HEALTH POLICY AND ANALYTICS
Public Employees' Benefit Board

Kate Brown, Governor

Chair Shaun Parkman will convene a public meeting of the PEBB Board on Tuesday, November 19, 2019, at 9:30 a.m. The meeting will be held in the boardroom of the Health Licensing Office at 1430 Tandem Ave., Ne, Suite 180, Salem, Oregon.

PEBB BOARD AGENDA
NOVEMBER 19, 2019

I.	9:30 a.m. – 9:35 a.m. Attachment 1 **ACTION**	**Welcome & Approval of October 15, 2019 meeting minutes** *Shaun Parkman, Chair*
II.	9:35 a.m. – 9:55 a.m. Attachment 2	**Consultant RFP Design Planning** *Brian Olson, PEBB/OEBB Contracts Coordinator*
III.	9:55 a.m. – 10:45 a.m. Attachment 3	**Concierge and Advocacy Services RFI Update** *Michael Garrett & Mitch Nigro, Mercer Health & Benefits, LLC*
10:45 a.m. – 10:55 a.m.		**BREAK**
IV.	10:55 a.m. – 11:15 a.m. Attachment 4	**Budget Update** *Ali Hassoun, OEBB/PEBB Director*
V.	11:15 a.m. – 11:30 a.m. Attachment 5	**WW Kurbo Recommendation** *Cindy Bowman, Director of Operations*
VI.	11:30 a.m. – 11:45 a.m. Attachment 6	**EviCore Implementation Delay** *Damian Brayko, Deputy Director*
VII.	11:45 a.m. – 12:10 p.m. Attachment 7	**Legislative Session Budget Note: Explore Rx/Pharmacy Utilization Tools** *Robert Valdez, Mercer Health & Benefits, LLC*
VIII.	12:10 p.m. – 12:25 p.m.	**Innovation Workgroup Update** *Shaun Parkman, IW Vice Chair* *James Matthisen, Mercer Health & Benefits, LLC*

IX. 12:25 p.m. – 12:35 p.m. **Director's Report/Other Business/Public Comment**

- **Updated Workplan**
- **Honoring Bill Barr's Service**

Adjourn

Public Employees' Benefit Board
Meeting Minutes
October 15, 2019

The Public Employees' Benefit Board held a regular meeting on October 15, 2019, at the DHS Health Licensing Office, Suite 180, 1430 Tandem Ave. Ne, Salem, Oregon 97301. Chair Shaun Parkman called the meeting to order at 9:30 a.m.

Attendees

Board Members:
Shaun Parkman, Chair
Kimberly Hendricks, Vice Chair
Bill Barr
Dana Hargunani, MD
Kim Harman
Siobhan Martin
Mark Perlman (phone)
Representative Andrea Salinas
Jeremy Vandehey

Board Members Excused/Absent:
Senator Betsy Johnson (non-voting member)

PEBB Staff:
Ali Hassoun, Director
Damian Brayko, Deputy Director
Rose Mann, Board Policy and Planning Coordinator
Rebecca Aparacio, Executive Assistant
Margaret Smith-Isa, Program Development Coordinator
Glenn Baly, Program Policy Liaison

Consultants:
Emery Chen, Mercer Health and Benefits, LLC
Robert Valdez, Mercer Health and Benefits, LLC
Michael Garrett, Mercer Health and Benefits, LLC
James Matthisen, Mercer Health and Benefits, LLC

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I. Call to order and approval of September 17, 2019 Board meeting minutes.

Chair Shaun Parkman called the meeting to order asked for a motion to approve the September 17, 2019 PEBB Board meeting minutes.

MOTION

Siobhan Martin moved to approve the minutes of the August 20, 2019 PEBB Board meetings. Dana Hargunani seconded the motion. The motion carried 7 – 0.

II. Strategic Planning – Attachment 2

Michael Garrett, Mercer Health & Benefits, LLC, led the Board in discussion on strategic planning.

III. Pharmacy Benefit Trends

Kendra Lofgren, West Market Pharmacy Lead, Mercer Health & Benefits, LLC

IV. PEBB Carrier Pharmacy Services and Programs – Attachments 4 thru 4c

Keith Bach, MD, PEBB Medical Director, Kaiser Permanente

Carly Rodriguez, Director, Clinical Pharmacy, Clinical Innovation Moda Health Plans

Helen Noonan-Harnsberger, PharmD, AVP Pharmacy Division and Heidi Chinwuba, PharmD, BCPS, BCACP, Clinical Pharmacy Manager, Providence Health Plans

Trevor Douglas, Director, Heidi Murphy and Chandra Wahrgren, Oregon Prescription Drug Program (OPDP)

V. Legislative Session Budget Note: Explore Rx/Pharmacy Utilization Tools– Attachment 5

Robert Valdez, Mercer Health & Benefits, LLC

VI. Public Comment

There being no public comment nor further business to come before the Board, Chair Shaun Parkman adjourned the meeting at 12:35 p.m.

Consultant RFP Design Planning
November 19, 2019
Brian Olson, Contracts Team Lead

Overview

The purpose of this update is to share some initial information on an upcoming Request for Proposals (RFP) for Consulting and Actuarial Services. Staff will return to the Board in the future with additional information and to request formal approval to move forward with the RFP.

Background

Under Section 30 of SB 1067 (2017), PEBB and OEBB must procure consulting and actuarial services no less than every three years. Staff has worked with our Department of Justice (DOJ) to determine that PEBB and OEBB should release the next RFP in June or July 2020 to comply with this legislation. The bill also included specific procurement requirements, such as requiring proposers to demonstrate how they will support the Boards' efforts to maximize provider efficiencies and achieve more organized systems of care.

What Do We Envision?

This RFP will be managed by the Office of Contracts and Procurement (OC&P). Currently, PEBB and OEBB staff are working with staff from the Oregon Health Authority's (OHA) Health Policy and Analytics (HPA) division and OC&P to establish project tasks and dates and to begin exploring how this RFP could be structured.

Staff envisions a single RFP that results in a consulting contract that will include the potential work that PEBB, OEBB, and HPA may need over the expected three-year contract term. Staff also envisions PEBB and OEBB having its own "mini-contracts" with program-specific work, tasks, budgets, and processes for assigning and accepting work. In addition, staff expects OHA to have the ability to enter into work orders or other project-specific agreements on an as needed basis. These projects could include work that benefits or impacts PEBB, OEBB, and HPA.

Staff envisions assembling a scoring and evaluation group that includes (1) one to two Board members from PEBB and OEBB, (2) one to two PEBB and OEBB staff, and (3) one to two HPA staff.

Timing

Staff anticipates coming back to the Board one to two more times to present additional details and to ask for formal approval to release the RFP. These additional discussions will likely occur between December 2019 and February 2020. In addition, staff expects the RFP to be released in June or July 2020. The selected vendor is expected to begin providing consulting services on January 1, 2021; however, the RFP will likely include an earlier transition and onboarding in the event a new consultant is selected for PEBB and OEBB.

Action

No Board action is requested at this time.

Attachment 3

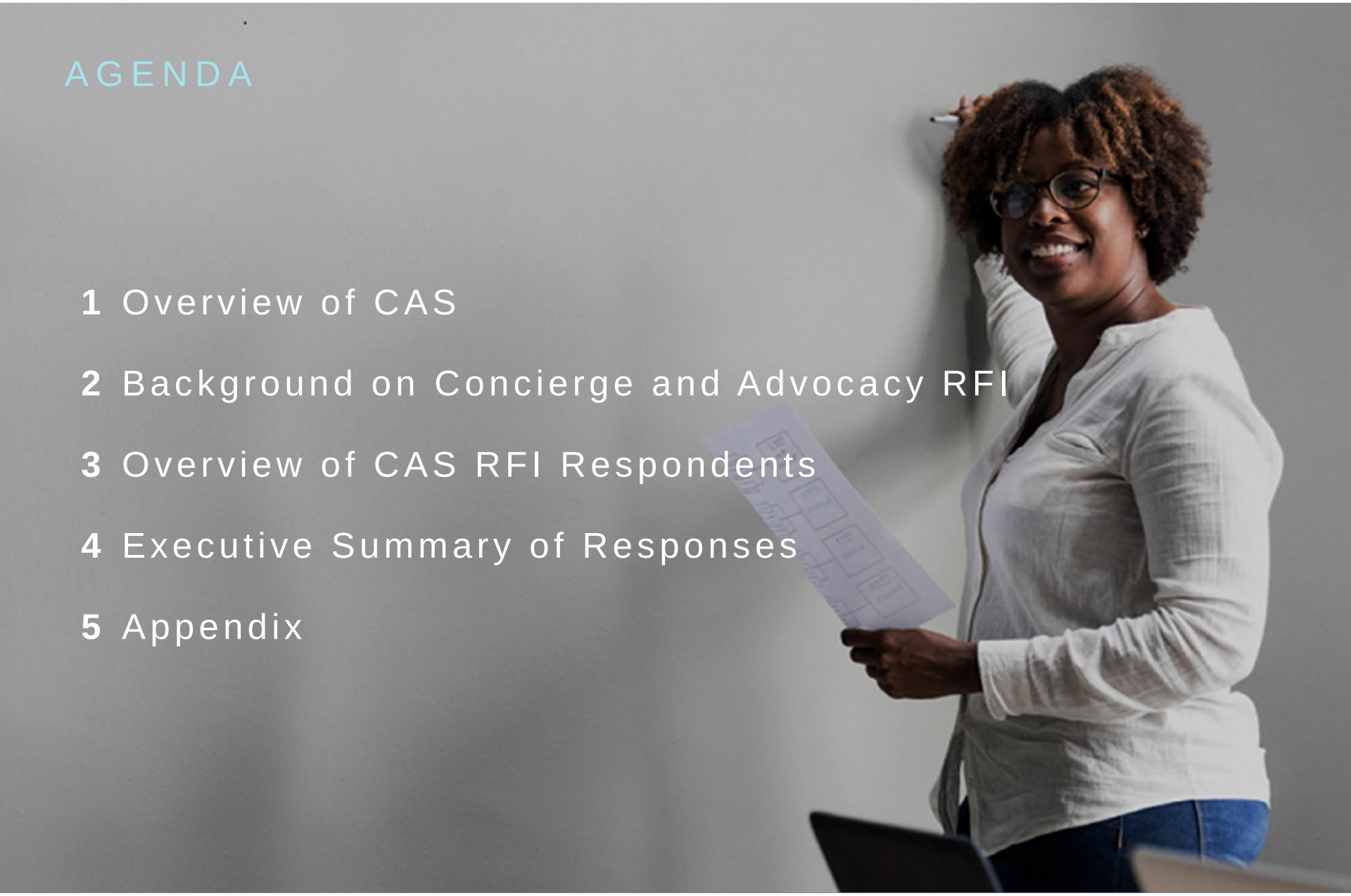
Oregon PEBB Board Meeting

Concierge and Advocacy Service Request for Information

November 19, 2019

MAKE TOMORROW, TODAY MERCER

AGENDA



1 Overview of CAS

2 Background on Concierge and Advocacy RFI

3 Overview of CAS RFI Respondents

4 Executive Summary of Responses

5 Appendix

01

OVERVIEW OF CAS

THE CONCIERGE AND ADVOCACY PARADIGM SHIFT

The delivery of advocacy-related services is changing

Transactional, volume-driven service

- Customer service functions measured on call volume, call times – the shorter the better
- Clinical support teams not necessarily integrated with the customer service or claims teams
- Limited integration between functions

Traditional carrier-led model

Transformative, outcome-focused service

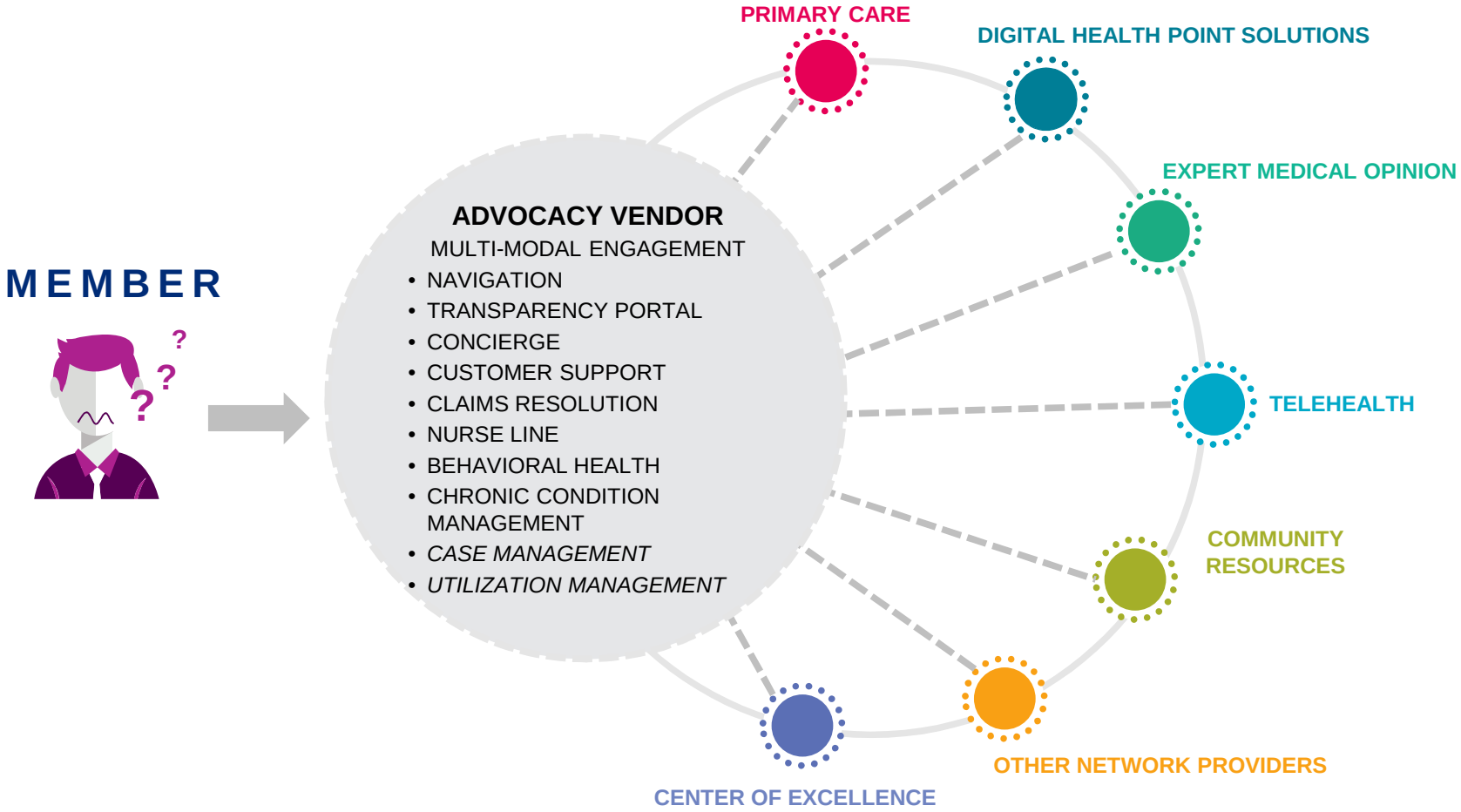
- Customer service measured on referrals to relevant services, identifying and resolving members' underlying questions
- Clinical teams seen as key in achieving proactive population health management
- Enhanced integration between functions; single point of contact where possible

Began as the carve-out niche, but carriers are adapting

THE MEMBER EXPERIENCE

SUPPORTED THROUGH ENHANCED MODELS

Central “front door” where members’ needs are identified with navigation to the right resource



BENEFIT STRATEGY

CONCIERGE AND ADVOCACY SERVICES ROLE

- What “problem” are you trying to solve? Where are there gaps in your current state?

Medical trend growth?

Improved customer service?

Enhanced clinical programs?
- Targeting chronic conditions?
- Targeting high-cost claimants?

Engagement in healthcare and benefit programs?

Return on program investment?

Drive to quality in-network providers?

Reduce administrative burden (for organization and/or member)?

Provide assistance with navigating benefits and health system?

- How you prioritize these goals (among others) will influence which type of advocacy model is right for your organization

GOALS OF CONCIERGE AND ADVOCACY SERVICE FOR OHA AND ITS MEMBERS

This request for information (RFI) is a process being used to gather information from responders in order to collect information and compare businesses that are offering products or services that on concierge and advocacy services.

GOALS FOR OHA

- Reduce medical trend
- Increase the engagement and effectiveness of care coordination for at-risk and high cost claimants
- Enhance “employer of choice perception” by members
- Improve adherence to evidence-based clinical guidelines improving the value of the healthcare services paid under the plan
- Reduce the hassles of benefit plan administration
- Support and educate members regarding benefits and healthcare services
- Promotes the goals of OHA’s key elements of the Coordinated Care Model, including:
  - Best practices to manage and coordinate care
  - Transparency in price and quality
  - Shared responsibility for health
  - Measuring performance
  - Paying for outcomes and health
  - Sustainable rate of growth

GOALS FOR MEMBERS

- Improve the member experience, engagement, and activation with healthcare services and the benefit plan
- Minimizes the burden of dealing with the administrative complexity of the benefit plan, such as expedited claims resolution
- Improve the experience of healthcare processes and services that lead to improved health outcomes
- Optimize the use of appropriate and timely benefit programs, healthcare services, and community resources
- Facilitate timely and appropriate access to high quality and cost-effective providers and healthcare services across the continuum of care
- Tailored services based on the needs and preferences of members/patients

02

BACKGROUND ON CONCIERGE AND ADVOCACY SERVICES (CAS) REQUEST FOR INFORMATION (RFI)

REQUEST FOR INFORMATION (RFI) — NOT A PROCUREMENT, BUT A MARKET CHECK

This request for information (RFI) is a process being used to gather information from responders in order to collect information and compare businesses that are offering products or services that on concierge and advocacy services (CAS)

This RFI does **NOT** commit or imply that the Oregon Health Authority (OHA) will issue a formal request for proposal (RFP)

The goal of this RFI is to collect information in order to inform the next step of OHA's decision making process

This RFI is being used to collect summarized information about CAS solutions, so that this is NOT a way to obtain detailed bids or work proposals

BRIDGE STRATEGIES

CAS IS ONE OF BRIDGE STRATEGIES

Strategies

Expert Medical Opinion (EMO)

Concierge and Advocacy Services (CAS)

Bundled Payments with Centers of Excellence (COE)

Digital Health Point Solutions

Approach

#1
PEBB identifies market capabilities in meeting its goals

#2
PEBB decides whether to include one or more of these strategies

#3
If interested, PEBB incorporates specifications into a procurement

STRATEGY: CONCIERGE FOR STATEWIDE

Overlay digital navigation and advocacy services to the PPO plan and create steerage by offering the highest level of benefits when receiving care through a concierge care management vendor

Savings:

Respondents see anywhere from a 1:1 up to a 4:1 Return on Investment (ROI) over time

How this stacks up with key criteria

- Demonstrated savings with guaranteed ROI from some vendors
- Some vendors provide reduced trend guarantees with first year savings if implemented on a total replacement basis
- Increased care coordination and improves the member experience at the expense of current plan administrators
- Maximum savings requires extreme disruption by outsourcing all customer service and care management to third party vendor

How this could make people happy

- High quality, high touch guidance through the health care system improves the experience
- Concierge service could help guide members and increase utilization of relevant point solutions

How this could frustrate people

- Change from current customer service and care management to a new administrator

TIMING	CARRIER/VENDOR	COMMUNICATION	IMPLEMENTATION
Medium	New	Continuous	High

CONTENT AND INFORMATION PROVIDED CONCIERGE AND ADVOCACY SERVICES (CAS)

The Concierge and Advocacy RFI contained the following information

Questions for Responders

Governor Kate Brown's strategy of Health Care for all: Sustaining the Oregon model of Health Care Coverage, quality and Cost Management

Background Document describing PEBB's intent and guidelines

De-identified data plan documents on the Statewide Plan

This RFI process may be used for other potential strategies for OHA

CAS RFI FRAMEWORK

Structure

The resources and organizational arrangements are in place to deliver services

- Qualifications and training of advocates
- Ratio of nurses to the member population

Process

The appropriate sequencing and delivery of activities that are carried out to deliver services

- Evidence-based clinical guidelines
- Screening for social determinants of health

Outcomes

The results of the services and interventions

- Reduction in hospitalizations and emergency department visits
- Member experience

CONCIERGE AND ADVOCACY SERVICES (CAS) REQUEST FOR INFORMATION (RFI)

CONTENT AND RECIPIENTS

RFI Content

- **OHA and CAS Background** was developed by both Mercer and OHA.
- **CAS questions** which were drafted by Mercer with input from OHA.
- **Attachments** sent alongside the RFI
- **RFI Background** document which indicates PEBB's background and identifies the appropriate context of the RFI
- **Summary Plan Design** for the Providence Statewide Plan.
- **Experience Report** of prior claims history for the Providence Statewide plan with de-identified data.
- **Governor Brown's Healthcare Strategy** for all Oregonians to have quality, affordable health care, regardless of who they are or where they live.

Questions Organization

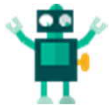
- **Structure:** Questions regarding the organization, staffing model, scope of services, etc.

- **Process – Organization:** Questions regarding internal processes and member experience

- **Process – Administration (Non-Clinical)**: Questions regarding how the concierge and advocacy service representatives assist members with claims, provider selection, benefit plan navigation, and other non-clinical services.

- **Process – Clinical:** Questions regarding the scope and range of clinical management programs, such as utilization management, case management, disease management, etc.

- **Integration:** Questions regarding their ability to share information and coordinate with other benefit providers.



- **Pricing, Performance Guarantees and reporting**

CONCIERGE AND ADVOCACY SERVICES (CAS) REQUEST FOR INFORMATION (RFI)

TIMELINE

1

- ✓ RFI released to vendors through ProposalTech – 8/5
- ✓ Questions due to Mercer – 8/12
- ✓ Mercer responds to the questions with help from OHA (no additional follow up questions) – 8/19
- ✓ Responses due back to Mercer – 9/9

2

- ✓ Mercer conducts questions and interviews for respondents – 9/23 – 9/27
- ✓ Mercer compiles responses while reviewing responses with OHA staff – 9/9 – 9/27
- ✓ Mercer & OHA potential interviews with selected responders – 9/30 – 10/11

3

- ✓ Mercer summarizes findings – 10/11 – 10/25
- ✓ Mercer works with OHA staff to update and finalize the findings – 10/28 – 11/1
- ✓ Mercer presents the report and findings to the PEBB Board – 11/19

Mercer works with OHA staff to determine next steps, if any, regarding CAS services

03

OVERVIEW OF CAS RFI RESPONDERS

CONCIERGE AND ADVOCACY RFI RESPONDERS

Potential Responders

evive

HealthAdvocate
Always at your side

PROVIDENCE
Health & Services

Quantum HEALTH

HMA

Accolade

Regence

consumermedical
Your Medical Ally

moda HEALTH

Collective Health

PacificSource ADMINISTRATORS

Mercer identified 11 potential respondents based on their advancements and achievements in the concierge and advocacy space.

CONCIERGE AND ADVOCACY RFI RESPONDERS

Respondents

evive

HealthAdvocate
Always at your side

PROVIDENCE
Health & Services

Quantum HEALTH

HIMA

Accolade

Regence

consumermedical
Your Medical Ally

moda HEALTH

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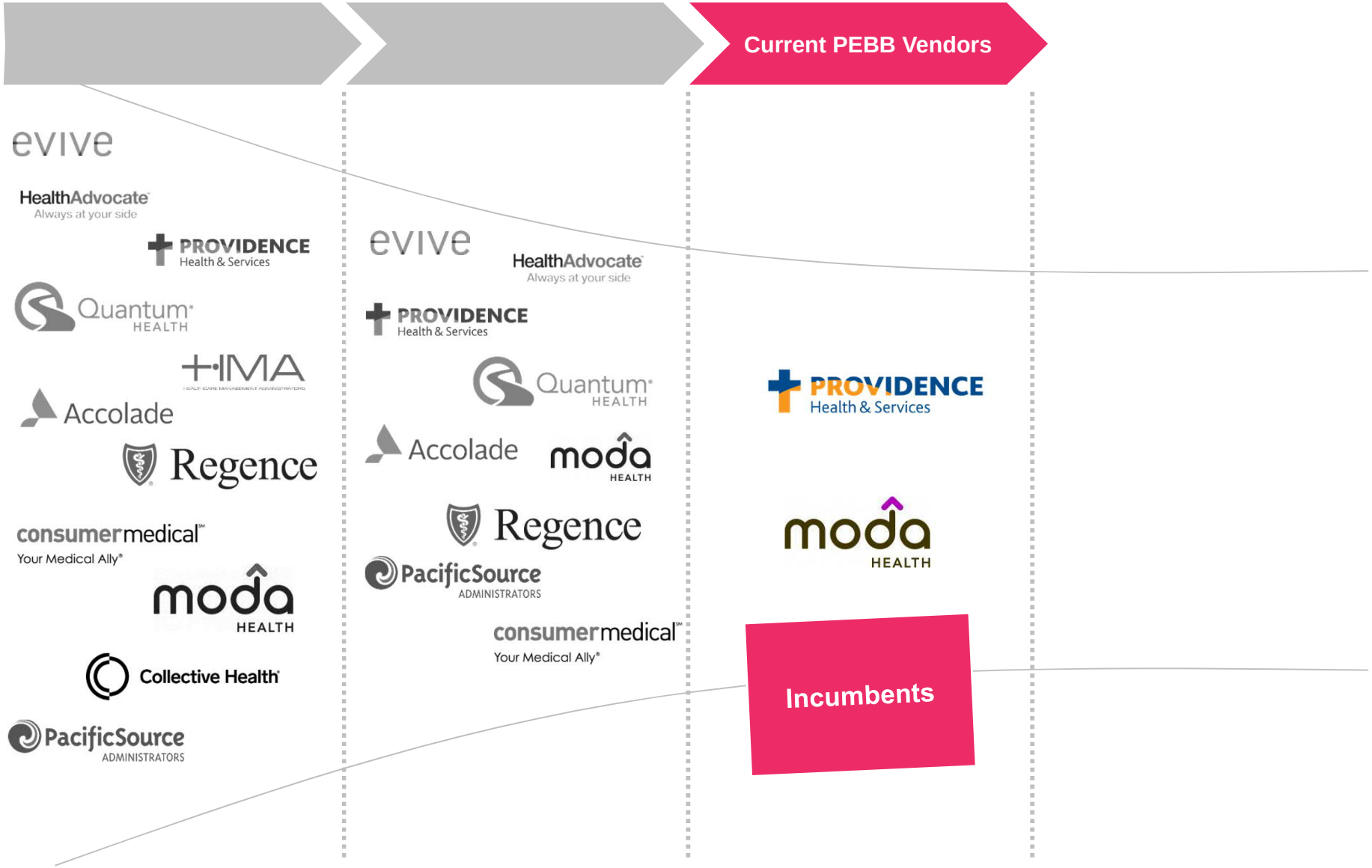
Regence

PacificSource ADMINISTRATORS

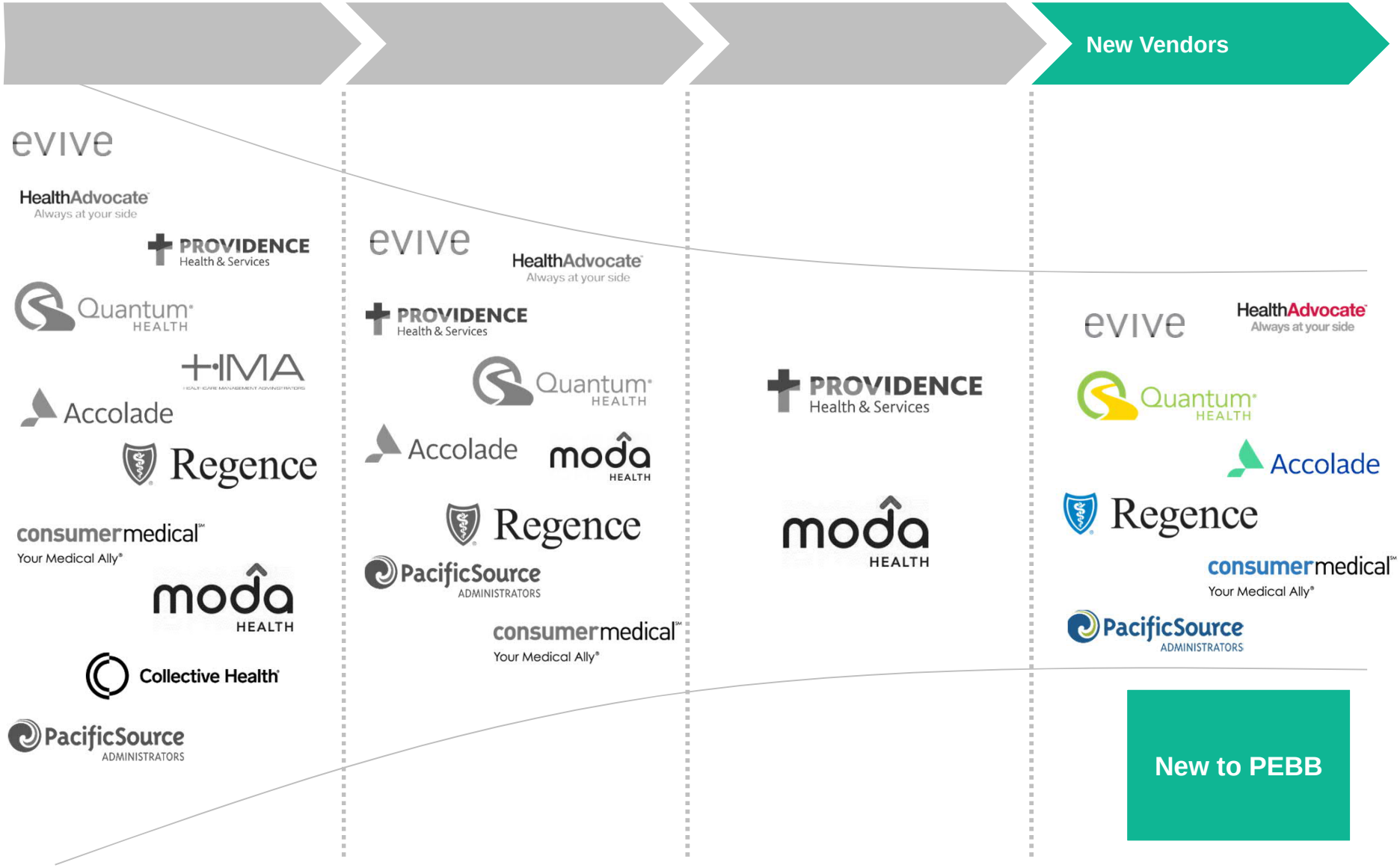
consumermedical
Your Medical Ally

9 Responders submitted answers

CONCIERGE AND ADVOCACY RFI RESPONDERS



CONCIERGE AND ADVOCACY RFI RESPONDERS



04

EXECUTIVE SUMMARY OF RESPONSES

OVERALL SUMMARY

COMMON THEMES

- Taking a whole person approach, including physical health, behavioral health, and social determinants of health
- Coaching approach with a focus on member engagement to identify needs and refer to benefit programs, healthcare services, and community resources as needed
- Deploying multi-disciplinary health professionals, e.g., Registered Nurses and Social Workers
- Leveraging the use of technology and data, e.g., predictive modeling, website, apps, machine learning, and artificial intelligence
- Providing a single point of contact for triaging members to the appropriate service
- Offering multi-channel access to services, e.g., email, text, phone, etc.
- Incorporating a robust communication campaign to drive member engagement
- Willing to put fees at risk for not meeting certain targets through performance guarantees
- Pricing based on a per employee per month (PEPM) format

OVERALL SUMMARY

KEY DIFFERENCES

- Some CAS responders only offered advocacy services (e.g., enhanced customer service), and others offered advocacy and clinical services
- Some CAS responders have been providing services for several years, others are developing them
- Some CAS responders require that they provide all advocacy and clinical services; others will allow the list of services to be customized
- Some CAS responders are fully aware of Oregon initiatives; others are not as familiar with the Oregon healthcare landscape
- Some CAS responders have experience with government agencies; others do not
- Some CAS responders have worked with providers and value based care arrangements; others have not

SECTIONS OF THE RFI

- **Structure:** Questions regarding the organization, staffing model, scope of services, etc.
- **Process – Organization:** Questions regarding internal processes and member experience
- **Process – Administration (Non-Clinical)**: Questions regarding how the concierge and advocacy service representatives assist members with claims, provider selection, benefit plan navigation, and other non-clinical services.
- **Process – Clinical:** Questions regarding the scope and range of clinical management programs, such as utilization management, case management, disease management, etc.
- **Integration:** Questions regarding their ability to share information and coordinate with other benefit providers.
- **Pricing, Performance Guarantees and reporting**

STRUCTURE

ORGANIZATION, STAFFING MODEL, SCOPE OF SERVICES

- Focus on identifying needs, providing education, referring to services when necessary
- Advocates and clinicians work in teams, including MDs, RNs, and Social Workers; some include pharmacists, nutritionists, and others
- **Training varies** from **3 days to 39 days** for orientation, and on-going training
- Staffing ratio ranges
  - **Advocates: 1:2,650 to 1:75,000**
  - **Clinicians: 1:6,550 to 1:18,750**
- Most responders perform initial and on-going credentialing of clinicians to verify licensure
- Data integration, ingesting, and sharing are performed with shared platforms by all staff
- **Range of clinical management services** from none to a broad array, e.g. utilization management, case management, disease management, expert medical opinion, behavioral health, etc.
- Use of data and predictive modeling to support proactive outreach to high risk members
- **Members are offered multi-channel communication options**, including phone, text, securing messaging, & on-line
- Communication campaigns include phone, mail, email, & mobile push notifications

STRUCTURE

ORGANIZATION, STAFFING MODEL, SCOPE OF SERVICES - CONTINUED

- Some monitor members seeking healthcare services with outreach for certain cases, e.g., member going to the emergency department
- All support steerage to in-network providers, some offer cost and quality transparency apps
- All measure and monitor member engagement (although definitions of engagement vary) with a **range from 8% to 80% of entire population engaged**
- All report on health service utilization metrics, some report on referrals to benefit programs
- **Some sub-contract certain services including some with off-shore sub-contractors**
- **Some have experience working with government benefit programs and boards; some have none**
- Most are willing to contract directly with the State or with the administrator

PROCESS — ORGANIZATION

INTERNAL PROCESSES AND MEMBER EXPERIENCE

- Holistic approach including family members and caregivers
- Complaints are received through various channels and resolution ranged from 7 days to 30 days
- **Variations in willingness to delegate advocacy or clinical services to risk bearing provider groups**
- Robust quality management for advocacy and clinical services
- Variable approaches for social determinants of health; such as using zip code data & assessments with interventions for transportation, financial wellness, child/elder care, food banks, etc.
- **Most focused on linguistic capabilities; others had broader approach to diversity and inclusiveness**
- Use of artificial intelligence and machine learning to identify high risk populations
- Range of answers related to accessing in-network specialists from sole reliance on data to proactive outreach to specialty practices to get timely appointments
- Most have web and app, some have mobile-enabled website with **engagement without rewards between 23% and 30% while engagement with incentives ranging from 40% to 97%**
- Communication at launch ranged with mailings, hard copy collateral, on-site events, email, and welcome kits
- All support members outside of Oregon

PROCESS — ADMINISTRATION OF *NON-CLINICAL* SERVICES

ASSISTING MEMBERS WITH CLAIMS, PROVIDER SELECTION, ETC.

- **Range of responses regarding claim resolution**, such as education and clarification of coverage and explanation of benefits, understanding benefit plan design, and navigating denials and appeals
- **Range of services for selecting providers**, such as finding quality providers, in-network providers, outreach to providers for available appointments, and coordinating expert medical opinions
- Most support members in pre-care and post-care fee negotiations with providers, and some negotiate single case agreements with providers
- Most use a customer relationship management tool that contains information about available benefits for members, and some also contain community services
- Range of other services, such as educational modules, care gap closure, shared decision making, and psycho-social support services

PROCESS — ADMINISTRATION OF *CLINICAL* SERVICES

SCOPE AND RANGE OF CLINICAL MANAGEMENT PROGRAMS

- Range of services from educational materials only to advocates and clinicians providing support, usually with RNs as the lead member-facing clinicians
- **Some use nationally recognized and validated assessment tools**, such as the Patient Activation Measure® (PAM®), motivational interviewing, and PHQ-2 for depression, to identify high risk members
- Most use their **own proprietary system using data from multiple sources to identify high risk members**, and a few use licensed tools, e.g., Milliman Advance Risk Adjustors
- Advocacy services are available to all members, and most use screening tools to identify members in need of clinician intervention
- Variability in percentage of member outreach and engagement:
  - **Identified for outreach with moderate to high risk: 6% to 15% of the entire population**
  - **High risk members engaged: 1% to 5% of the entire population**
  - **High cost claimants engaged: 50% to 80% of all high cost claimants**

PROCESS — ADMINISTRATION OF *CLINICAL* SERVICES

SCOPE AND RANGE OF CLINICAL MANAGEMENT PROGRAMS - CONTINUED

- **Range of clinical interventions**, e.g. education, care coordination, care transitions, medication reconciliation, utilization management, expert medical opinion coordination, behavioral health, & community resources
- **Most use an care assessment process by RNs to develop care plan** for physical health, behavioral health, and social determinants of health
- **Some conduct utilization management** (including pre-service, concurrent, and post-service reviews), and some require utilization management to be part of their solution suite
- Some use nationally recognized evidence-based clinical guidelines, e.g., MCG Goal Length of Stay for hospitalizations, American Society of Addiction Medicine for substance use disorders, and U.S. Preventive Services Task Force for screenings

INTEGRATION

ABILITY TO SHARE INFORMATION AND COORDINATE WITH OTHER BENEFIT PROVIDERS.

- **All accept, ingest, and use medical claims data** (and some use other types of data) then apply proprietary algorithms to identify, outreach, and engage members who are at risk
- **Most see themselves as the center of integration** between all vendors, some indicated a willingness to participate benefit vendor trainings
- All indicated the ability to make referrals to other benefit vendors and to receive referrals, some track referrals to ensure the member actually engage
- **All are willing to do bilateral data sharing**, and some specified data transfers via application programming interface (API) or secure file transfer protocol (SFTP)
- **Range in depth of integration with other vendors**, e.g., data transfers, warm transfers, vendor cross-training, on-going benefit vendor meetings
- Most support coordination with value based care arrangements, such as the Coordinated Care Model (CCM) and patient centered primary care homes (PCPCHs)

PRICING

- Pricing rages from $7 per employee per month (PEPM) up to $34 PEPM
- Most respondents offer a range of solutions which range in intensity and price points, such as enhanced customer services and clinical management services (e.g. utilization management, case management); some are educational only
- Some Concierge and Advocacy services are subject to one time implementation fees up to $300K

PERFORMANCE GUARANTEES (PGS)

- Most respondents are willing to put 10% to 40% of fees for not meeting certain targets which may or may not include the following:
  - **Member Experience/Satisfaction**
  - **Clinical metrics** such as increase in primary care, preventive care, closing gaps in care, medication adherence, and steerage to other health plan programs
  - **Account Management** satisfaction
  - **Operational** such as implementation, customer service metrics, and call center volumes
  - **Cost Savings** such as medical trend and return-on-investment (ROI)
  - **Some respondents** are willing to discuss additional PGs or negotiate on existing

RETURN ON INVESTMENT (ROI)

- Typical ROIs across books of business are anywhere from a 1:1 up to a 4:1 ROI over time, depending on the intensity and types of services provided
- Some respondents already offer or are willing to discuss ROIs to measure steerage to other health plan programs and/or point solutions.

REPORTING

- Respondent may report on the following items, some respondents do not report the entire list but are willing to discuss:
  - **Health service utilization** such as telemedicine, inpatient admits, behavioral health visits, pharmacy metrics, ER admissions, general screenings
  - **Member experience/satisfaction** such as trends in usage and case management
  - **Referrals to other benefit vendors**, such as referrals to digital health point solutions
  - **Cost savings and ROI** such as financial summaries, engagement, readmissions and performance guarantees
  - **Member engagement** such as interactions, family engagement, other solutions
  - **Care gaps and quality** such as HEDIS measures, readmission rates, primary care utilization, lengths of stay
- Respondents either report or are willing to try and accommodate the Oregon Health Plan Quality metrics to the best of their ability

KEYS TO SUCCESSFUL IMPLEMENTATION

CONSENSUS FROM RESPONDERS

- Strong ***leadership support from the PEBB Board***, including ***dedicated OHA resources and support*** to actively participate in the implementation
- Clear, consistent, and compelling ***communication to members*** regarding CAS services that demonstrate the value proposition of these services
- ***Robust project management*** work plan with timelines, accountabilities, and deliverables; including problem solving to address barriers to progress
- Facilitate ***data sharing and data integration*** agreements between all parties
- Clearly ***identify the scope and specific requirements for the CAS vendor***, including the success metrics
- Ensure that the ***CAS vendor understands the Oregon landscape***, PEBB customers, providers, and community resources

RECOMMENDATIONS

MERCER'S POINT OF VIEW

- CAS allows the State the opportunity to potentially enhance the member experience, increase adherence to evidence-based clinical guidelines, increase use of available benefits and services, and save money
- CAS services are rapidly evolving with emerging capabilities and enhancements through technology and staffing approaches
- Although CAS services are more expensive than traditional customer service, this will need to be countered through demonstrated and verifiable cost savings and quality improvements
- Modular approach to an RFP that includes CAS
  - Allow for state discretion if CAS is included in the scope of work
  - Allow for bidders to only bid on CAS, including advocacy and/or clinical services
  - Require the apparent successful bidder to work with an external CAS vendor, if desired
  - Require relevant and significant performance guarantees (PGs) related to The Triple Aim
  - Require a customized approach to CAS that incorporate Oregon-specific initiatives
  - Require periodic performance assessments and independent verification of clinical, financial, and member outcomes

06

APPENDIX

GLOSSARY OF TERMS

- **Accountable Care Organization (ACO)**: This is a group of health care providers, potentially including doctors, hospitals, health plans and other health care constituents, who voluntarily come together to provide coordinated high-quality care to populations of patients. The goal of coordinated care provided by an ACO is to ensure that patients and populations — especially the chronically ill — get the right care, at the right time and without harm, while avoiding care that has no proven benefit or represents an unnecessary duplication of services.
- **Alternative Payment Model (APM)**: This is a payment approach that gives added incentive payment to provide high-quality and cost effective care. APMs can apply to a specific clinical condition, a care episode, or a population. The APM framework began as a payment model classification system originally presented by the Centers for Medicare & Medicaid Services (CMS) and later modified by the HCP LAN workgroup, and it tracks progress toward payment reform and provides a pathway for the delivery of person-centered care.
- **Bundled payment**: a model that pays multiple providers across multiple settings for healthcare services associated with a defined “episode of care” under a single payment rate. Bundled payment is sometimes called “episode-based payment.”
- **Care coordination**: This is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care.
- **Capitation**: The per capita (per patient or beneficiary) payment arrangement for providing a specific menu of health services to a defined population over a set period of time. The provider usually receives, in advance, a negotiated monthly payment from the payer. This payment is the same regardless of the amount of service rendered by the provider.
- **Case management (CM)**: This is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual’s and family’s comprehensive health needs through communication and available resources to promote quality cost-effective outcomes.
- **Centers of excellence (COE)**: These are specialized programs within healthcare institutions which supply exceptionally high concentrations of expertise and related resources centered on particular medical areas and delivered in a comprehensive, interdisciplinary fashion.
- **Clinically integrated network**: This is defined as a collection of health providers, such as physicians, hospitals, and post-acute specialists that join together to improve care and reduce costs. Such networks generally share record systems, track data, and rely on evidence-based guidelines to provide high-quality care across participating providers.
- **Comprehensive Primary Care Plus (CPC+)**: This is program from the Centers for Medicare & Medicaid Services (CMS) this is a regionally based, multi-payer advanced medical home model offering an innovative payment structure to improve healthcare quality and delivery. It is a five year federal program beginning in January 2017. Over 150 practices in Oregon have been selected to participate in CPC+.

GLOSSARY OF TERMS

- **Coordinated Care Organization (CCO)**: This is a network of all types of health care providers (physical health care, addictions and mental health care and dental care providers) who work together in their local communities to serve people who receive health care coverage under the Oregon Health Plan (Medicaid).
- **Digital Health Point Solutions:** is the convergence of digital technologies with health, healthcare, living, and society to enhance the efficiency of healthcare deliver while making medicine more personalized and precise. The discipline involves the use of information and communication technologies to help address health challenges. These technologies include both hardware and software solutions as well as telehealth, web-based analysis, email, mobile phones and applications, text messages, wearable devices, and remote monitoring devices.
- **Fee-for-service**: a model in which providers are reimbursed by payers at negotiated rates for individual services delivered to patients without financial responsibility for the total cost for specified episodes of care or for a population of patients. This category also includes pay-for-performance incentives that accompany fee-for-service payments.
- **Full Continuum of Care**: All aspects of care delivery, spanning preventive to end-of-life services in all settings.
- **Global payment**: a model that establishes spending targets to cover all of the expected costs for healthcare services to be delivered to a specified population during a stated time period. Global payment is called by other names, including “total-cost-of-care payment” and “population-based payment.”
- **Health Care Payment Learning & Action Network (HCP LAN)**: This is a public-private partnership established to accelerate transition in the healthcare system from a fee-for-service payment model to those that pay providers for quality care, improved health, and lower costs.
- **Narrow Networks**: A strategy employed by health insurance companies (payers) that limit the number and types of physicians that are included in their network. In return, those physicians “in the network” typically extend greater discounts to the payer and receive greater numbers of patients. This arrangement may be primarily be based on deep discounts and not necessarily on quality metrics.
- **Patient Attribution**: The method used to determine which provider group is responsible for a patient’s care and costs.
- **Patient-Centered Primary Care Home (PCPCH), also called Patient-Centered Medical Home (PCMH)**: This is an approach to providing comprehensive primary care for children, youth, and adults. This is a health care setting that facilitates partnerships between individual patients, and their person physicians, and when appropriate, the patient’s family.
- **Pay for performance (PFP or P4P)**: An incentive system offered by some payers to healthcare providers based on their quality practices and/or outcomes or other factors. P4P programs come in a variety of forms based on the payer. Examples include Medicare’s Quality Payment Program (QPP). Some other programs offer financial incentives to providers who can meet evidence-based standards of care for particular conditions, such as heart disease, asthma and breast cancer screening that may exist both in government and private health plans or programs.
- **Population-Based Payment Model (PBM)**: A payment model in which a provider organization is given a population-based global budget or payment and accepts accountability for managing the total cost of care, quality, and outcomes for a defined patient population across the full continuum of care.
- **Population Health**: The health outcomes of a group of individuals, including the distribution of such outcomes within the group. It is an approach to health that aims to improve the health of an entire human population.

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NOTES ON SECTIONS OF RFI

- **Structure**
  - Advocates, health assistants, customer service professionals, and similar terms are used to describe the non-clinical staff members who provide enhance customer service
- **Process — Organization**
  - **Artificial Intelligence** is the broader concept of machines being able to carry out tasks in a way that we would consider “smart”. AI stands for Artificial intelligence, where intelligence is defined acquisition of knowledge intelligence is defined as an ability to acquire and apply knowledge. The aim is to increase chance of success and not accuracy.
  - **Machine Learning** is a current application of AI based around the idea that we should really just be able to give machines access to data and let them learn for themselves. ML stands for Machine Learning which is defined as the acquisition of knowledge or skill. The aim is to increase accuracy, but it does not care about success.
- **Process — Non-Clinical**
  - **A Single Case Agreement (SCA)** is a contract between an insurance company and an out-of-network provider for a specific patient, so that the patient can see that provider using their in-network benefits, i.e., the patient will only have to pay their routine in-network co-pays for sessions after meeting their in-network deductible (if any)). The fee for the service that will be paid by the insurance company is negotiated by the insurance company and the provider as part of the SCA.
  - **Customer relationship management (CRM)** tool is a technology for managing all your company’s relationships and interactions A CRM tool with contact management, referral coordination, and more.

NOTES ON SECTIONS OF RFI

- **Process — Clinical**
  - **High risk members** are those members who have indications of being susceptible to incurring healthcare services and costs.
  - **High cost claimants** are usually defined as members who have had in excess of $50,000 to $100,000 in incurred claims in a year. They are the most expensive source of healthcare costs, beating out medical inflation, pharmaceuticals, and any specific disease or condition, the study found, adding that according to the National Business Group on Health, these claimants are the top cost driver for 43% of large employers.
  - The **Patient Health Questionnaire *(PHQ-2)*** asks about the frequency of depressed mood and anhedonia over the past two weeks.
  - **Patient Activation Measure (PAM)** is a commercial product which assesses an individual's knowledge, skill, and confidence for managing one's health and healthcare.
  - **The Agency for Healthcare Research and Quality (AHRQ)** defines care coordination as the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services
  - **Care transition** refers to the coordination and continuity of health care during a movement from one healthcare setting to either another or to home, called care transition, between health care practitioners and settings as their condition and care needs change during the course of a chronic or acute illness.
  - Hospital **discharge planning** is a process that determines the kind of care a patient needs after leaving the hospital. Discharge plans can help prevent future readmissions, and they should make the move from the hospital to home or another facility as safe as possible.

NOTES ON SECTIONS OF RFI

- **Integration**
  - **Benefit Vendors**: Other benefit vendors could include employee assistance programs (EAPs), wellness programs, and other benefits programs not offered by the CAS vendor
  - An **application programming interface (API)** is an interface or communication protocol between a client and a server intended to simplify the building of client-side software. It has been described as a “contract” between the client and the server, such that if the client makes a request in a specific format, it will always get a response in a specific format or initiate a defined action. An API may be for a web-based system, operating system, database system, computer hardware, or software library.
  - **Secure File Transfer Protocol (SFTP)**, also called SSH File Transfer Protocol, is a network protocol for accessing, transferring and managing files on remote systems. SFTP allows businesses to securely transfer billing data, funds and data recovery files. SFTP uses SSH to transfer files and requires that the client be authenticated by the server. Commands and data are encrypted in order to prevent passwords and other sensitive information from being exposed to the network in plain text.
  - **A warm transfer** is when you speak with the new agent before the call is transferred. You can tell the destination agent about the caller's issue and give any background information before transferring the call (without the caller hearing). Then, all three parties can speak together.


MERCER
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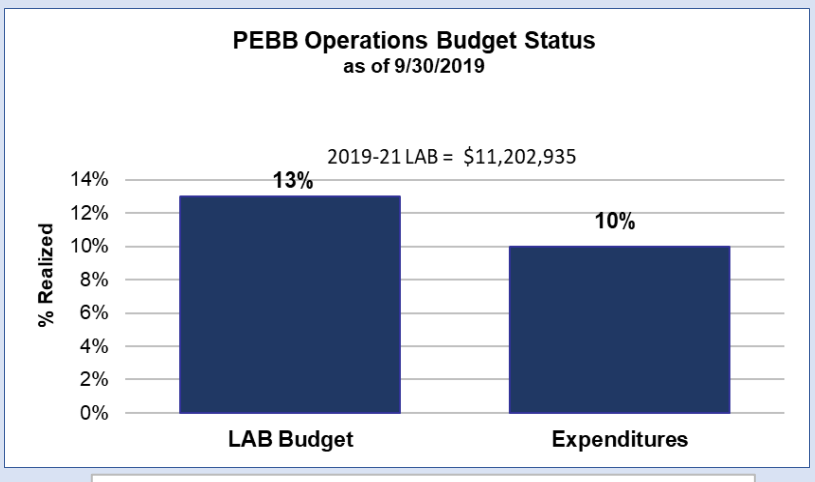
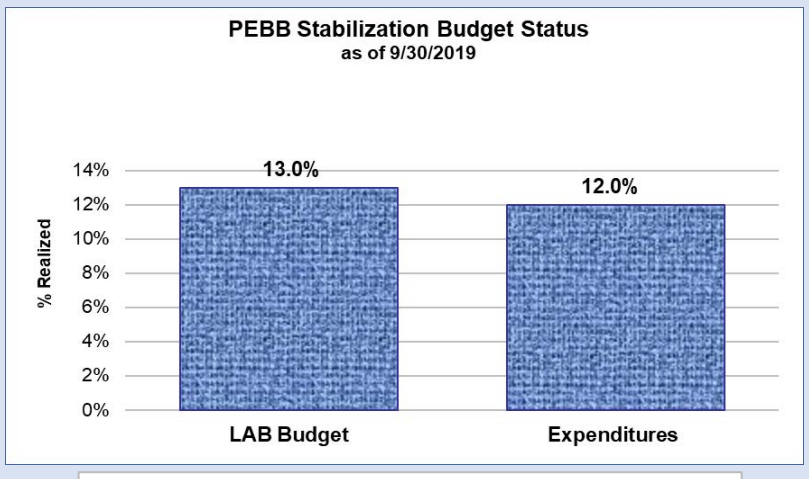
PERFORMANCE DASHBOARD REPORT – OCTOBER 2019

Cash Position and Budget Status



TAKEAWAY: Expenditures are running below budget



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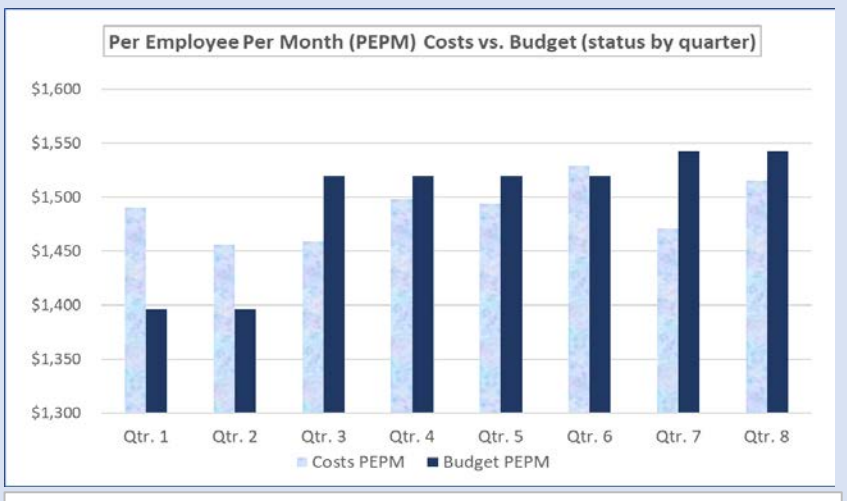


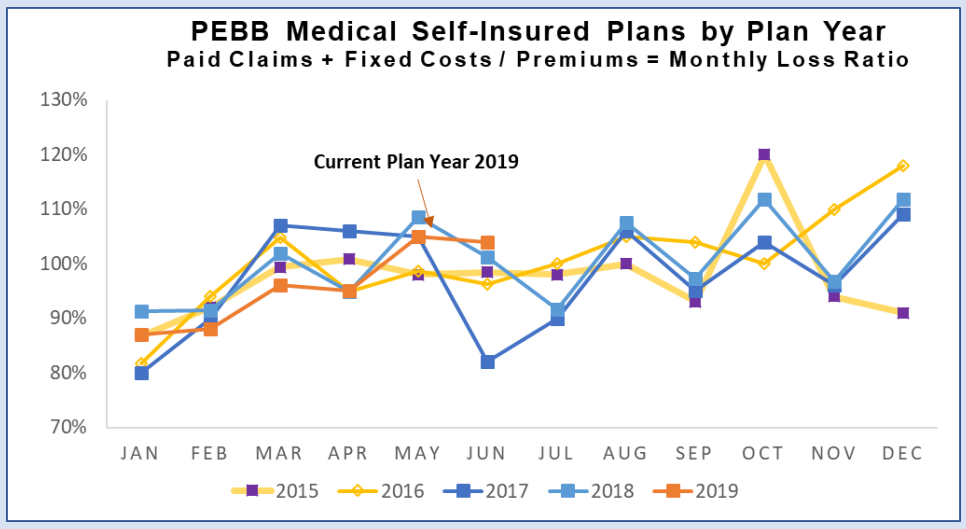
TAKEAWAY: Current Status is Under Budget by $12.28 PEPM through 24 months of the 2017-19 biennium. 97% of the 2017-19 biennial budget was expended.

PEBB 2019 Reserve Funding Report	
2019 Beginning Balance (Stabilization Fund):	$279,462,358
Plan Year Surplus or (Deficit) through June 2019:	$13,652,771
2019 Current Cash Balance:	$293,115,129

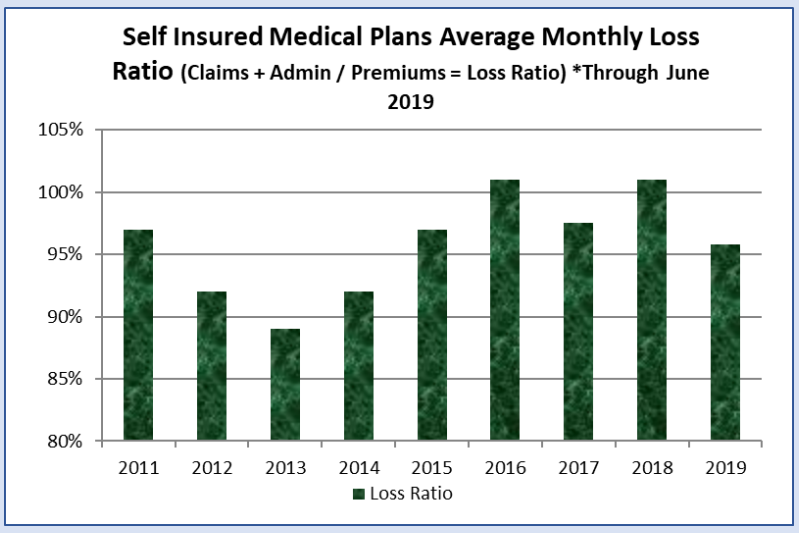
Notes: 1) Claims Runout and HEM costs would reduce balance by approximately ($63 million). 2) 2019 RBC Mid target is $202.7M 3) HB 2377 directs $15M transfer to General Fund May 2021.

TAKEAWAY: Cash Reserve has increased by $13,652,771 through June 2019

Self-Insured Plan Performance



Takeaway: Through June 2019, costs paid per employee per month have decreased by (-0.99%) over 2018. Premiums collected have gone up by 3.84% which is in line with the self-insured medical plan renewal rates.



PEBB Self Insured Medical Plan Premium Equivalent PEPM (As Receipted)							
Plan Year	2013	2014	2015	2016	2017	2018	2019
Premium PEPM	$1,261.81	$ 1,253.42	$ 1,240.50	1276.93	$ 1,345.34	$ 1,385.81	$ 1,439.08
Pct change		-0.66%	-1.03%	2.94%	5.36%	3.01%	3.84%

PEBB Self Insured Medical Plan Actual Costs PEPM (Paid Basis)							
Plan Year	2013	2014	2015	2016	2017	2018	2019
Costs PEPM	$1,119.60	$ 1,159.44	$ 1,214.19	1287.31	$ 1,314.00	$ 1,399.80	$ 1,385.93
Pct change		3.56%	4.72%	6.02%	2.07%	6.53%	-0.99%

Programs

2019 Medical Plan Enrollment (March 2019 Census)				
Plans	Employees	Dependents	Total	Pct. Of Total
Providence Statewide	18,828	31,205	50,033	35.7%
Providence Choice	19,234	30,165	49,399	35.2%
Moda	4,886	8,058	12,944	9.2%
Not Enrolled	3,209	-	3,209	2.3%
Kaiser	9,760	14,997	24,757	17.6%
Total	55,917	84,425	140,342	100.00%

2019 PEBB Member Types (Compare March 18' vs March 19')			
Member Type	March 18'	March 19'	Inc/(Dcr)
Active/Semi-Independ.	49,490	51,478	4.0%
Opt-out/Waive	2,922	3,209	9.8%
Self-Pays	61	67	9.8%
Retirees	902	984	9.1%
COBRA	162	179	10.5%
Total	53,537	55,917	4.45%

WW Kurbo Program
(2020 Plan year)

November 19, 2019

Cindy Bowman, Director of Operations

Overview

At the September 17th, 2019 meeting the Board reviewed information on Kurbo, WW's (formerly Weight Watchers) new program to support healthy eating and behavior modification for youth age 17 years and younger. The information presented at this time acknowledged some national media concerns when Kurbo was launched, generally related to concerns that weight management programs could promote negative cultural pressures around body image and weight among children and teenagers.

At the September meeting the Board deferred a decision on whether to offer Kurbo in 2020 pending OEBB's Strategies on Evidence and Outcomes Workgroup's (SEOW) review of the program. This report provides an update on SEOW's review of Kurbo and a recommendation regarding offering the program to PEBB members age 10-17 years in 2020.

Board action is requested.

WW/Kurbo and PEBB Benefits

In summer 2019 WW launched a program-wide transition to shift participants under age 18 from the traditional WW program to Kurbo, a weight management offering specifically developed for children and adolescents. WW offered to provide Kurbo free-of-charge to PEBB for the 2020 plan year with program pricing addressed in subsequent renewals. After reviewing Kurbo and supporting information, PEBB/OEBB staff agreed that Kurbo should be offered to PEBB/OEBB members to ensure that dependents (ages 10-17) continue to have access to a weight management program through WW as approved by the Boards for the upcoming plan years. Declining Kurbo would mean that PEBB/OEBB's WW benefit would no longer be available to members under age 18.

Multiple stories appeared in national media in August 2019 that raised potential negative consequences of the Kurbo method for promoting healthy eating among children/teenagers. The OEBB Board requested that SEOW examine the Kurbo proposal in greater detail, including considering recommendations from contracted health plans. The PEBB Board deferred a decision on Kurbo pending SEOW's review.

SEOW Review of Kurbo

In October SEOW conducted further review of the Kurbo program and sought input from PEBB and OEBB contracted health plans.

1) **OEBB Strategies on Evidence and Outcomes Workgroup (October 2019)** - PEBB/OEBB medical carriers provided a review of the Kurbo Program proposal with recommendations for implementing the Kurbo Program. SEOW recommended that PEBB/OEBB implement the Kurbo Program starting 1/1/2020 and requested that staff work with WW on the following items:

- Utilization/Outcome reporting:
  - Change in BMI or BMI ranges
  - Incidence of Eating Disorders
  - Change in healthy behaviors
  - Participation/utilization

- Explore the possibility of a data exchange process with carriers to notify providers

- Communications/Marketing:
  - Communications should indicate that Kurbo is a pilot program for OEBB and PEBB
  - Participation is voluntary and members should contact their doctor about participating if they have any concerns
  - Pounds lost should not be included in any marketing materials

2) **Weight Watchers, Carriers and Staff Follow-up (October 2019)**

- WW will report on PEBB/OEBB participation in Kurbo that includes (enrollment, engagement, change in weight status, change in healthy behaviors, program satisfaction). WW will provide an aggregate report on the number of eating disorder incidents identified for PEBB/OEBB participants in Kurbo

- Participants indicating that they're depressed during enrollment will be screened out of the Kurbo Program

- WW will indicate that Kurbo is a pilot program for 2020, participation is voluntary and will remove references to pounds lost in communications materials

Recommendation

Staff recommends that PEBB implement Kurbo for WW participants ages 10-17 years, effective with the start of the 2020 plan year.

EviCore Implementation Change

Nov. 19, 2019

Damian Brayko, Deputy Director

Overview

Providence has run into a number of complexities related to the EviCore implementation.

Background

The CorePath program that Providence is implementing isn't fully aligned with what was discussed for the EviCore implementation for PEBB. With CorePath, the provider is required to submit a notification to EviCore with the first visit. If the provider submits the notice, the process is invisible to the member. However, if the provider fails to submit the notice, then the service is denied (to the provider if in-network/to the member if out-of-network). This is different than what has been communicated to PEBB and PEBB members. There is concern from Providence that this would result in a poor member experience due to the denied or delayed services.

The ask is to delay implementation of PEBB EviCore for 1 year (to 2021). This would allow Providence to implement the program and thoroughly test the functionality on their commercial membership. Once key processes are streamlined, Providence would be in a much better position to administer it for PEBB. The delay would also give Providence time to create a better communication plan for PEBB members that is clearer on the process and experience expectations.

The 2020 rates include $.35 PEPM specifically for EviCore. Providence would reduce the 2020 rates by that amount. If implementation is delayed as requested, Providence will update the 2021 rate as part of their upcoming renewal proposal.

This will not have any impact on any of the other programs, services, performance guarantees, or initiatives that Providence is working on, or have in place, for PEBB.

Staff Recommendation

Mercer had estimated EviCore would save approximately $1.6M for PEBB in the 2020 plan year (split evenly between Choice and Statewide). Mercer also has indicated that the loss of potential savings should not have a significant impact on PEBB's budget as Providence has been trending a bit lower this year, building up more surplus for 2019 than was projected during the renewal process. Also, for 2020, the PEBB funding assessment of $20.8M will help mitigate the potential loss of savings.

Since Mercer does not foresee issues from a budget perspective for delaying implementation until 2021, and the PEBB member experience in the Providence system would be greatly improved, staff recommends delaying EviCore implementation to the 2021 plan year.

Action

Board action is requested.

HEALTH WEALTH CAREER

Attachment 7

LEGISLATIVE SESSION BUDGET NOTE: EXPLORE RX UTILIZATION TOOLS

PUBLIC EMPLOYEES' BENEFIT BOARD

November 19, 2019

LEGISLATIVE SESSION BUDGET NOTE

PURPOSE

- Review the current online pharmacy tools available to PEBB members, including the various elements
- Marketplace review of online pharmacy tools (including Cambia's Medsavvy)
- Compare PEBB tools to market tools

WHY IS RX PRICE TRANSPARENCY IMPORTANT?

- Engaged members are typically healthier members
- Prescription drug utilization tools:
  - Create visibility into the price variances based on a patient's Rx benefit, the dispensing pharmacy and the pharmacy cash pricing with or without discount offers
  - Link many stakeholders, including patients, providers, pharmacies, and health and pharmacy benefit payers
  - Offer real-time personalized pharmacy and drug-specific benefit data, in addition to the plan-level formulary and benefit information
  - Can improve low medication adherence and decrease wasted medication, ultimately improving patient care quality

PHARMACY PRICING TOOLS MARKETPLACE

Pharmacy Benefit Managers	PEBB Carriers	Market Alternatives
CVS pharmacy®	PROVIDENCE Health Plan	MEDSAVVY®
EXPRESS SCRIPTS®	KAISER PERMANENTE®	Rx Savings Solutions
OPTUM®	moda HEALTH	BLINK HEALTH
		GoodRx
		familywize® The smart way to save on prescriptions.
		Nimble
		InsideRx

PEBB CARRIER SUMMARY

	Providence	Kaiser	Moda
Overview	Members can: • View prescription claims history • Price compare medications using treatment cost estimator, which runs a real-time test claim for actual benefit estimate • Retrieve and view drug information • Link to pharmacy directory	Members can use the online tool to: • Obtain personalized drug cost estimates for a wide range of common prescription drugs based on their health plan benefits and accumulations. • Better understand and plan for the cost of their medications. • Compare the price of generic medication versus brand name medication. • Choose a pharmacy location that is most convenient. • See the cost difference between mail order pharmacy and an outpatient pharmacy	Member login to the Prescription Price Check Tool to: • Account for accumulators and provide the most up-to-date member cost information based on the member's claims history during the plan year • Display formulary status, applicable utilization management edits (e.g., prior authorization, step therapy, quantity level limitations) • Compare cost information (member and plan cost), generic options (if applicable), and therapeutic options (if applicable)
Accessibility	Available to members online at myProvidence.com	Available to members online at kp.org	Available to members online at myModa.com and the Moda app
Available Information	Members are able to access a comprehensive suite of pharmacy tools including claim history lookup, treatment cost estimator, drug information, and formulary and pharmacy directory information	Members can select "Drug Price Check" and can type in the full name or the first three letters of the drug to populate options. Once a drug is selected, the member can change the quantity, identify similar drugs, or search for a pharmacy. Coverage alerts display based on the member's plan (e.g., a specialty drug that requires prior authorization).	Members can look up a specific product (e.g., medication name, strength, dosage, formulation, etc.) and adjust specific quantities, days' supply, and dispensing pharmacy. The tool simultaneously displays pricing at retail, mail order, and specialty pharmacies, allowing for the member to compare costs.
Member Outreach?	No member outreach	No member outreach	No member outreach
Quality Data?	Drug quality not rated	Drug quality not rated	Drug quality not rated
Cost	None	None	None (RTBC TBD)
Additional Information	Going live with Real Time Benefit Check (RTBC) in November 2019		Currently piloting RTBC, expected to be available to PEBB in 2021

REAL TIME BENEFIT CHECK (RTBC)

PRICE & BENEFIT TRANSPARENCY AT THE POINT OF PRESCRIBING

- RTBC leverages technology to provide patient-specific benefit information, improving transparency and ensuring accurate display of tier/preferred information to health care professionals without them ever having to leave their electronic medical record
- RTBC solves data issues surrounding formulary and benefit information, including:
  - Inaccurate display of preferred status and tier level
  - PA indicator missing or incorrect
  - Benefit information at plan, not patient level
- RTBC data pulled in real-time and direct from payer, which provides for more detailed benefit information at patient level

Real Time Benefit helps patients get the most appropriate care, at the most appropriate price

Sources: Providence and SS&C Technologies, Inc.

Accurate Information

Connects to Electronic Medical Record (EMR), returning real time patient and plan specific pricing information using plan benefits

→

Informed Prescribers

Returns benefit requirements and clinical concerns (PA*, drug not covered, drug interactions, duplicate therapy, etc.)

→

Price Transparency

Suggests lower cost therapeutic alternatives for top drug classes

→

Cost Savings

Provides channel options to optimize savings

REPRESENTATIVE MARKET ALTERNATIVES SUMMARY

	MedSavvy	RxSavings Solutions	GoodRx, Blink Health
Overview	MedSavvy is a medication and pharmacy marketplace that: • Gives members a personalized experience to access medication options, effectiveness results, and prices to help them find beneficial treatments that fit their budget • Has a specialized pharmacy team that reviews published evidence medications and assigns each drug an evidence grade • Monitors the marketplace, and alert participants to important, actionable information –including safety alerts, savings opportunities and adherence reminders	Rx Savings Solutions layers on top of an employer's pharmacy benefit to provide personal prescription guidance, built around: • Complete Transparency – A patented online tool delivers an unbiased view of every price and available savings opportunity for an existing or future prescription within the plan • Intelligent Software – Algorithms quickly analyze all possible clinical and financial therapies to maximize savings opportunities • Proactive Engagement – Multi-channel outreach keeps members informed of savings opps, medication schedules, etc.	The internet now makes it easier to track down the cheapest generic prescription medications. Two examples are GoodRx and Blink Health, which both provide medication prices and direct customers on buying options. Price transparency platform and script optimization solution to save employers and employees money on drug spend through pharmacy transfers, alternative therapeutics, generic alternatives, cash and coupon prices, and better dosage and days supplies.
Accessibility	Online	Push messaging around savings opportunities via text messaging or emails	Online and mobile apps
Available Information	Assigns a report card-style grade to medications for a disease, illness or health condition it treats  • Grades are based on review of scientific evidence on how well medications work and how good the science is for that research • Criteria is developed from best practices in evidence-based medicine • Grades are assigned by a specially-trained pharmacist team • Methodology is recognized by the Institute for Clinical and Economic Review (ICER)	• Contact Prescriber automates the process of switching a member's prescription for savings opportunities. • Medicine Cabinet/Reminders organizes all member prescriptions into one visual display and enables adherence reminders. • Medication Reports generate complete lists of all member medications and savings suggestions prior to a doctor visit. • Dependent Invitations are emails sent on behalf of members to adult dependents with savings opportunities. • Pharmacist Notes offer guidance on medications, possible interactions and other critical, clinical information.	GoodRx collects drug prices from thousands of pharmacies to show where a specific medication can be purchased at the lowest price. They also aggregate coupons and discount programs from manufacturers. Blink Health partners directly with drug manufacturers and negotiates lower prices for medications. They conveniently let consumers pick up medications at a pharmacy or order them by mail. Importantly, coupons on these sites often make the price of a medication lower than the copay through the prescription plan.
Outreach?	Yes (to both members and providers)	Yes	No
Quality Data?	Yes	No	No
Cost	Up to ~$2.50 PEPM	~$2.00 PEPM	None


MERCER
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pebb
Public Employees' Benefit Board

2020

Oregon Health Authority

JANUARY						
SUN	MON	TUE	WED	THU	FRI	SAT
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

FEBRUARY						
SUN	MON	TUE	WED	THU	FRI	SAT
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29

MARCH						
SUN	MON	TUE	WED	THU	FRI	SAT
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

APRIL						
SUN	MON	TUE	WED	THU	FRI	SAT
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

MAY						
SUN	MON	TUE	WED	THU	FRI	SAT
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

JUNE						
SUN	MON	TUE	WED	THU	FRI	SAT
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

JULY						
SUN	MON	TUE	WED	THU	FRI	SAT
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

AUGUST						
SUN	MON	TUE	WED	THU	FRI	SAT
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

SEPTEMBER						
SUN	MON	TUE	WED	THU	FRI	SAT
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

OCTOBER						
SUN	MON	TUE	WED	THU	FRI	SAT
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

NOVEMBER						
SUN	MON	TUE	WED	THU	FRI	SAT
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

DECEMBER						
SUN	MON	TUE	WED	THU	FRI	SAT
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

PURPLE – PEBB BOARD and INNOVATION WORKGROUP; Third Tuesday of the month.
ORANGE – PEBB LEADERSHIP – Every other Wednesday of the month at 8:30 a.m. (except on a holiday)
RED – PEBB OPEN ENROLLMENT
GRAY SHADED – STATE HOLIDAYS