HEALTH WEALTH CAREER

Attachment 5

OREGON PEBB BOARD MEETING

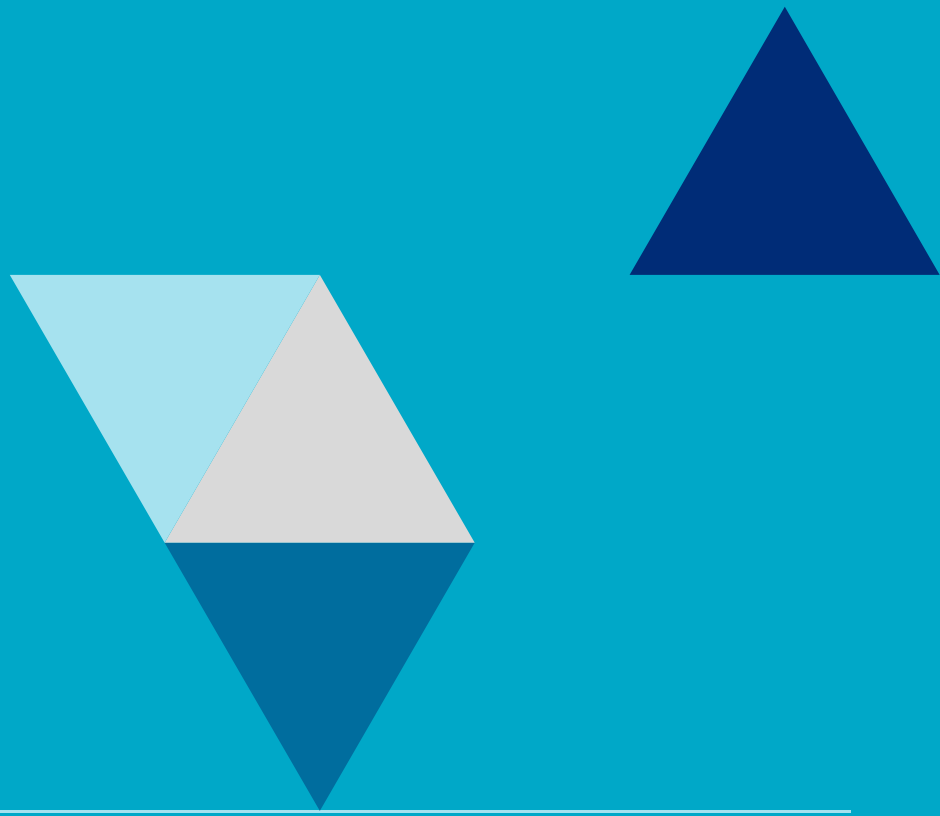
2020 RENEWAL RESULTS ROUND 2

MARCH 19, 2019

2020 RENEWAL DISCUSSION
OVERVIEW AND AGENDA

1. Plan background
2. Round 2 Follow-Ups
   - Medical
   - Non-medical
3. Next steps
4. Appendix — Financial information and Round 1 Responses

PLAN BACKGROUND



BACKGROUND
OVERVIEW OF COVERAGE

CARRIER	LINE OF COVERAGE	FUNDING	2019 INCREASE	2020 INITIAL INCREASE
Kaiser Permanente	HMO	Fully-insured	2.9%	3.0%
Kaiser Permanente	Deductible	Fully-insured	2.9%	3.0%
Moda	Medical / Rx	Self-insured	4.0%	0.0%
Providence Choice	Medical / Rx	Self-insured	5.4%	1.3%
Providence Statewide	Medical / Rx	Self-insured	3.9%	5.8%
Delta Dental of Oregon	Dental	Self-insured	2.0%	4.8%
Kaiser Dental	Dental	Fully-insured	3.4%	1.1%
Willamette Dental Group	Dental	Fully-insured	3.4%	7.9%
Vision Service Plan	Vision	Self-insured	2.9%	-0.1%
The Standard	Life and Disability	Various	5.1%	0.0%
ASI Flex	FSA, Commuter	Service contract	0.0%	0.0%
Benefit Help Solutions	COBRA Administration	Service contract	0.0%	0.0%
Cascade	Employee Assistance Plan (EAP)	Service contract	0.0%	0.0%

ROUND 2 FOLLOW-UPS

MEDICAL

CARRIER RECOMMENDATIONS FROM ROUND 1

PROVIDENCE Health Plan

- Implement PT/OT medical necessity review after the 12th visit ★
- Expand spinal manipulation benefit to include massage therapy ★
- Emphasize value-based payment contracting strategies
- Promote benefit differential between outpatient hospital services and ASCs ★

moda HEALTH

- Continue to mature and align its efforts on value-based-care
- Increased quality of care with services delivered through recognized medical homes (PCPCHs) and implementing CPC+
- Change specialty medications under medical benefit to be 20% coinsurance ★
- Shift medical infused medications to be under the pharmacy benefit ★

KAISER PERMANENTE®

- Expansion of telehealth services:
  - Virtual urgent care
  - Video consults
  - Text messaging capabilities
  - Mobile health partners
  - Development of AI
- Utilization Management
  - Reducing practice variability
  - Decreasing rates for inpatient and ER
  - Optimizing pharmacy

★ Explored as part of Round 2 responses

PROVIDENCE PROPOSED CHANGES

Question: *Providence suggested specific benefit changes as part of the Round 1 renewal responses. PEBB is interested in ensuring the plans have similar benefit designs and clinical guidelines for the benefits offered. For each of the changes, describe if you can administer the change, the cost impact, and whether you'd propose a modification*

	PROVIDENCE Health Plan **Original Recommendation:**	moda HEALTH	KAISER PERMANENTE®
Implement PT/OT medical necessity review after the 12th visit	• Implement PT/OT medical necessity review after the 12th visit • Cost: +$0.35 PEPM to the administrative fee, ~$160K • Estimated Savings: -0.3% or $2 million prior to administrative fee	• Moda currently contracts with eviCore to provide medical necessity review for PT/OT/ST • Providers are required to submit additional information after the 6th visit • Moda recommends keeping it at the 6th visit	• Kaiser's integrated care model already incorporates clinical and medical necessity review throughout the patient's course of treatment • Kaiser would not need to implement this change
Expand spinal manipulation to include massage therapy	• Adding massage therapy as a benefit may encourage members to seek this lower-cost treatment for addressing anxiety, stress, and pain • Estimated cost: +1% or $7 million	• Impact to add coverage for massage therapy with a 12 visit annual limit is 1.0% of claims, or $660K	• Kaiser agrees with expansion of the alternative care benefit to include massage therapy • Depending on design, the cost impact is 0.5% - 0.73% ($850K - $1.2M)
Promote benefit differential between outpatient hospital and ASC	• Allows outpatient procedures to be delivered in lower cost settings • This differential should be considered for radiology services as well	• Moda is open to alignment with Providence • Moda suggested $25 copay for outpatient surgery at an ASC and $100 copayment at an outpatient hospital	• Kaiser's integrated care model already guides patients through the care continuum to lower cost alternatives • This recommendation would not be necessary

MODA PROPOSED CHANGES

Question: *Moda suggested specific benefit changes as part of the Round 1 renewal responses. PEBB is interested in ensuring the plans have similar benefit designs and clinical guidelines for the benefits offered. For each of the changes, describe if you can administer the change, the cost impact, and whether you'd propose a modification*

	PROVIDENCE Health Plan	moda — Original Recommendation:	KAISER PERMANENTE®
Alignment of medical and pharmacy benefit cost share Change specialty medications under medical benefit to be 20% coinsurance	• Providence already has a similar infusible medication program that manages one patient at a time, determining the site of care that will be most clinically and cost effective for the patient • Providence would suggest changing cost sharing to copay more similar to pharmacy benefit, if any change was made	• Nearly all of the medical benefit drug spend is for specialty drugs, which also have a $5 copay, however, specialty medications covered under the pharmacy benefit have a $100 copay • This creates an incentive for members to seek treatment with a more costly infused medication than an oral or self-injectable medication that has lower cost, yet comparable safety and efficacy • The 20% coinsurance would result in a -0.3% claims impact, or ~$(200K)	• Kaiser could make the change to 20% after deductible • Cost impact is -0.24%, or $400K
Pharmacy Benefit Optimization Program Shift medical infused medications to be under the pharmacy benefit	• Given how drugs on the medical benefit are priced and reimbursed, anything other than a flat copay or coinsurance with a max will introduce price variability for the member • Providence does not believe the lower cost share is driving people to use drugs under the medical benefit • PEBB already has the "better of" benefit applied for oncology medications meaning they pay the lower of either the medical or pharmacy cost-share	• Shifts coverage of six traditionally medical benefit medications to the pharmacy benefit • Members continue to utilize their same medications, same provider, and receive their infusion/injection at the same place, but reimbursement would occur under the pharmacy benefit instead of medical, and therefore, have a pharmacy benefit copay • Results in an estimated -0.28% claims impact, or ~$(200K)	• This benefit is not applicable under Kaiser's integrated system

KAISER PROPOSED CHANGES

Question: *Kaiser suggested specific benefit changes as part of the Round 1 renewal responses. PEBB is interested in ensuring the plans have similar benefit designs and clinical guidelines for the benefits offered. For each of the changes, describe if you can administer the change, the cost impact, and whether you'd propose a modification*

	PROVIDENCE Health Plan	moda HEALTH	KAISER PERMANENTE® Original Recommendation:
Change a subset of DME items that are currently $0 member cost share (CADD pumps, enteral pumps, etc.) to the DME cost share.	• TBD	• Moda already covers those subset of DME items at regular INN and OON cost shares	• No rating impact for this change
Change oral chemo drugs from $0 member cost share to the lesser of Clinically Administered Medication cost share or RX cost share.	• TBD	• Anti-cancer medications are currently covered at the applicable cost sharing for the plan • Under both medical and Rx benefit, it would be a $10 copay	• If PEBB accepts the 20% coinsurance change on the Clinically Administered Benefit, members would pay this new coinsurance or the Rx cost share, whichever is lower

ALTERNATIVE CARE BENEFITS

Question: *PEBB would like to further explore physical, occupational, speech therapies, chiropractic care, and massage benefits. Carriers were asked to fill out the table below for each of those services*

	Visit Limits			Physician Prescription Required?			Prior authorization or concurrent review?			Other Benefit Plan Provisions		
	Prov	**Moda**	**Kaiser**	**Prov**	**Moda**	**Kaiser**	**Prov**	**Moda**	**Kaiser**	**Prov**	**Moda**	**Kaiser**
Physical / Occupational / Speech Therapy	60	60	20	eviCore does not require PA; but can add provider attestation if required by health plan	No	Yes	Both – eviCore recommends the initial evaluation/visit occurred to collect required clinical information; requests for ongoing care may be submitted as early as 7 days prior to requested start date	Yes, registered at initial visit, then PA required after 6th visit	No	N/A	Additional visits may be approved following acute head or spinal cord injury	
Chiropractic	No visit limit (annual max of $1,000 for chiro)	No visit limit (annual max of $1,000 for chiro)	No visit limits	No	No	No	No	No	UM program satisfies NCQA standards	Additional visits may be approved following certain injuries	Additional visits may be approved following acute head or spinal cord injury	$1000 max per year. Max includes chiro, naturopath, and acupuncture
Massage Therapy	Not covered	Not a covered benefit	Not currently covered, would have 12-visit limit	Not covered	Not a covered benefit	No	Not covered	Not a covered benefit	UM program satisfies NCQA standards	Not covered	Additional visits may be approved following acute head or spinal cord injury	

ALTERNATIVE CARE BENEFITS
MERCER RECOMMENDATIONS

- **Visit Limits**: Keep the current 60 visit limits for Providence and Moda but implement medical necessity review after the 12th visit for both carriers
  - Moda already uses eviCore to review after the 6th visit, with a denial rate of 7.46%
  - Recommend that all carriers conduct medical necessity review after the 12th visit for standardized processes to reduce provider confusion and monitor utilization
- **Physician Prescription**: Required for Physical, Occupational, and Speech therapies
  - This would be a change for Providence and Moda as prescriptions are not required for those services today; Kaiser requires a prescription
- **Massage Therapy**: Do not add as a covered benefit due to cost considerations
  - Claim / premium impact would be an increase of 0.5 – 1.0%
- **Chiropractic**: No prescription but medical necessity review after 12th visit
  - Do not require MD/DO physician prescription
  - Conduct medical necessity review after the 12th visit to monitor utilization

PROVIDENCE
ROUND 2 FOLLOW-UP SUMMARY

Inpatient allowed costs – explain the drivers behind the increase in inpatient cost per admission of 13% for Choice and 9% for Statewide	Providence has seen allowed cost per admission increases of 6.7% for Choice and 9.4% for Statewide (Jan – Nov 2017) Reasons: • 5.1% of Choice increase and 1.2% of Statewide is due to an increase in severity based on DRG weight • No material change in distribution of admits shifting to hospitals with higher DRG base rates • Providence focused to lower outpatient rates for several hospitals which meant the bulk of the increase went to an increase in inpatient rates. Salem Hospital, OHSU, and Sacred Heart were done this way • Remaining trend could be related to an increase in outlier cases overriding the DRG base rate payment. The 2019 contracting efforts included changes to limit cases from reverting to outlier status
eviCore – Implement PT/OT medical necessity review	• Providence's engagement with eviCore will begin effective 5/1/2019 for commercial lines of business • eviCore will use evidence-based clinical guidelines to complete these reviews • The medical necessity review will just cover physical and occupational therapy, would not cover speech, chiropractic, or massage therapy • Education happens on the member and provider level – eviCore uses data analytics to inform their efforts in outreaching directly to Providers. Providers with higher patient volume will get onsite and in-person visits to explain the medical necessity review – They also have a Provider Engagement Team that will onboard all providers – PHP's account team has an assigned Provider Engagement Director to collaborate with PHP's provider relations team to help assess the network and prioritize educational efforts in advance of the start of the program; will track trends and utilization
Ambulatory Surgical Centers – Benefit Differentials – How would a member know the difference between an ASC and outpatient hospital?	• PEBB member materials will be update to explain the difference – PHP can separate on benefit summaries, modify online language, and send targeted email messages • Members will have ability to search for an ASC in the online directory, or call customer service for assistance • Provider education will take place via online provider portal, ProvLink, as well as targeted to major provider groups, particularly in the areas with a high concentration of PEBB members and ASCs • PHP would work with PEBB to determine the criteria used for this benefit as well as an exceptions process
Network changes – First Health / First Choice network in 2019	• No change to the fixed cost component in the network fees • Savings will be experienced in the travel wrap access fees – reducing the expense to Providence and clients from 15% of savings to 9% of savings

PROVIDENCE DESIGN CHANGES
MERCER RECOMMENDATIONS

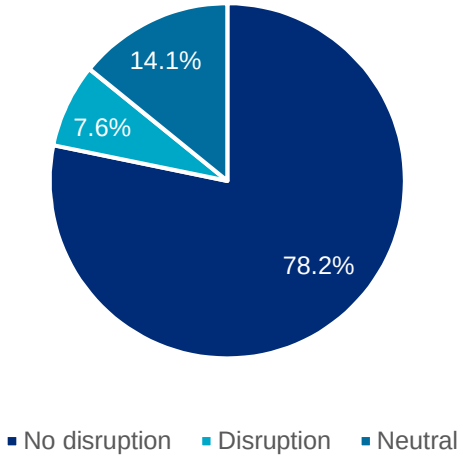
- **Alternative Care**: described on previous slide
- **Benefit differential for ambulatory surgical centers**: Pending sample of member communications and information on which providers will be specifically outreached to
  - Moda is open to this benefit design as well, even proposing $25 copay for outpatient surgery at an ASC and $100 copayment

MODA
ROUND 2 FOLLOW-UP SUMMARY

Connexus Network Change	• Synergy/Summit will be replaced with an updated CCM, focused on high performing primary care clinics which have either PCPCH or CPC+ certification, or NCQA for bordering states • Some members will be disrupted but more providers will be available overall • Synergy/Summit risk model will terminate effective 12/31/2019 but the provider network will remain beyond 1/1/2020. If PEBB remains on Synergy, it will result in decreased access for PEBB members because not all current Synergy/Summit primary care providers meet the certification requirements. • It is possible for PEBB to keep the current Synergy/Summit network of providers in the new CCM, but this would result in more network disruption for PEBB members for PCPCH access • Moda does not have a specific plan if SB1067 is repealed • Moda does not expect any cost implications due to the network growth • Moda feels the new primary care focused approach will provide greater incentive for PCPs to coordinate care than what currently exists under Synergy/Summit model • New facilities: all Providence hospitals as well as McKenzie-Willamette Medical Center • Value-based-payment will improve (even move to category 4A) with the CCM 2.0 Connexus network
Alignment of medical and pharmacy benefit cost share	• Align medical benefit medication cost share to PEBB's specialty pharmacy benefit cost share (or market) • PEBB members currently only pay $5 for infused or injected specialty medications paid under the medical benefit, less than the $100 copay for self-administered specialty medications paid under the pharmacy benefit • This incentivizes PEBB members to utilize medications under the medical benefit, which are almost always more expensive than similar medications under the pharmacy benefit • The proposed change would only affect those receiving their medications under the medical benefit
Pharmacy Benefit Optimization Program	• Shifts coverage of six traditionally medical benefit medications to the pharmacy benefit and results in cost savings to PEBB • Members continue to utilize their same medications, same provider, and receive their infusion/injection at the same place, but reimbursement would occur under the pharmacy benefit instead of medical, and therefore, have a pharmacy benefit copay • Members can also receive enhanced medication support through specialty pharmacists, copay assistance, and care coordination from the specialty pharmacy dispensing the drug • Combined with Change #1, the cost to the member would be neutral or improved
Change formulary tier structure (not included in Round 1)	• Modify formulary tier structure to ensure that members utilizing formulary medications receive best value • With the change, when non-formulary medications are approved they would have a higher copay than formulary medications – Non-formulary generics would have a $30 preferred brand copay rather than the $10 formulary generics copay, consistent with the "High Cost Generics" program – Non-formulary brands would have a $50 copay • With this change, members utilizing non-formulary medications would experience an increased cost share of $20 per month relative to what they are paying now

MODA
CONNEXUS NETWORK CHANGE

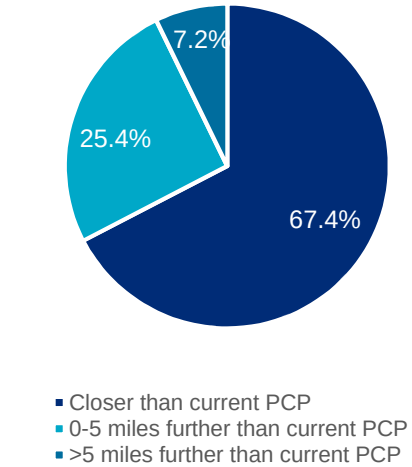
Overall Disruption	Members
Total Members	12,688
No Disruption • Members can keep current PCP	9,924
Disruption • Members will have to find a new PCP	969
Neutral • Members do not currently have a PCP	1,795



Top Counties

County	Members	# Disrupted	% Disrupted
Marion	1944	64	3.3%
Multnomah	1225	158	12.9%
Jackson	962	60	6.2%
Lane	739	24	3.2%
Linn	732	40	5.5%

Out of the total disrupted members…	Members
Total Disrupted Members	969
Disrupted members with CCM PCP closer than their current PCP	653
Disrupted members with CCM PCP between 0-5 miles further than current PCP	246
Disrupted members with CCM PCP greater than 5 miles further than current PCP	70



Of those being disrupted…

County	Closer than current PCP	0-5 miles further	>5 miles further
Marion	85.9%	14.1%	0.0%
Multnomah	93.0%	7.0%	0.0%
Jackson	81.7%	16.7%	1.7%
Lane	95.8%	4.2%	0.0%
Linn	62.5%	37.5%	0.0%
Total	86.4%	13.3%	0.3%

MODA DESIGN CHANGES
MERCER RECOMMENDATIONS

- **Connexus Network**: Mercer recommends agreeing to network change to further align with CCM 2.0 goals
  - Overall greater access to PCP's with PCPCH or CPC+ certifications
  - Some members would be disrupted but most will have options for PCPs which are closer than their current PCP
- **Alignment of medical and pharmacy benefit cost share**: Mercer recommends making infused / injectable medications under the medical benefit at least as costly to members as if they were administered under the pharmacy benefit ($100 copay)
- **Pharmacy Benefit Optimization Program**: Mercer recommends implementing this program due to cost savings for PEBB and limited (even enhanced) member experience
- **Formulary Tier Structure**: Pending further information on disruption from Moda

SUMMARY OF ALL CHANGES
MERCER RECOMMENDATIONS

Vendor	Change	Cost Impact	Mercer Recommendation
All	Alternative Care Benefits	+0.35 PEPM to admin, ~$160K annually -0.3% or $2,000,000 claim savings	Visit Limits and Review: Keep the current 60 visit limits for Providence and Moda but implement medical necessity review after the 12th visit limit for both carriers Physician Prescription: Required for Physical, Occupational, and Speech therapies Massage Therapy: Do not add as a covered benefit due to cost considerations Chiropractic: Review after 12th visit for medical necessity
PROVIDENCE Health Plan	Benefit differential for ambulatory surgical centers	Pending	Pending sample member communications but Moda open to the change
moda HEALTH	Connexus Network	None	Yes – alignment with CCM 2.0 strategies
	Alignment of medical and pharmacy benefit cost share	-0.3% or $200,000 claim savings	Yes – incentivizes member to use less costly site of care
	Pharmacy Benefit Optimization Program	-0.28% or $200,000 claim savings	Yes – cost savings with limited member disruption
	Formulary Tier Structure	-0.3% or $200,000 claim savings	Pending further information on member disruption
KAISER PERMANENTE®	Change a few DME items to the true DME cost share	None	Yes – alignment of benefits
	Change oral chemo drugs from $0 member cost share to the lesser of Clinically Administered Medication cost share or RX cost share.	Pending	Pending further information on cost impact

ROUND 2 FOLLOW-UPS

NON-MEDICAL

ROUND 2 FOLLOW-UPS

COST OF IMPLANTS AND ORTHODONTIA

	moda HEALTH	KAISER PERMANENTE®	Willamette Dental Group
Implants	Average allowed amount: **$2,348**	Average allowed amount: **$1,857**	Average cost: **$4,902**
Ortho	Average billed amount: **$4,243**	Did not provide	Average cost: **$6,577**

ROUND 2 FOLLOW-UPS
MODA - COST AND UTILIZATION

Benefit	Cost	Utilization
Implants *covered at 50% after the deductible; up to the $1,750 annual benefit maximum*	Average allowed amount: **$2,348**	An average of 614 members received an implant per year
Orthodontia *are covered at 50% up a lifetime maximum of $1,500*	Average billed amount: **$4,243**	1,765 members utilized orthodontic services per year

ROUND 2 FOLLOW-UPS
PROPOSED CHANGES

Benefit	Former Benefit	New Benefit	Claims Impact
Space maintainer	The Plan allowed once per space. Space maintainers for primary anterior teeth or missing permanent teeth or for members age 14 or over are not covered.	The Plan allows once per space per quadrant as a lifetime benefit. Space maintainers for primary anterior teeth or missing permanent teeth or for members age 19 or over are not covered.	Minor
Restorative services – Basic	The Plan disallowed indirectly fabricated post and core in addition to crown. Participating providers write off the charges.	The Plan denies indirectly fabricated post and core in addition to a crown unless more than half of the coronal tooth structure is missing.	Minor
Endodontic Services	Retrograde fillings were covered.	Retrograde fillings by the same dentists within a 2-year period of the initial retrograde filling is not covered.	Minor
Oral surgical Services	Osseous surgery was covered subject to consultant review.	Osseous surgery is limited to 2 quadrants per date of service.	Minor
Oral surgical services	Bone replacement graft was covered subject to consultant review.	Bone replacement grafts are limited to once per single tooth or multiple teeth within a quadrant in any 3-year period.	Minor
Oral surgical services	Oral and Maxillofacial surgery was covered subject to consultant review.	A separate charge for post- operative care done within 30 days following oral surgery is included in the charge of the original surgery.	-0.25% or 110,000 in claims savings
Prosthodontic services	Re-cement or re-bond implant/abutment supported crown or fixed partial denture was covered.	Re-cement or re-bond implant/abutment supported crown or fixed partial denture is limited to once in any 12- month period.	Minor

ROUND 2 FOLLOW-UPS
PROPOSED CHANGES (CONT.)

Benefit	Former Benefit	New Benefit	Claims Impact
Restorative services	Composite restoration in posterior tooth was not covered. Member paid the difference between amalgam and composite. Inlays were considered an optional service and an alternate benefit of an amalgam filling was provided.	Composite restoration in posterior tooth is covered. Inlays are an optional service and the alternate benefit will now be composite filling.	+1% or $440,000 in additional claims spend
Oral surgical services	Brush biopsy was not covered	Brush biopsy is covered twice in a 12-month period.	0.06% or $30,000 in additional claims spend
Prosthodontic services	The final crown and implant abutment over a single implant were covered. This benefit was limited to once per tooth or tooth space in any 7-year period. The final implant-supported bridge retainer and implant abutment, or pontic were covered. The benefit was limited to once per tooth or tooth space in any 7-year period.	The final crown and implant abutment over a single implant are covered. This benefit is limited to once per tooth or tooth space over the lifetime of the implant. The final implant-supported bridge retainer and implant abutment, or pontic are covered. The benefit is limited to once per tooth or tooth space over the lifetime of the implant.	-0.1% or $40,000 in claims savings

ROUND 2 FOLLOW-UPS

Composite Fillings / Restoration for Posterior Teeth

- Amalgam filling and anterior composite filling material is covered at 100% after a $20 office visit fee
- Posterior composite filling material is covered at 100% after a $20 OV charge up to the cost equivalent amalgam filling material. The member must pay the difference between the cost of an amalgam and composite filling when placed on a posterior tooth.
- Impact to remove the buy-up on the restorative benefit: 1.5% or increase of +$0.53 PMPM
    - This is to remove the member buy-up for the difference in cost of amalgam v. composite

Cost / Utilization

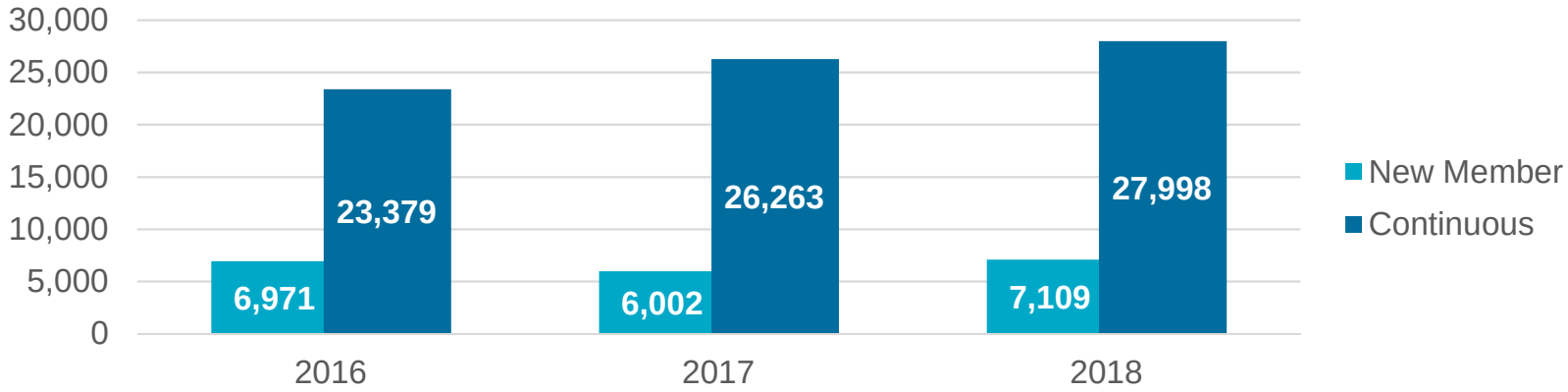
Orthodontia			
Year	**2016**	**2017**	**2018**
Annual $	$662,903	$662,872	$677,488
PMPM	$3.91	$3.91	$4.02

Implants			
Year	**2016**	**2017**	**2018**
Services / 1000	5.75	4.30	5.91
Allowed Amount / Service	$1,665	$1,852	$1,857
Paid / Service	$910	$849	$795

RENEWAL REPONSES

Willamette Dental Group

Change in Membership



Composite Fillings

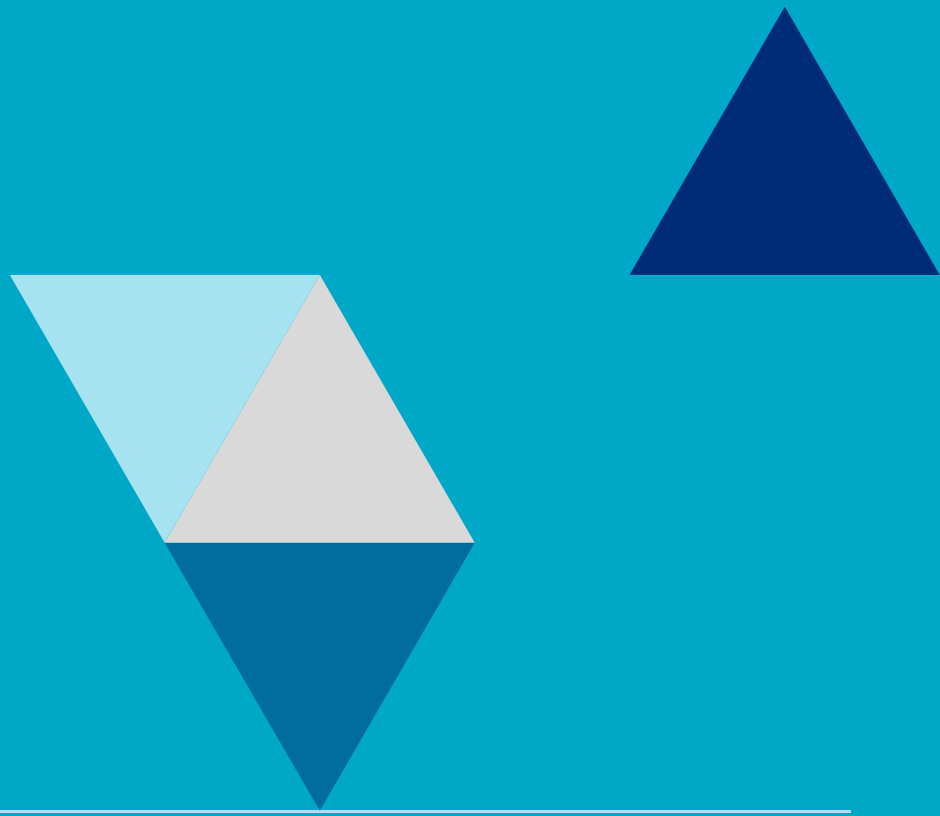
- Covered under a $20 copay (2019) whether it is amalgam/ composite and does not distinguish by location (posterior costs the same)

Cost / Utilization

	Implants		
Year	Implant Surgery Service Count	Unique Patients per Implant	Average Cost per Implant
2016	55	36	$4,589
2017	76	52	$4,710
2018	149	93	$4,902

	Orthodontia	
Year	Ortho Service Count	Average Cost
2016	254	$6,912
2017	299	$7,197
2018	447	$6,577

NEXT STEPS



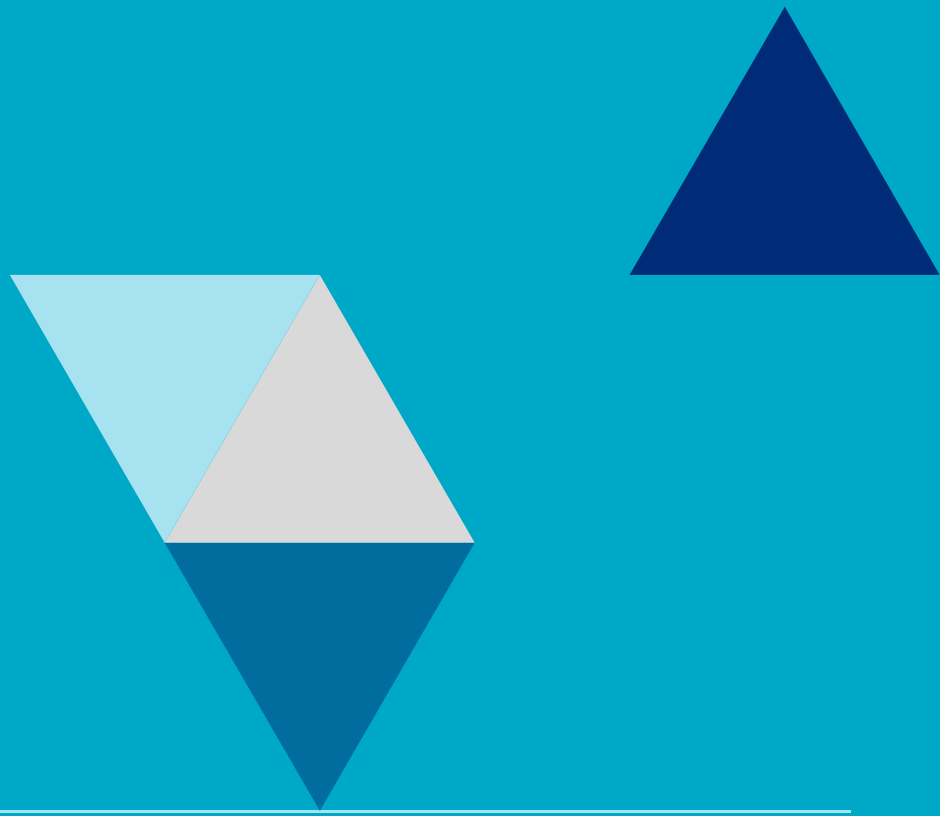
NEXT STEPS

- Finalize projections / premiums for all carriers, based on current plan designs
- Request final follow-ups for vendor proposed changes for 2020
- During April Board meeting:
  - Continue strategy discussion
  - Review best and final offers
  - Composite rate update
  - Finalize plan changes or request additional changes based on composite rate projection

2020 RENEWAL OVERVIEW AND TIMELINE

	2019 DATE	ACTION ITEM	RESPONSIBLE PARTY
✔	Jan. 4	Round One renewal letters sent to carriers	PEBB and Mercer
✔	Jan. 25	Carriers responses to Round One renewal letters due	Carriers
✔	Feb. 13	Final Materials of Round One responses due to PEBB	Mercer
✔	**Feb. 19**	**Board Meeting – Overview of Round One Responses**	**PEBB and Mercer**
✔	Feb. 22	Round Two renewal letters sent to carriers	PEBB and Mercer
✔	March 6	Carriers responses to Round Two renewal letters due	Carriers
✔	March 13	Final Materials of Round Two responses due to PEBB	Mercer
	March 19	**Board meeting — Overview of Round Two responses**	**PEBB and Mercer**
	March 22	Best and Final renewal requests sent to carriers	PEBB and Mercer
	April 3	Carrier responses to Best and final letters due	PEBB and Mercer
	April 10	Best and Final responses/materials due to PEBB	Mercer
	April 16	**Board meeting — Review of Best and Final Offers**	**PEBB and Mercer**
	May 15	Final materials for approval of best and final offers and final rates due to PEBB Board	Mercer
	May 21	**Board meeting – Approval of Best and Final offers and final rates**	**PEBB and Mercer**
	May 24	Final 2018 renewal letters sent to carriers for signature	PEBB and Mercer
	May 31	Signed final renewal letters returned to PEBB and Mercer	Carriers

APPENDIX



BENEFIT PLAN DESIGNS AND RATES

MEDICAL

Plan Provider Status	Kaiser Deductible	Kaiser HMO	Moda Summit/Synergy Coordinated Care Plan		PEBB Statewide PPO		Providence Choice (Medical Home)	
Benefit Plans	Kaiser Network	Kaiser Network	Care Home	Out of Network	In Network	Out of Network	Medical Home	Out of Network
Standard Deductible	$250/individual, $750/family	$0	$250/individual, $750/family	$500/individual, $1500/family	$250/individual, $750/family	$500/individual, $1500/family	$250/individual $750/family,	$500/individual $1500/family
Additional non-HEM participant deductible[3]	$100/individual, $300/family	$100/individual, $300	$100/individual, $300/family		$100/individual, $300/family		$100/individual, $300/family	
Out-of-pocket max.	$1500/individual $4500/family	$600/individual $1200/family	$1500/individual $4500/family	$4000/individual $12,000/family	$1900/individual $5700 family	$4800/individual $14,400/family	$1500/ individual, $4500/family	$4000/ individual, $12,000/family
Primary care visit	$5, deductible waived	$5	$10, first four visits deductible waived	30%	15% or 10%[4] first four visits, deductible waived	30%	$10, first four visits deductible waived	30%
Specialty care visit	$5 w/referral, deductible waived	$5, with referral	$10	30%	15%	30%	$10, with referral	30%
Outpatient mental health / Substance abuse care	$5, deductible waived	$5	$10, deductible waived	30%	15%, deductible waived	30%	$10, deductible waived	30%
Preventive	$0, deductible waived	$0	$0, deductible waived	30%	0%, deductible waived	30%	$0, deductible waived	30%
Inpatient hospital per admission	$50/day up to $250 max	$50/day, up to $250 max	$50/day to $250 max	$500 + 40%	15%	$500 + 40%	$50/day to $250 max	$500 + 40%
Outpatient surgery in a hospital setting	15%	$5	$10	$100 + 40%	15%	$100 + 40%	$10	$100 + 40%
Urgent care	$25, deductible waived	$5	$25	$25	15%	15%	$25	$25
Emergency department	$75	$75	$150	$150	$150 + 15%	$150 + 15%	$150	$150

PRESCRIPTION DRUGS

Plan Provider Status	Kaiser Deductible	Kaiser HMO	Moda Summit/Synergy Coordinated Care Plan		PEBB Statewide PPO		Providence Choice (Medical Home)	
Benefit Plans	Kaiser Network	Kaiser Network	Care Home[1]	Out of Network[1]	In Network	Out of Network	Medical Home	Out of Network[1]
Prescription Deductible	N/A	N/A	$50/Individual / $150/Family		$50/Individual / $150/Family		$50 Individual / $150/Family	
Prescription Out of Pocket Max	N/A	N/A	$1000/Individual / $3000/Family		$1000/Individual / $3000/Family		$1000/Individual	
Prescription drugs	• $5 generic • $25 brand • 50% up to $100 max non-formulary brand • $50 Specialty • Mail order (31-90 day), $5 generic, $25 formulary brand, 50% up to $100 max non-formulary brand	• $1 generic • $15 brand • $50 Specialty • Mail order (31-90 day), $1 generic, $15 brand	• $10 generic • $30 preferred brand • Copay x 2.5 for 90-day • $100 specialty	• $10 generic • $30 preferred brand • $100 specialty • Copay x 2.5 for 90-day • Member pays difference between in network rate and billed amount	• $10 generic • $30 brand • Copay x 2.5 for 90-day • $100 specialty	• Reimbursed as if filled in network; member pays difference between network rate & billed amount	• $10 generic • $30 brand • Copay x 2.5 for 90-day • $100 specialty	• Reimbursed as if filled in network; member pays difference between in network rate and billed amount

DENTAL

Plan	Kaiser Dental	Delta Dental (Moda) PPO		Delta Dental (Moda) Premier	Willamette Dental Group
Provider	Kaiser	In-Network	Out-of-Network	Participating	Willamette
Deductible: individual/family	None	$50/$150	$50/$150	$50/$150	None
Annual max coverage	$1,750	$1,750	$1,750	$1,250	None
Diagnostic & preventive services	$0 copay, not applied to annual max coverage	0%, no deductible	10%, no deductible	0%	$10 copay
Basic & maintenance services	$5 copay + 20%, not applied to annual max coverage	20% year 1 10% year 2 0% year 3	30%	50%	$20 copay for fillings, other basic services covered with OV copay
Crowns	$5 copay + 25%	50%	50%	50%	$250 copay
Implants	$5 copay + 50%	50%	50%	Not covered	Varies
Dentures	$5 copay + 50%	50%	50%	50%	$290 copay
Orthodontia	$5 copay + 50% to $1500	50% to $1500	50% to $1500	Not covered	$2500 copay

CURRENT RATES

2019 Medical Rates — Actives

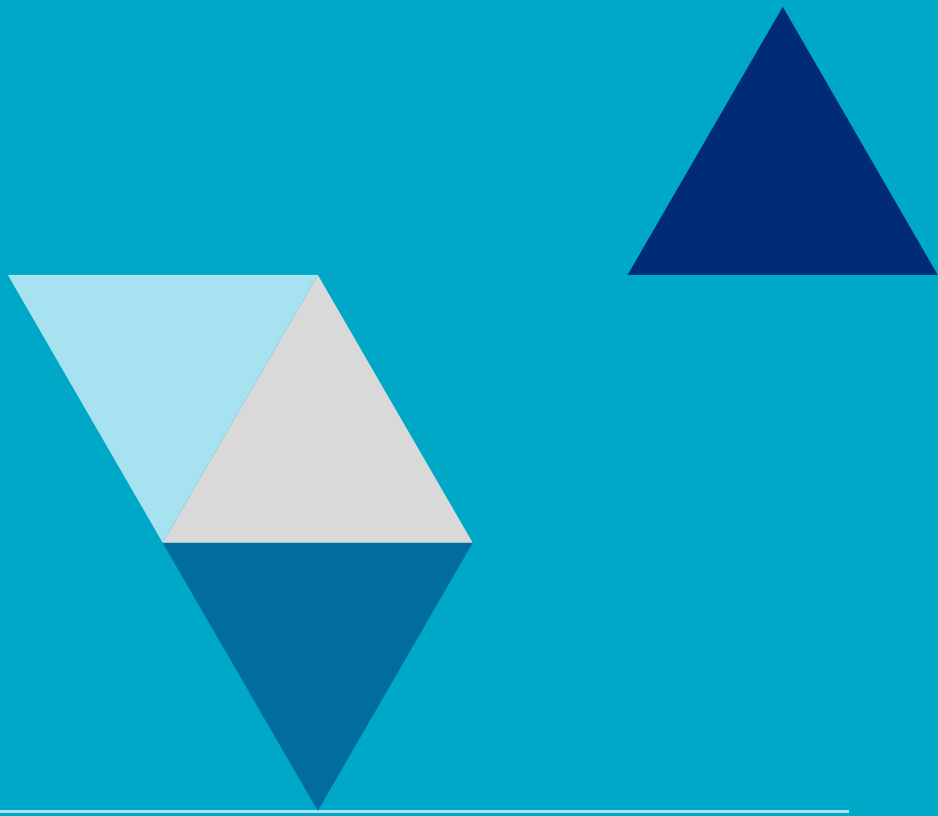
	Employee	Employee and Spouse/Partner	Employee & Child(ren)	Employee and Family
Kaiser	$767.75	$1,535.51	$1,305.16	$2,072.92
Kaiser Deductible	$701.30	$1,402.62	$1,192.23	$1,893.54
Moda Summit, Synergy	$698.37	$1,396.75	$1,187.23	$1,885.62
PEBB Statewide	$786.53	$1,573.09	$1,337.12	$2,123.66
Providence Choice	$682.07	$1,364.12	$1,159.51	$1,841.57

2019 Dental Rates — Actives

	Employee	Employee and Spouse/Partner	Employee & Children	Employee & Family
Kaiser Permanente	$63.75	$127.50	$108.39	$172.14
ODS (Moda) Premier	$55.52	$111.05	$94.39	$149.91
ODS (Moda) PPO	$51.31	$102.61	$87.21	$138.52
Willamette Dental Group	$52.50	$105.01	$89.28	$141.77

FINAL DECISIONS

2019



MEDICAL
FINAL DECISIONS FOR 2019

ALL CARRIERS' PREMIUMS INCLUDE THE HB2391 1.5% HEALTH PLAN ASSESSMENT

KAISER

- Expanded service area to Lane County
- Changed dependent coverage to terminate at end of month after turning age 26
- Initial proposal of 5.9%, reduced to 2.9%

MODA

- Self-insured effective 1/1/2019
- Increase Emergency Room copay from $100 to $150
- Changed dependent coverage to terminate at end of month after turning age 26
- Fully-insured renewal of 8.1%, reduced to 4.0% by self-funding and increasing ER copay

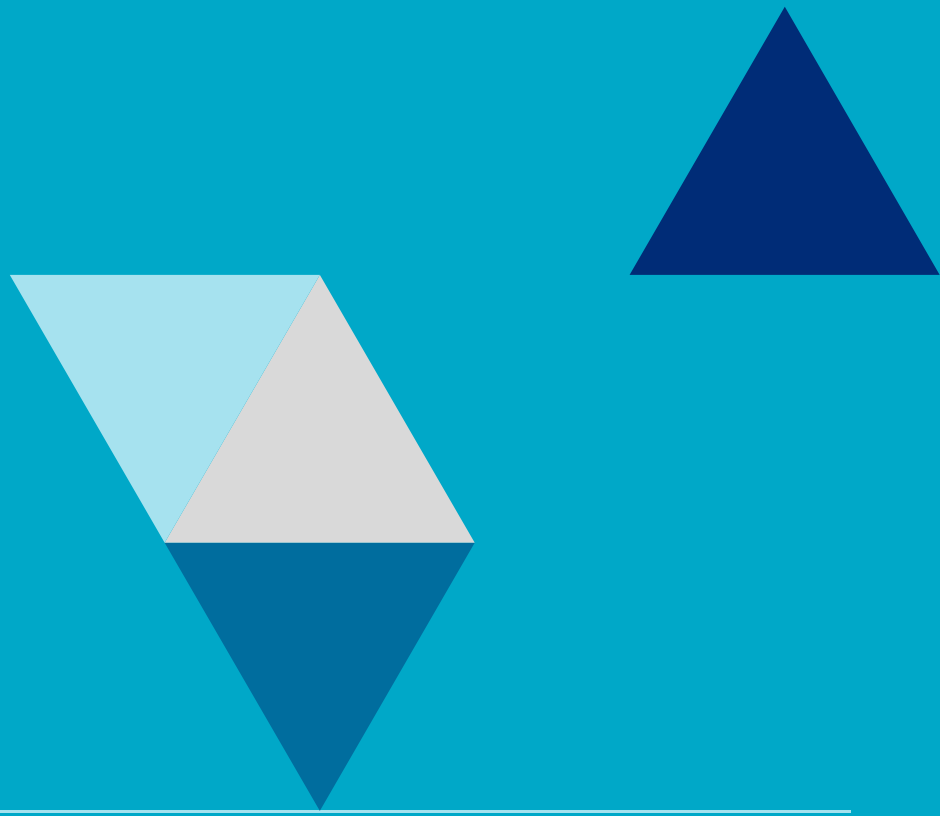
PROVIDENCE

- Increase Emergency Room copay from $100 to $150 on Choice and Statewide
- Statewide out-of-pocket maximum changes to…
  - $1,900 / $5,700 FT IN
  - $4,800 / $14,400 FT OON
  - $3,200 / $9,600 PT IN
  - $7,500 / $22,500 PT OON
- Reduced triple aim incentive from $15 PEPM to $13.63 (Statewide) and $13.20 (Choice)
- Statewide: accrual increase of 3.9%, no admin increase
- Choice: accrual increase of 5.4%, no admin increase

NON-MEDICAL
FINAL DECISIONS FOR 2019

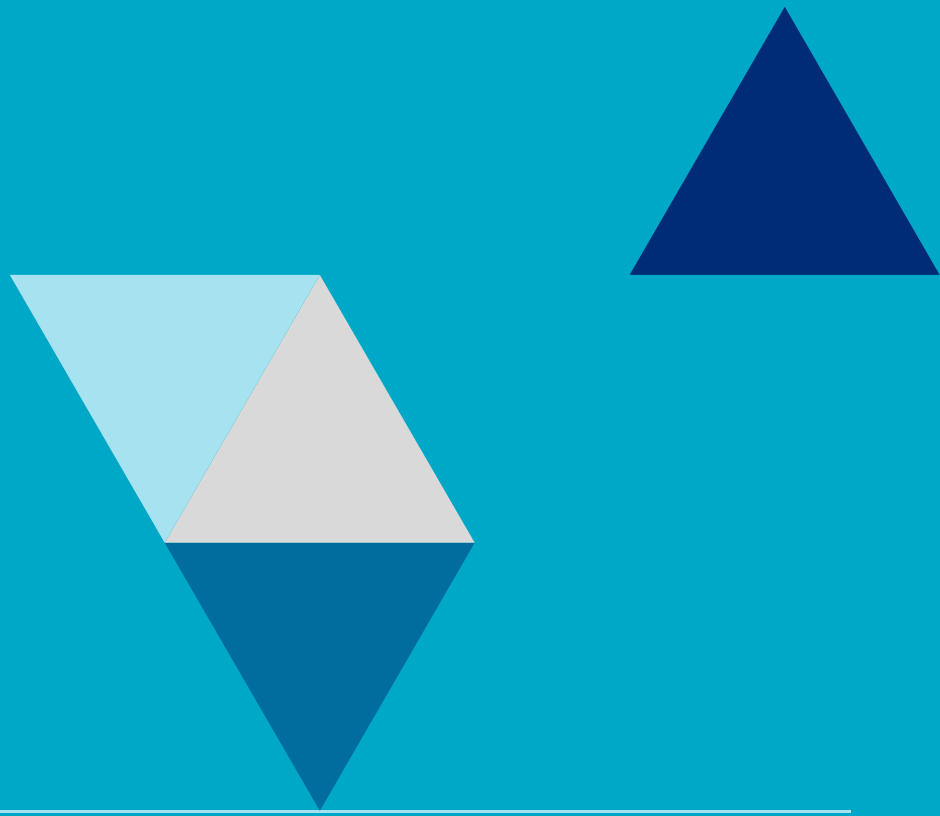
LINE OF COVERAGE	CARRIER	FINAL DECISIONS
Dental	Delta Dental (Moda)	• Simplified the Athletic / Occlusal Guard Benefit • Adding coverage for nitrous oxide
	Willamette	• Various copay changes: • Office Visit Copay from $5 to $10 • Fillings from $0 to $20 • Crowns & Bridges from $190 to $250 • Dentures from $190 to $290 • Root Canals from $0 to $150 • Surgical Extractions from $0 to $40 • Orthodontia from $1,500 to $2,500
	Kaiser	• Simplified the Athletic / Occlusal Guard Benefit
Vision	VSP	• Broke out the fitting and evaluation fee from the contact lens total allowance • Cover standard progressive / ethos lenses
Life / Disability	The Standard	• Reduced Basic rates 10-15% • Increased Optional Life rates by 5% • Held the STD rate • Increased the LTD rates overall by 5.3% (negotiated)
Other	Cascade Centers – EAP	• Status quo, no changes
	ASI – Flex	• Status quo, no changes
	BHS – COBRA / Self-pay	• Status quo, no changes

ROUND 1 MATERIAL



MEDICAL

2020 FINANCIAL OUTLOOK



KAISER MEDICAL

FULL-TIME HEM HMO RATES (PEPM)	2019	2020	% INCREASE
Employee	$775.67	$798.72	2.97%
Employee & Spouse/Partner	$1,551.35	$1,597.44	
Employee & Children	$1,318.64	$1,357.82	
Employee & Family	$2,094.32	$2,156.54	

FULL-TIME HEM DEDUCTIBLE RATES (PEPM)	2019	2020	% INCREASE
Employee	$708.54	$729.59	2.97%
Employee & Spouse/Partner	$1,417.09	$1,459.19	
Employee & Children	$1,204.53	$1,240.32	
Employee & Family	$1,913.08	$1,969.92	

- Factors Include:
  - Preliminary quote
  - 4.25% medical and pharmacy annual trend
  - The following fees:
    - $84.63 PEPM ($32.55 PMPM) medical retention, $24.75 PEPM ($9.52 PMPM) other benefits, $4.71 PEPM ($1.81 PMPM) group specific charges (Weight Watchers, flu shot clinic, commercial driver's exam), and assumes 1.5% OR State premium tax will be dissolved in 2020.
  - $500,000 pooling point

MODA
SELF-FUNDED MEDICAL

Fees and Rates:

ASO PROPOSED FEES (PEPM)	2019	2020	% CHANGE
Moda	$75.97	$76.85	1.2%

Trend Assumptions:

6.5% Medical Annual Trend

10.0% Rx Annual Trend

Annualized Trend (Jan 2015 to Dec 2018):

5.5% Medical Annual Trend

9.7% Rx Annual Trend

PEPM Administration Fees:

• Base administration	$55.35
• Utilization Management	$7.12
• Disease Management	$1.10
• Health Coaching	$3.69
• Tobacco cessation services	$0.95
• Nurse line	$1.25
• Weight Management Program	$1.15
• Access Fees	$5.30
• Injectable Benefits Management	$0.94

MODA

MEDICAL — PRELIMINARY FULL-TIME RATES

PRELIMINARY PREMIUM RATES	2019	2020	% CHANGE
Employee	$705.58	$705.77	0.0%
Employee & Spouse/Partner	$1,411.16	$1,411.54	0.0%
Employee & Children	$1,199.49	$1,199.81	0.0%
Employee & Family	$1,905.07	$1,905.58	0.0%
Composite	$1,372.53	$1,372.91	0.0%

- Notes:
  - Rates do not include PEBB fees (consultant and admin)

PROVIDENCE
MEDICAL — ASO FEES

ASO PROPOSED FEES (PEPM)	2019	2020	% CHANGE
Statewide			
Base ASO	$40.92	$42.13	3.0%
Triple Aim Incentive (PEPM)	$13.63	$13.63	0.0%
Total Admin	**$54.55**	**$55.76**	**2.2%**
Choice			
One year rate guarantee	$58.44	$60.22	3.0%
Triple Aim Incentive (PEPM)	$13.20	$13.20	0.0%
Total Admin	**$71.64**	**$73.42**	**2.5%**

- Notes:
  - For the 2019 plan year, Providence reduced the Triple Aim incentive from $15 PEPM to the amounts shown above in order to get a rate pass on the total administration fee
  - Fees above do not include PEBB fees (consultant and admin)

PROVIDENCE
SELF-FUNDED MEDICAL

PRELIMINARY ESTIMATED RENEWAL	2019	2020	% CHANGE
Choice	$1,314	$1,331	1.3%
Statewide	$1,550	$1,641	5.8%

Projected Trend:

6.5% Medical Annual Trend

10.0% Rx Annual Trend

Annualized Trend (July 2014 – Dec. 2018):

CHOICE	STATEWIDE	
5.4%	7.0%	Medical
9.3%	10.1%	Rx

KEY COST DRIVERS

1

Risk scores continue to increase

- Choice increased 1.0% from 2013 to June 2018 on an annualized basis and 1.3% in the most recent 12 month period
- Statewide have increased 2.1% from 2013 to June 2018 on an annualized basis and 1.5% in the most recent period

2

Inpatient Costs

- Allowed costs per inpatient admission increased approximately 13% for Choice and 9% for Statewide
- Admits per 1000 decreased 8.5% and 1.9% for Choice and Statewide respectively

Trends continue to outpace 3.4% cap

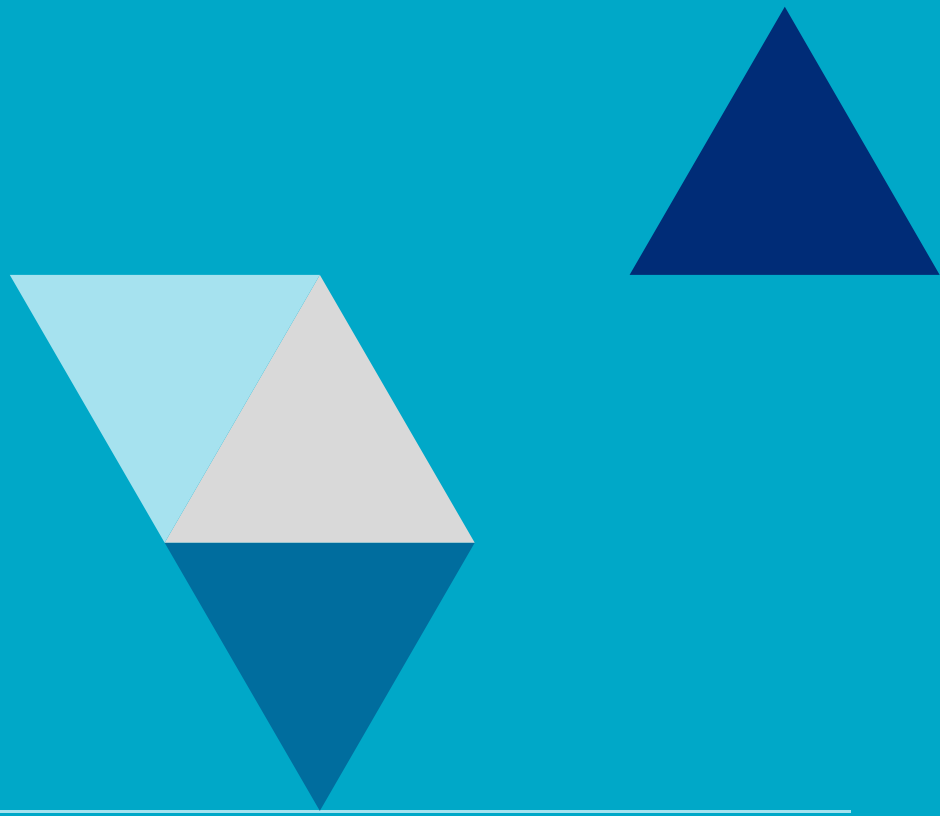
- Providence's average PPO and EPO combined medical trend is 8.3%; pharmacy trend is 10.3%
- Trends for CDHP combined medical and pharmacy is 10.3%

PROVIDENCE
MEDICAL — PRELIMINARY FULL-TIME RATES

PRELIMINARY PREMIUM RATES (PEPM)	2019	2020	% CHANGE
Statewide			
Employee	$794.66	$840.90	5.8%
Employee & Spouse/Partner	$1,589.32	$1,681.80	5.8%
Employee & Children	$1,350.92	$1,429.52	5.8%
Employee & Family	$2,145.58	$2,270.42	5.8%
Choice			
Employee	$689.10	$697.73	1.3%
Employee & Spouse/Partner	$1,378.20	$1,395.46	1.3%
Employee & Children	$1,171.47	$1,186.14	1.3%
Employee & Family	$1,860.57	$1,883.87	1.3%

- Notes:
  - Rates do not include PEBB fees (consultant and admin)

MEDICAL



MEDICAL
HISTORICAL RATE INCREASES

	2015	2016	2017	2018	2019	2020 (ROUND 1)
Kaiser HMO	0.0%	4.4%	3.3%	5.0%	2.9%	4.6%
Kaiser Deductible	0.0%	4.4%	3.3%	5.0%	2.9%	4.6%
Moda	n/a	2.4%	3.5%	FT: 7.2% PT: 7.7%	4.0%	0.0%
Providence Choice	-0.8%	3.3%	3.2%	7.0%	5.4%	1.3%
Providence Statewide	0.2%	3.9%	8.2%	5.9%	3.9%	5.8%

Red font indicates above 3.4%

- Increases prior to PEBB admin, commissions, and funding assessment; includes plan changes
  - 2019 rate increases include 1.5% provider tax
- Providence has proposed one-year 2.2% increase to administrative fees for Statewide and a one-year 2.5% increase for Choice
  - Includes no change to Triple Aim Incentive
- Moda proposed an increase of 1.2% to administrative fees

CARRIER TOP RECOMMENDATIONS DETAILS

PROVIDENCE Health Plan

Question: *Based on what you know about the PEBB membership, where do the biggest opportunities lie and what are the top three to five strategies your organization recommends PEBB pursue in partnership with you to advance quality, care experience, and cost goals?*

Recommendation and/or Observation #1	• For their commercial book of business, Providence is partnering with eviCore to implement PT/OT medical necessity and treatment appropriateness review for services after the 12th visit. Goal is to reduce costs and increase the quality of care by leveraging clinical evidence based guidelines coupled with specialized professional expert reviewers. – PEBB members would still have access to the 60 visits, but after the 12th visit, the treatment would be reviewed by eviCore – **Cost: +$0.35 PEPM to the administrative fee** – **Estimated Savings: -0.3% or $2 million prior to administrative fee**
Recommendation and/or Observation #2	• Expand spinal manipulation benefit to include massage therapy subject to the existing benefit limitations. – PEBB's alternative care benefit includes coverage for spinal manipulation and acupuncture but excludes massage therapy – PEBB's benefits only allow for minimal units of massage when submitted in conjunction with spinal manipulation – Adding massage therapy as a benefit may encourage members to seek this lower-cost treatment for addressing anxiety, stress, and pain – **Estimated cost: +1% or $7 million**
Recommendation and/or Observation #3	• Emphasize value-based payment contracting strategies that align targets with CCO 2.0 metrics, Patient-Centered Primary Care Home (PCPCH) standards, and other multi-payer initiatives. – PEBB can support provider participation in community collaboratives such as the initiative in Salem where an incentive around Total Cost of Care is tied to meeting a 3.4% year-over-year total cost of care target coupled with an incentive around quality metrics
Recommendation and/or Observation #4	• Promote benefit differential between outpatient hospital services and ASCs allowing outpatient procedures to be delivered in lower cost settings. – This differential should be considered for radiology services as well – Hospitals participating in community collaboratives with risk tied to 3.4% would be covered at the same benefit level as free standing radiology centers

CARRIER TOP RECOMMENDATIONS DETAILS

Question: *Based on what you know about the PEBB membership, where do the biggest opportunities lie and what are the top three to five strategies your organization recommends PEBB pursue in partnership with you to advance quality, care experience, and cost goals?*

Recommendation and/or Observation #1	• Value-Based Care (VBC) – Moda will continue to mature and align its efforts on value based care – Currently, all Moda PEBB members are in a VBC model of care, which includes elements of shared risk, quality payments, and care management fees – As PEBB and OHA develop goals for the percentage of payments to be made under a VBC arrangement and any categorization of these payments using the LAN VBC framework, Moda will work with PEBB to align its efforts
Recommendation and/or Observation #2	• Primary Care Focus – Moda has seen success in terms of cost savings and increased quality of care with services delivered through recognized medical homes (PCPCHs) – Included in Moda's contract with PEBB are quality metrics related to the number of members served by a PCPCH – Based on these elements, Moda would like to engage more members with recognized PCPCH's – This can happen through a combination of benefit design and member outreach in partnership with PEBB
Recommendation and/or Observation #3	• Pharmacy: Change specialty medications under medical benefit to be 20% coinsurance – PEBB's current benefit design incentivizes members to utilize infused, provider-administered medications under the medical benefit, which are almost always more costly than self-administered medications covered under the pharmacy benefit – The current copay is $5 for infusion drugs, which represents a 0.12% cost share. – Nearly all of the medial benefit drug spend is for specialty drugs, which also have a $5 copay, however, specialty medications covered under the pharmacy benefit have a $100 copay – This creates an incentive for members to seek treatment with a more costly infused medication than an oral or self-injectable medication that has lower cost, yet comparable safety and efficacy – The 20% coinsurance would result in a -0.3% claims impact
Recommendation and/or Observation #4	• Pharmacy: Shift medical infused medications under the pharmacy benefit – Moda recommends PEBB opt into the Pharmacy Benefit Optimization program, which shifts the reimbursement of select infused specialty medications from the medical benefit to the pharmacy benefit – By doing this, reimbursement becomes a fixed percentage of the average wholesale price (AWP) of a drug, so drug cost is predictable and significantly lower than when paid under the medical benefit – Members could continue to see the same provider and receive their infusion at the same location, but the medication would be supplied to the infusion location by a specialty pharmacy rather than the provider going through their own process – The program would result in a -0.28% claims impact

CARRIER TOP RECOMMENDATIONS DETAILS

Question: *Based on what you know about the PEBB membership, where do the biggest opportunities lie and what are the top three to five strategies your organization recommends PEBB pursue in partnership with you to advance quality, care experience, and cost goals?*

Recommendation and/or Observation #1

Telehealth

- Telehealth services allow KP members to access services conveniently and cost effectively
- Contrary to typical plan telehealth deployments, every encounter – phone, email, video – is completed with KP's e-portal and documented in the members' electronic medical record (EMR), so KP clinicians have a complete picture of members' health, deliver a better member experience, and resolve issues more efficiently
- Telephonic care and video visits are less expensive and can satisfy member needs without defaulting to more expensive face-to-face visits
- Kaiser is making investments in these areas:
  - Expansion of Virtual Urgent Care
  - Implementing Video consults in specialty departments including Palliative Care, Ophthalmology, Oncology, and Orthopedic Cast Room
  - Providing telehealth options for Inpatient and Continuing Care Services
  - Text messaging for appointment reminders and cancer screening care gap scheduling reminders
  - Mobile Health Partners (MHP) paramedic services offering select appointment services at member's home or offices
  - Adoption of new programs in 2019: Deployment of AI supported virtual-urgent care visit and "Chat with a Doc" program to augment real time telehealth services

VISIT TYPE	OUTPATIENT VISITS	TOTAL PAID CLAIMS PMPM	COST PER OUTPATIENT VISIT
Office Visit	74,141	$54.46	$209.91
Virtual Care Visit	14,078	$2.06	$41.76
Total	88,214	$56.52	$183.09

Recommendation and/or Observation #2

Utilization Management

- Kaiser is focusing on the following elements from their operating plan:
  - Reducing practice variability
  - Decreasing day rate (days/1000) of inpatient care and ER use
  - Optimizing pharmacy cost via use of mail order pharmacy; optimizing use of specialty and infused medications; and optimizing site of service for medication delivery as clinically appropriate, convenient, and cost efficient for KP members
  - Reduce cost per service by increasing virtual care while reducing outpatient utilization
- Kaiser is seeing movement with virtual dermatology, outpatient total joint replacement, reducing length of stay in KP hospitals, and reducing readmissions

LAN VALUE-BASED-PAYMENTS

Question: *What is the dollar amount and percent of overall PEBB payments in each of the LAN Value-Based Payment categories?*

CATEGORY	SUB-CATEGORY	DESCRIPTION	PROVIDENCE	MODA	KAISER
Fee for Service – No link to quality & Value	1	n/a		$14,095,620 (32%)	$15,315,368 (11.2%)
Fee for Service – Link to quality & value	2A	Foundational payments for infrastructure & operations	$2,790,000 (0.5%)	$900 (0%)	
	2B	Pay for reporting			
	2C	Pay for performance	$23,550,000 (3.9%)		
APMs built on Fee-For-Service architecture	3A	APMs with shared savings	$20,550,000 (3.4%)	$1,236,308 (3%)	
	3B	APMs with shared savings and downside risk	$138,630,000 (22.8%)	$27,961,778 (63%)	
Population – based payment	4A	Condition-specific population-based payment	$20,000 (0.0%)	$959,588 (2%)	
	4B	Comprehensive Population-Based payment			
	4C	Integrated finance & delivery system			$121,611,968 (88.8%)
		Total	$185,540,000 (30.5%)	$44,254,194	$136,927,337

- Value based payments are self-reported by the vendors
- See next slides for important caveats

LAN VALUE-BASED-PAYMENTS
CARRIER CAVEATS AND NOTES

Question: *What is the dollar amount and percent of overall PEBB payments in each of the LAN Value-Based Payment categories?*

		WHAT'S INCLUDED?		
Category	**Sub-Category**	**Providence**	**Moda**	**Kaiser**
Fee for Service – No link to quality & Value	1			Contracted hospitals / facilities
Fee for Service – Link to quality & value	2A	CPC+ PCPCH Cap	PCPs not participating in the Synergy/Summit shared savings model, but receiving PCPCH capitation (e.g. payments for Connexus members in the C3 program)	
	2B			
	2C	Pay-for-performance		
APMs built on Fee-For-Service architecture	3A	PMG total cost of care	CPC+ Track 1 Providers CPC+ Track 2 providers not participating in the APM portion of the Track 2 model Synergy/Summit PCP providers participating in shared savings, without co-owned specialty practices or facilities (e.g. hospitals)	
	3B	3.4% target	Multi-specialty clinics and hospitals participating in the Synergy/Summit shared risk / shared savings model	
Population – based payment	4A	Joint bundle	CPC+ Track 2 providers participating in the APM portion of the Track 2 model	
	4B			
	4C			
Data Based on:		January – September 2018, annualized	Incurred in 2018; paid through December 2018	2017

LAN VALUE-BASED-PAYMENTS
CARRIER CAVEATS AND NOTES

Question: *What is the dollar amount and percent of overall PEBB payments in each of the LAN Value-Based Payment categories?*

- **Providence:**
  - The percentages shown are representative of the percentage of payments that fall into LAN categories out of the entire medical, Rx, and Behavioral Health paid amounts
- **Moda:**
  - If a provider contract contains multiple elements that fall into different categories, all dollars are assigned to the highest payment category
  - In cases where a health system has multiple TINs, the dollars may be allocated to different categories by TIN (for example, OHSU has separate TINs for its hospital services and physician services)
    - As payment models evolve and as more experience is gained with categorizing dollars, Moda may decide to alter their allocation decisions
  - Dollars were categorized according to the contract terms of the entity billing the claim
    - For example, Moda's primary care physicians, specialists, and hospitals are held financially accountable for pharmacy costs; however, Moda's interpretation of the LAN framework is that actual pharmacy claims are fee-for-service that fall into Category 1 since the pharmacy billing the claims does not have any APM in its contract that bears no risk over quality and utilization

IMPORTANT NETWORK CHANGES FOR 2020

NETWORK CHANGES

Question: *Describe any changes to your network and intended partners for 2020. Detail new providers and financial implications of these proposed changes. Please also provide any major hospital or physician groups with open contracts or those that are up for negotiation*

PROVIDENCE Health Plan

- Effective January 1, 2019, First Health replaced PHCS/Multiplan as Providence's national wrap network and First Choice Health Network (FCHN) replaced BrightPath in Idaho, Montana, Alaska outside of Providence's domestic facilities
- Benefits include
  - 17% more in-network hospital
  - 22,000 more ancillary facilities
  - Access to 873,000 providers and facilities nationwide

moda HEALTH

- Effective January 1, 2020, Moda is proposing to use its broadest network, Connexus
- Connexus includes more PCPCH and CPC+ providers
  - Moda's approach will be to focus on high performing primary care clinics
- Connexus will add Providence Health System and its associated providers, pending further conversations with Providence
- The effect for PEBB members will be that some existing primary care clinics will no longer be available for members to select their primary care medical home

KAISER PERMANENTE®

- Kaiser does not anticipate any changes to KPNW's contracted network as of January 1, 2020
- Salem hospital is up for renewal 10/1/2020, but Kaiser fully-expects a long-term renewal
- Expanding behavioral health network and anticipate new contracts effective January 1, 2020

IMPORTANT NETWORK CHANGES FOR 2020
SERVICE AREA CHANGES

Question: *Describe any service area changes PEBB should consider for the 2020 plan year*

PROVIDENCE Health Plan

- Providence is not proposing any service area changes for Choice or Statewide at this time

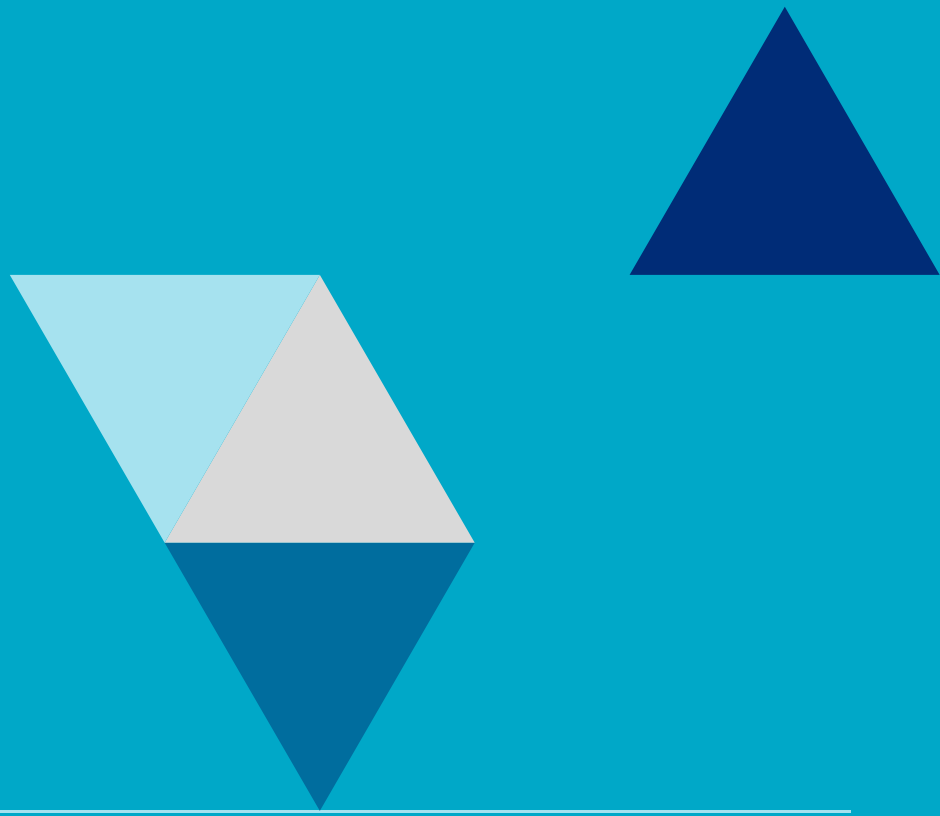
moda HEALTH

- Moda is not proposing any service area changes for the 2020 plan year at this time

KAISER PERMANENTE®

- Kaiser is not planning on service area expansion, but they are adding to their current service area:
  - Newberg – KP PCP is providing primary care access at Newberg Urgent Care. KP members will also have access to Newberg Urgent Care
  - McMinnville – KP will provide access to KP Primary Care Providers and other specialty care services through KP, Willamette Valley Eye Clinic, Salem Health, and Doernbecher Children's Hospital.
  - Beaverton MRI Expansion – New unit will improve region wide access later in 2019

NON-MEDICAL



2020 NON-MEDICAL RENEWALS
HISTORICAL RATE INCREASES

	2016	2017	2018	2019	2020 (ROUND 1)
Self-Funded Vendors					
Delta Dental of Oregon (ODS)	-1.1%	1.0%	1.9%	2.0%	4.8%
Vision Service Plan (VSP)	3.5%	-1.4%	0.7%	2.9%	(0.1%)
Fully-Insured Vendors					
Kaiser Dental	7.7%	4.5%	0.0%	3.4%	1.1%
Willamette Dental Group (WDG)	0.0%	5.4%	2.5%	3.4%	7.9%
The Standard	0.0%	0.0%	0.0%	5.1%	0.0%
Contract Vendors					
ASI Flex	-9.2%	0.0%	0.0%	0.0%	0.0%
Benefit Help Solutions (BHS)	0.0%	0.0%	0.0%	0.0%	0.0%
Cascade	0.0%	0.0%	0.0%	0.0%	0.0%

Red font indicates above 3.4%

- Self- Funded rate accounts for both administrative and premium increases

2020 DENTAL RENEWAL PROPOSAL
DELTA DENTAL OF OREGON

2020 COMPOSITE BUDGET RATES

Delta Dental of Oregon	2019	2020	Increase % / $	
Traditional	$111.93	$117.31	4.8%	$1,249,000
Preferred	$101.18	$106.05	4.8%	$884,000
Part-Time	$74.28	$77.86	4.8%	$15,000
Combined	$106.87	$112.02	4.8%	$2,148,000

Assumptions

- Claims through December 2018
- 3.0% Trend
- Excludes consultant commission (0.13%) and PEBB Admin.
- December 2018 Enrollment

ADMINISTRATION

Year	PEPM Fee	Rate Increase
2018	$6.10	Rate Hold
2019	$6.20	1.5%
2020	$6.30	1.5%

- 2020 is the final year of a three-year rate guarantee
- Note: the admin fee includes $0.20 for the Oral Health Initiative

2020 PLAN DESIGN CONSIDERATIONS

Former Benefit	New Benefit	Financial Impact	Mercer Comments
• Composite restoration in posterior tooth was not covered. Member paid the difference between amalgam and composite • Inlays were considered an optional service and an alternate benefit of an amalgam filling was provided	• Composite restoration in posterior tooth is **covered** • Inlays are an optional service and the **alternate benefit will now be composite filling**	• +1.0% of premium or $468,000	• Recommend, depending on composite rate
• Oral and Maxillofacial surgery was covered subject to consultant review	• A **separate charge for post-operative care done within 30 days following oral surgery** is included in the charge of the original surgery	• -0.25% of premium or ($117,000)	• Recommend
• Brush biopsy was not covered	• Brush biopsy **covered twice in a 12-month period**	• +0.06% of premium or $28,000	• Recommend
• Final crown and implant abutment over a single implant were covered. This benefit was limited to once per tooth or tooth space in any **7-year period** • The final implant-supported bridge retainer and implant abutment, or pontic were covered. This was limited to once every 7 years	• The final crown and implant abutment over a single implant are covered. This benefit is limited to once per tooth or tooth space over the **lifetime of the implant** • The final implant-supported bridge retainer and implant abutment, or pontic were covered. This is limited to **once per lifetime**	• -0.1% of premium or ($47,000)	• Recommend

For a complete list of plan design considerations, refer to the Appendix. The rest of the changes have negligible claims impact.

2020 DENTAL RENEWAL PROPOSAL
KAISER DENTAL

2020 COMPOSITE BUDGET RATES

Kaiser	2019	2020	Increase % / $	
Full Time Rates • EE Only • EE + SP • EE + CH • EE+ FAM • CH Only	**$118.43** • $63.45 • $126.90 • $107.87 • $171.32 • $51.14	**$119.77** • $64.17 • $128.34 • $109.09 • $173.26 • $51.72	1.1%	$92,000
Part Time Rates • EE Only • EE + SP • EE + CH • EE + FAM • CH Only	**$90.20** • $47.32 • $94.64 • $80.45 • $127.77 • $38.09	**$91.23** • $47.86 • $95.72 • $81.37 • $129.23 • $38.52	1.1%	$1,000
Combined	**$118.11**	**$119.44**	**1.1%**	**$93,000**

Assumptions

- Status Quo Plan Design
- 5.5% trend being used, with data through October 2018
- No change in retention costs (administration)
- Composite calculated with January 2019 Enrollment

2020 PLAN DESIGN CONSIDERATIONS

• Board Consideration	Financial Impact	Mercer Comments
• None	• n/a	• n/a

2020 DENTAL RENEWAL PROPOSAL
WILLAMETTE DENTAL GROUP (WDG)

Willamette Dental Group

2020 COMPOSITE BUDGET RATES

Willamette	2019	2020	Increase % / $
Full Time and Part Time	$100.78	$108.75	7.9% / $1,151,000

Note:
- Large increases will continue until population stabilizes, or new members are offset by those enrolled over time

Notes and Assumptions

Willamette's preliminary status quo 2020 renewal offer represents a **7.9%** increase based on the following:
- Increase of over 2,500 new members between January 2018 and December 2018; new members cost 197% more in Year 1 versus Year 2
- Utilization for orthodontia increased 54%; crowns up 22%; fillings up 19%
- Underwriting calculation calls for a 20.2% increase
- 5.9% trend being used, with data through December 2018
- Underwriting was provided with and without the ACA tax of 1.9%; due to the rate concession, the $2.21 PEPM for 2020 does not impact the renewal

2020 PLAN DESIGN CONSIDERATIONS

Board Consideration	Financial Impact	Mercer Comments
• For 2020, WDG will require the following new implant benefit design: – Dental implant surgery will be covered up to an annual maximum of $1,500 with a limit of one tooth space per year – Current benefit: $2,745 copay for a single tooth, up to $5,060 copay for two teeth and $7,210 for three teeth	• -1.4% of premium or $207,000	• Required by WDG-underwritten plans
• Chronic Condition Dental Management Program	• No demonstrated ROI	• Not recommended

Note:
- WDG does not recommend any copay changes for the 2020 renewal, apart from implants, as there is not enough data at this time to support changes

2020 VISION RENEWAL PROPOSAL
VISION SERVICE PLAN (VSP)

2020 COMPOSITE BUDGET RATES

VSP	2019	2020	Increase % / $	
Base	$17.56	$17.54	-0.1%	($8,000)
Buy-Up	$26.34	$26.32	-0.1%	($3,000)
Combined	$20.12	$19.72	-0.1%	($11,000)

Assumptions

- Claims through December 2018
- 2.0% Trend
- Excludes consultant commission (0.13%) and PEBB Admin.
- December 2018 Enrollment

ADMINISTRATION

Year	PEPM Fee	Rate Increase
2019 - 2021	$1.19	0.0%

- Second year of three-year rate guarantee

2019 PLAN DESIGN CONSIDERATIONS

Board Consideration	Financial Impact	Mercer Comments
• Suncare: allows members to utilize their frame benefit for non-prescription ready-made sunwear in lieu of prescription eyewear	• +3.0% of 2020 premium – $298,000 for all Base + Buy-up – $102,000 if just applied to the Buy-up (no impact to composite rate as members pay the cost difference)	• Dependent upon 3.4% target, but this would be a valuable benefit to members • Could just apply to the Buy-up plan to pass the benefit to members

VSP® SUNCARE ENHANCEMENT

While 79% of people know the sun's ultraviolet (UV) rays cause skin cancer, only 6% know it can harm the eyes.[1] UV exposure can lead to the development of serious eye diseases, including tumors, cataracts, and macular degeneration. These diseases can result in increased medical costs, lost productivity, and drastic impacts to quality of life.

VSP Suncare Enhancement Summary	
Eyewear	• Members can use their frame allowance toward non-prescription sunglasses from their VSP Provider's frame board, exhausting both their lens and frame eligibility. • Encourages members without a prescription to visit their VSP provider and get an annual eye exam.
Suncare Facts	
Cataracts	• Annual mean medical costs associated with cataracts in the U.S. are approximately $11,743 per person (18-65 years old).[2]
Macular Degeneration	• Wearing the proper sunglasses may reduce the risk of macular degeneration. • People who spent 5 or more hours a day outdoors as teenagers or in their thirties had twice the risk of developing early macular degeneration than those who reported spending less than 2 hours a day outdoors.[3]
Tumors and Growths	• Without proper eyewear, excessive UV exposure can cause tumors (cancerous and non-cancerous), tissue growths, or yellowish, slightly raised lesions to form over the white part of your eye.
Sunburn	• UV rays can burn the cornea, which can cause tearing, pain, redness, swollen eyelids, headache, a gritty feeling in the eyes, halos around lights, hazy vision, and temporary loss of vision.
Children and Suncare	• Children's eyes are more susceptible to UV rays because the lenses inside their eyes are less capable of filtering the rays. • Children receive 3 times the annual UV exposure of an adult.[5]

VSP® Suncare Enhancement

20%

of all cataracts are caused by extended exposure to UV rays.[6]

1.8 million

Americans age 40 and older have macular degeneration and an additional

7.3 million

are at substantial risk of developing it.[4]

80%

of our lifetime exposure to UV rays occurs by age 18.[1]

[1]*Source: Eye Didn't Know That! Site, Transitions Optical, Inc, accessed April 2010*
[2]*Source: U.S. Department of Health and Human Services Medical Expenditure Panel Survey, 2006* [3]*Source: Cruickshanks KJ, Klein R, Klein BE. Sunlight and age-related macular degeneration: the Beaver Dam Eye Study. Arch Ophthalmol. 1993: 111(4): 514-518.*
[4]*Source: Improving The Nation's Vision Health: A Coordinated Public Health Approach, Center for Disease Control and Prevention, 2006.*
[5]*Source: Improve Your Vision Improve Your Game, Transitions Optical, Inc, accessed April 2010*
[6]*Source: World Health Organization*

2020 EAP RENEWAL PROPOSAL
CASCADE CENTERS

Rates:

VISITS	2019	2020	INCREASE
Three Visits	$1.04	$1.04	Rate Pass
Five Visits	$1.33	$1.33	Rate Pass

Utilization

	2017	2018
Individual EAP services	4,503	4,940
• *In Person visits*	*2,426*	*2,568*
• *Work/Family/Life*	*1,332*	*1,424*
Group services	3,328	5,040

Proposed Plan Changes/Enhancements:

Overview

- WholeLife Directions (WLD) is a complement to Cascade's existing EAP and wellbeing services
- It provides proactive mental health engagement and instant connection to personalized programs

CASCADE CENTERS
WHOLELIFE DIRECTIONS

WholeLifeDirections
Journey to the Best You

TWO LEVELS OF INTERVENTION

Individual User Level

Includes the WholeLife Scale (WLS) assessment, ongoing self-use cognitive behavioral programs, and educational outreach to sustain engagement

Organizational Level

Includes supervisor training, materials for employee engagement, and targeted intervention programs based on unique employer needs identified through the WLS

FEATURES

- **Complete Mental Health Appraisal** – Nine domains of mental health are evaluated. Can be completed within 8-10 minutes
- **Individual Summary** – Each participant receives immediate confidential feedback about their results including high risk areas, suggested actions, next steps, and resources
- **Immediate In-Assessment feedback** – Participants receive immediate prompts for action based on their answers
- **Participation Reports** – Ability to view who took the WLS to provide incentives for participating
- **Employer Aggregate Report** – Overall snapshot of the assessed population
- **WholeLife Directions; Total Wellness Campaign** – The WLD campaign promotes overall wellbeing and is based on the outcomes of each company's aggregate WholeLife
- **Online Cognitive Behavioral / Mindfulness Tool** e Scale results evidence based online/app based mental treatment

STUDY RESULTS

Since 2017, several independent research studies were conducted to collect data to investigate the effect the WLD program had on mental health in the workplace:

- The WLD program was found to provide an effective intervention for employees experiencing distress:
  - Pre and post measures of absenteeism show that participants experience an 18% improvement in absenteeism following the WLD assessment and intervention
  - After participation in the WLD self-use programs, participants were found to have a 48% symptom reduction for anxiety
  - A 59% reduction for symptoms of depression was found for participants after receiving intervention through the WLD app programs
  - WLD sessions were demonstrated to significantly reduce social anxiety for participants
  - 91% of participants reported the WLS program engaged them positively
- The 2016 PEBB pilot exceeded expectations in both utilization rate and outcomes

PEBB PILOT OUTCOMES

For PEBB members the results showed statistically significant improvement in the (4) areas below post EAP intervention:
Notes. *Lower scores are a better outcome; **Higher scores are a better outcome.

	PRE EAP	POST EAP	DIFFERENCE
Absenteeism*	9.259	7.732	16% Improvement
Presenteeism*	3.619	2.751	24% Improvement
Life Satisfaction**	2.911	3.49	20% Improvement
Work Distress*	2.459	2.206	10% Improvement

COST

- $0.18 PEPM
- One-time implementation fee of $1,200 across all of PEBB (not per agency)
- Total cost approximately $120K

LIFE & DISABILITY
THE STANDARD

- 2020 is the 2nd year of a two-year rate guarantee

	COVERED LIVES	2018 RATES	CURRENT RATES Effective 1/1/2019	CHANGE % FROM 2018	RATE GUARANTEE
Basic Life					
• Active	52,464	$0.200	$0.180	-10%	2 years
• Judicial	512	$0.330	$0.280	-15%	2 years
• Dependent	29,894	$1.290	$1.290	0%	2 years
Optional Life	45,910	Step Rates	Step Rates	5%	2 years
Voluntary AD&D					
• Employee	11,230	$0.020	$0.020	0%	2 years
• Family	14,691	$0.034	$0.034	0%	2 years
Disability					
Short Term Disability*	26,735	$0.690*	$0.690**	0%	2 years
LTD 1 (60% 90 EP)	12,737	$0.510	$0.537	5%	2 years
LTD 2 (60% 180 EP)	4,988	$0.180	$0.190	6%	2 years
LTD 3 (66 2/3% 90 EP)	4,911	$1.060	$1.115	5%	2 years
LTD 4 (66 2/3% 180 EP)	3,742	$0.270	$0.284	5%	2 years

* STD: 0.05% of this rate is withdrawn from the PDA under 606814 on a monthly basis. Policyholder remits premium based on .64% of Volume.
** Beginning January 1, 2019, PDA funds will not be used to subsidize the STD rate. Policyholder will remit premium based on .69% of Volume.

FLEXIBLE SPENDING ACCOUNT AND COMMUTER BENEFITS ADMINISTRATION

ASIFLEX

	RATE INCREASE
FSA and Commuter Administration	Rate Pass

ITEM	FEE
Set Up Fee • Initial Plan Year • Renewal Plan Year	Waived
Monthly Administration PPPM	$2.95
Optional ASIFlex Card PPPM • Replacement or additional card sets	Included • $5.00 billed to participant FSA
Employee Communication • PDF documents • WebEx group meetings • Onsite Enrollment Meetings	 • No Charge • No Charge • $250 per day, plus travel expenses

COBRA ADMINISTRATION
BENEFIT HEALTH SOLUTIONS (BHS)

	RATE INCREASE
COBRA, Retiree, Semi-Independent & Self-Pay Administration	Rate Pass

BOARD CONSIDERATION	DESIGN IMPACT	FINANCIAL IMPACT	
Continue with all BHS services (COBRA, Retiree, Semi-Independent & Self-Pay)		Per Service Option • Service Representative: $1,000 per month ($750 COBRA; $250 Retiree) • Qualifying Event Letter: $4.00 per letter • Per COBRA Continuant: $7.25 per month • Per Retiree: $7.25 per month • Open Enrollment Questionnaire: $3.15 per letter	
COBRA and Semi-Independent only services	• Service rep eliminated • Implements an annual set-up fee	• Annual Set Up Fee:$1,000 per month – (Service Rep $1,000 a month (goes away)) • Qualifying Event Letter: $10.00 per letter • Per COBRA continuant: $10.50 per month • Open Enrollment Questionnaire: $6.50 per letter	
COBRA only services	• Service rep eliminated • Implements an annual set-up fee	Per Service Option The per service rate is higher for COBRA administration: • Annual Set Up Fee: – $1,000 per month – (Service Rep $1,000 a month (goes away)) • Qualifying Event Letter: $10.00 per letter • Per COBRA continuant: $10.50 per month • Open Enrollment Questionnaire: $6.50 per letter	Per Employee Per Month Option – $0.20 PEPM

DDOR 2020 PROCESSING GUIDELINES

BENEFIT CHANGES
DELTA DENTAL PROCESSING GUIDELINES

REFERENCE	FORMER BENEFIT	NEW BENEFIT	EXPLANATION	CLAIMS IMPACT*
Benefits and Limitations Space maintainer	The Plan allowed once per space. Space maintainers for primary anterior teeth or missing permanent teeth or for members age 14 or over are not covered.	The Plan allows once per space per quadrant as a lifetime benefit. Space maintainers for primary anterior teeth or missing permanent teeth or for members age 19 or over are not covered.	Delta Dental processing policy.	negligible
Benefits and Limitations Restorative services - Basic	The Plan disallowed indirectly fabricated post and core in addition to crown. Participating providers write off the charges.	The Plan denies indirectly fabricated post and core in addition to a crown unless more than half of the coronal tooth structure is missing.	Delta Dental processing policy.	negligible
Benefits and Limitations Endodontic services	Retrograde fillings were covered.	Retrograde fillings by the same dentists within a 2-year period of the initial retrograde filling is not covered.	The retreatment is included in the charge for the original care.	negligible
Benefits and Limitations Oral surgical services	Osseous surgery was covered subject to consultant review.	Osseous surgery is limited to 2 quadrants per date of service.	Delta Dental processing policy.	negligible

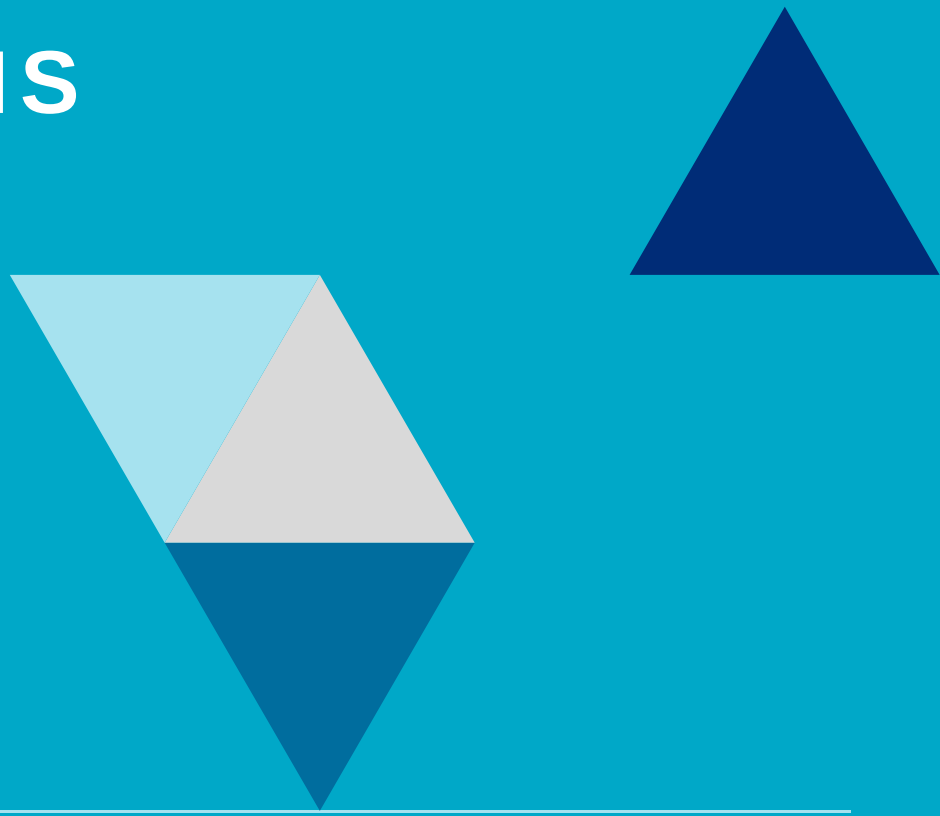
BENEFIT CHANGES
DELTA DENTAL PROCESSING GUIDELINES

REFERENCE	FORMER BENEFIT	NEW BENEFIT	EXPLANATION	CLAIMS IMPACT*
Benefits and Limitations Oral surgical services	Bone replacement graft was covered subject to consultant review.	Bone replacement grafts are limited to once per single tooth or multiple teeth within a quadrant in any 3-year period. Benefits for bone replacement grafts are not covered when submitted with apicoectomy sites, implants, mucogingival/soft tissue grafts, periradicular surgery, ridge augmentation or preservation procedures, sinus elevation, defects from cyst removal, hemisections or with extractions.	Delta Dental processing policy. This procedure does not occur often.	negligible
Benefits and Limitations Oral surgical services	Oral and Maxillofacial surgery was covered subject to consultant review.	A separate charge for post-operative care done within 30 days following oral surgery is included in the charge of the original surgery.	Delta Dental processing policy.	-0.25%
Benefits and Limitations Prosthodontic services	Re-cement or re-bond implant/abutment supported crown or fixed partial denture was covered.	Re-cement or re-bond implant/abutment supported crown or fixed partial denture is limited to once in any 12- month period.	Delta Dental processing policy. Usually there are underlying issues with the implant or abutment if additional re-cementing or re-bonding is made.	negligible

BENEFIT CHANGES
DELTA DENTAL PROCESSING GUIDELINES

REFERENCE	FORMER BENEFIT	NEW BENEFIT	EXPLANATION	CLAIMS IMPACT*
Benefits and Limitations Restorative services	Composite restoration in posterior tooth was not covered. Member paid the difference between amalgam and composite. Inlays were considered an optional service and an alternate benefit of an amalgam filling was provided.	Composite restoration in posterior tooth is covered. Inlays are an optional service and the alternate benefit will now be composite filling.	Composite fillings on posterior teeth is standard dental practice.	+1%
Benefits and Limitations Oral surgical services	Brush biopsy was not covered	Brush biopsy is covered twice in a 12-month period.	This procedure plays a role in the early detection of oral pre-cancers and cancers.	0.06%
Benefits and Limitations Prosthodontal services	The final crown and implant abutment over a single implant were covered. This benefit was limited to once per tooth or tooth space in any 7-year period. The final implant-supported bridge retainer and implant abutment, or pontic were covered. The benefit was limited to once per tooth or tooth space in any 7-year period.	The final crown and implant abutment over a single implant are covered. This benefit is limited to once per tooth or tooth space over the lifetime of the implant. The final implant-supported bridge retainer and implant abutment, or pontic are covered. The benefit is limited to once per tooth or tooth space over the lifetime of the implant.	With more data and implant designs more advanced, the frequency for final crown and abutment can be per lifetime with continual maintenance.	-0.1%

GLOSSARY OF TERMS



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+.

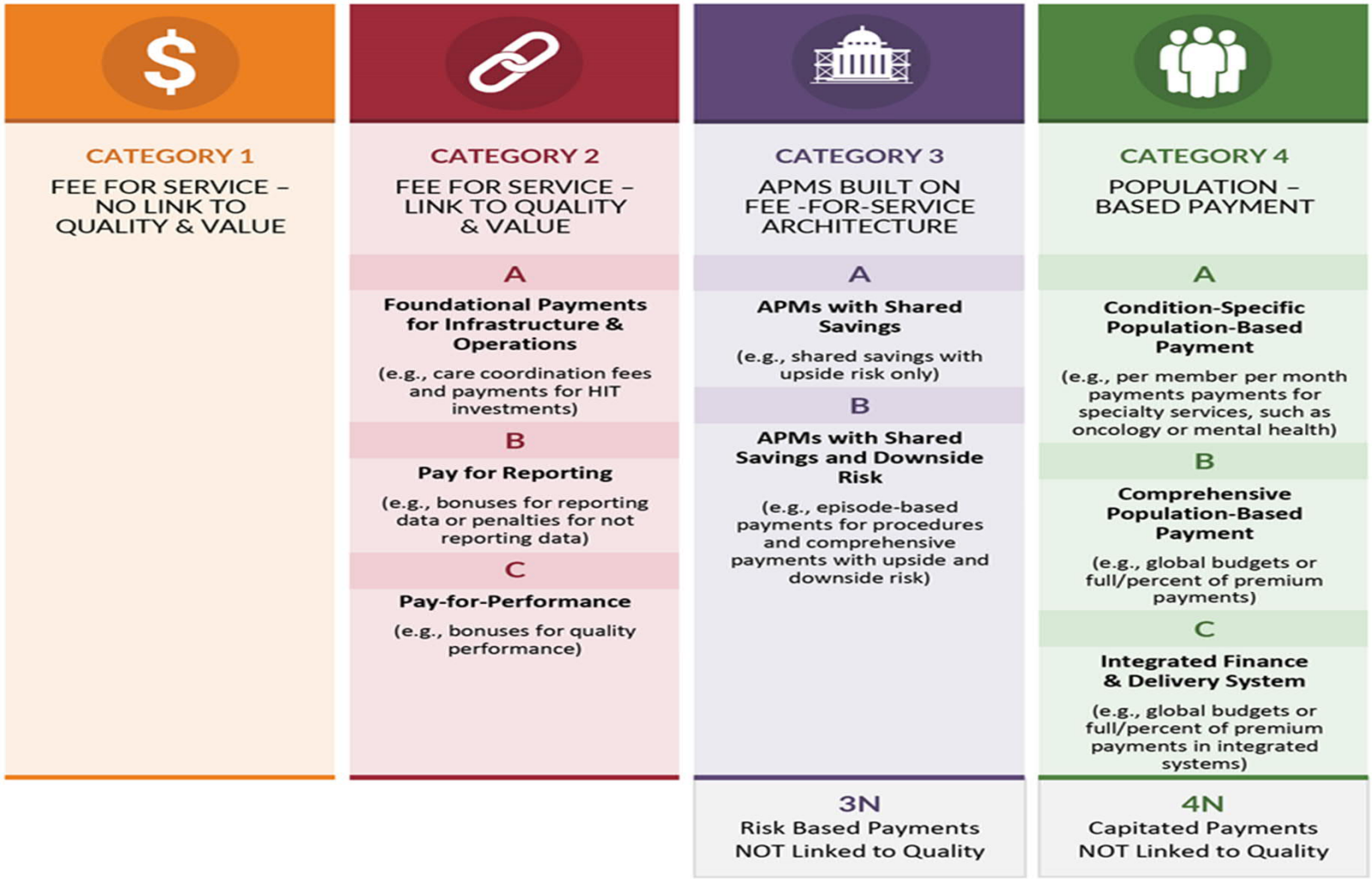
GLOSSARY OF TERMS

- **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).
- **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.

GLOSSARY OF TERMS

- **Population health management:** An approach to health care delivery that aims to improve the overall health outcomes of a defined population of individuals, based on the preservation of health, prevention of disease, and management of acute and chronic disease among members of the group. It typically relies on the aggregation of patient data across multiple health information resources, and analysis of data and actions through which care providers can improve both clinical and financial outcomes.
- **Risk adjustment:** A statistical process that attempts to take into account the known and latent comorbid conditions of a patient cohort when comparing health care outcomes or health care costs.
- **Risk Scoring:** A numeric value assigned to a particular patient in a risk adjustment system that indicates the relative level of spending that is expected for that patient and/or the relative level of quality or outcomes that can be expected in the delivery of care to that patient relative to other patients.
- **Risk Stratification:** A process of identifying, predicting, and separating patient populations into high-risk, low-risk, and likely to be at high risk (or rising-risk group) to assist in population health management activities.
- **Shared risk**: a model that holds the provider financially responsible for a negotiated portion of costs that exceed a predetermined budget, in exchange for provider eligibility for a portion of any savings generated below the predetermined budget. Shared-risk arrangements can be applied to global or bundled payments.
- **Shared savings:** a model that allows the provider to share in a portion of any savings generated below a predetermined budget. Shared-savings arrangements can be applied to global or bundled payments.
- **Total Cost of Care (TCOC):** A broad indicator of spending for a given population (i.e., payment form payer to provider organizations). In the context of PBM models, in which provider accountability spans the full continuum of care, TCOC includes all spending associated with caring for a defined population, including provider and facility fees, inpatient, and ambulatory care, pharmacy, behavioral health, laboratory, imaging, and other ancillary services (e.g., home health, hospice, durable medical equipment, supplies, etc.)
- **Value-based Care**: This is about empowering and rewarding providers to provide the right care, at the right time, in the right setting.
- **Value-based insurance design (VBID):** This is an insurance benefit design strategy that encourages use of high-value clinical services by aligning consumer spending with high-quality and beneficial health services and medications.
- **Value-based Payment:** This is a new payment method for healthcare services to providers aimed at rewarding value (quality of care), not volume (fee-for-service), so that providers assume more accountability for the quality and cost of care, incentivizing higher-value care, by health plans or purchasers.
- **Value-based Purchasing:** Purchasers, plan sponsors, and employers use to incent higher value care (i.e., quality metrics in contracts, payment based on quality and outcomes).

PEBB'S ROADMAP VS. OHA'S CCO 2.0 FINANCIAL ROADMAP



Source: APM Framework, HCP-LAN,2017