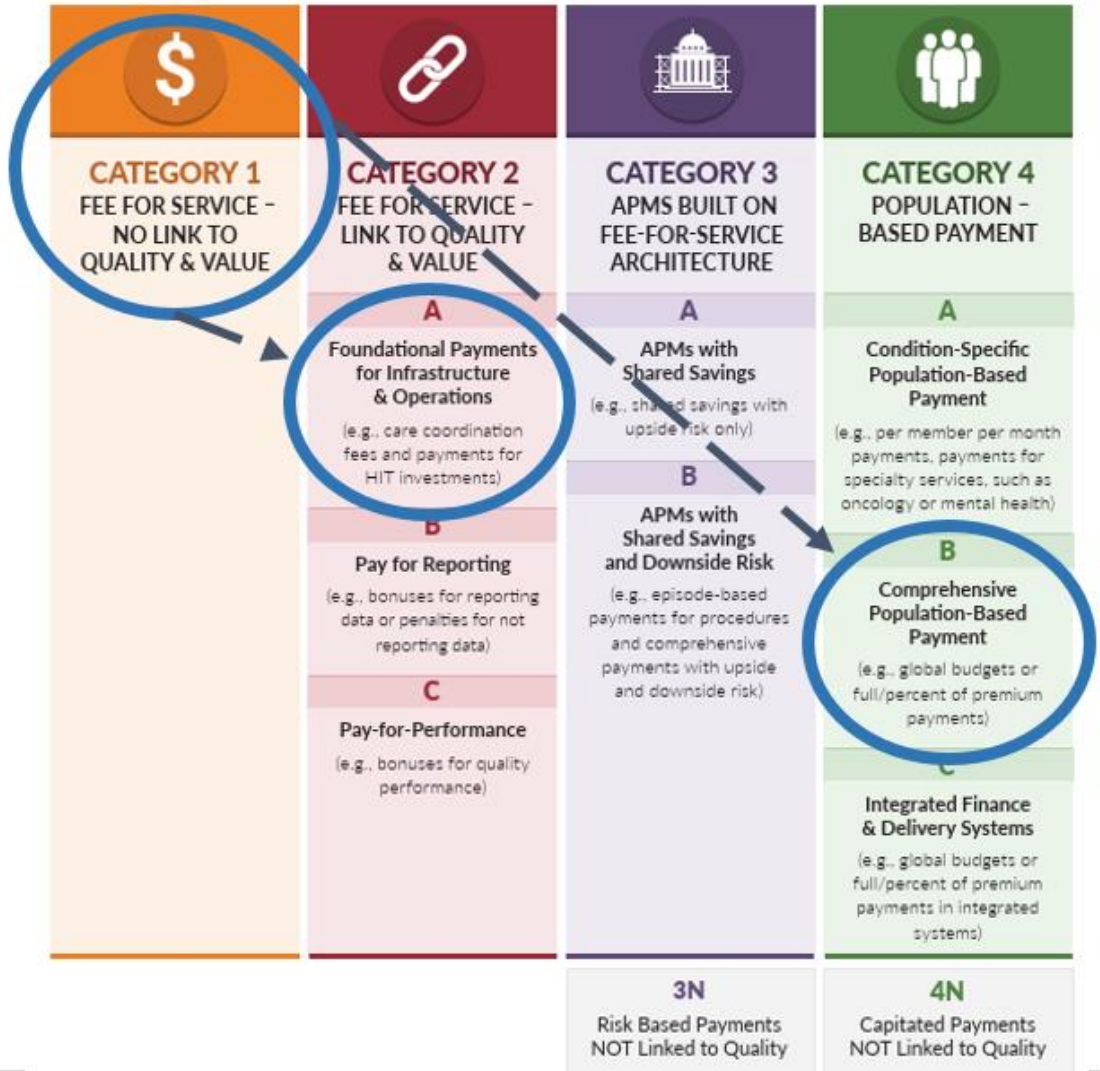
QUALITY RELATED BONUS PAYMENTS AND GLOBAL BUDGET LEAPFROG THE HCP–LAN



FLOATING % MEDICARE TO MEET 3.4%

- Baseline payments as a % of Medicare can float up or down based on whether the 3.4% limitation is met during the prior year
  - Upside Potential – Increased efficiency could yield increased unit prices, incentive to eliminate waste
- Or savings could accrue to the purchaser

THE GLORIOUS VISION — WILDEST DREAMS

Members

- Member loves support from new coach, advocate, navigator, app
- Price transparency
- Quality at the forefront
- Integration of behavioral health and social determinants of health interventions
- No surprise billing

Providers

- Providers appreciate streamlined equitable payment, access to health records, and rewards for quality, efficiency, and member satisfaction
- Payments go up if efficiency increases
- Meaningful explicit financial support for provider transformation
- Higher payment for BH and PCP

Broader Goals

- 3.4% budget requirements met by design
- Meet legislative requirements (200% / 12% / 3.4%) and statewide goals (70% 3b or better)
- PEBB/OEBB Benchmark – determine success and failure of competing health plan models on a risk adjusted basis

THE GLORIOUS VISION – SYSTEM DESIGN

Member Advocacy/Concierge

Decision Support
Care Management
Integrated Social Solutions
Integrated Behavioral Health
System Navigation Assistance
Price Comparison Assistance
Quality Comparison Assistance
APP / Phone / Virtual

New Fangled ASO

Credential/Maintain Network
Administer Fee Schedule
Pay Claims
Calculate Bonus Payments
Provider Data Portal
Evaluate Quality Metrics
Transparent Dashboard Reporting

PEBB/OEBB Board/Staff

Calculate Global Budget Adjustments
Publish Reports and Results
Compare to CCM Plans
Overall Management

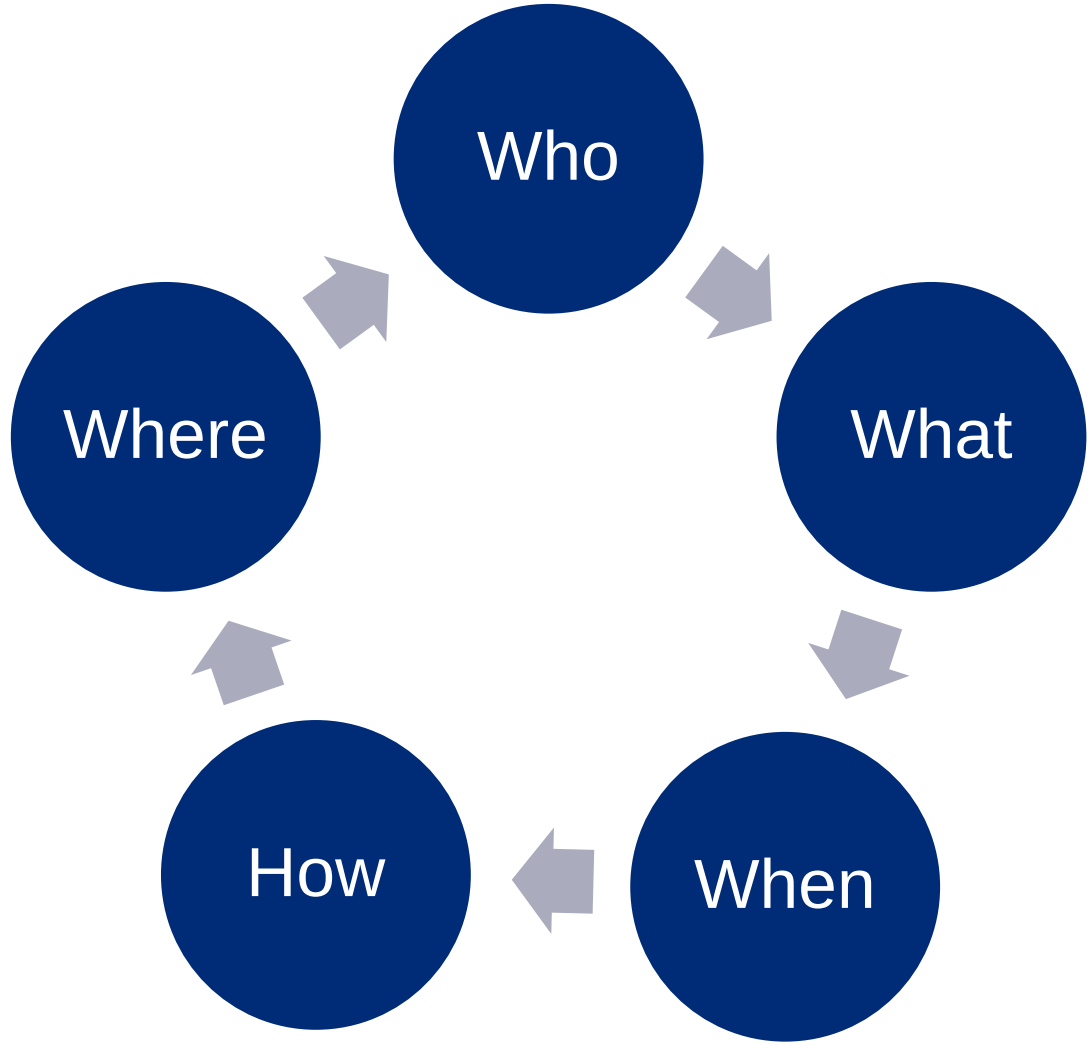
GETTING THERE

TRANSFORMATION IN PHASES

INNOVATION — TRANSFORMATION IN PHASES

- Phase 1 – Context Shift
  - Advocacy based administration
  - “Rate taking” to equitable “rate setting”
  - Global budget adjuster
  - Start at current % of Medicare or close
  - Increase Primary and BH
  - Clearly articulated and contracted VBP/APM interventions to be phased in (quality bonus, shared savings, infrastructure)
- Phase 2+ – Incentive Tailoring
  - Quality and savings incentives begin on prioritized basis
  - Primary care targets based on total cost of care goals and quality metrics
  - Specialty care targets based on episode of care cost and quality metrics
  - Facility care targets based on quality and safety metrics

QUESTIONS AND DISCUSSION



MERCER

MAKE TOMORROW, TODAY