Chair Shaun Parkman will convene a public meeting of the PEBB Board on Tuesday, October 15, 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

I.	9:30 a.m. – 9:35 a.m. Attachment 1 **ACTION**	**Welcome & Approval of September 17, 2019 meeting minutes** *Shaun Parkman, Chair*
II.	9:35 a.m. – 10:05 a.m. Attachment 2	**Strategic Planning** *Michael Garrett, Mercer Health & Benefits, LLC*
III.	10:05 a.m. – 10:35 a.m. Attachment 3	**Pharmacy Benefit Trends** *Kendra Lofgren, West Market Pharmacy Lead, Mercer Health & Benefits, LLC*
	10:35 a.m. – 10:45 a.m.	**BREAK**
IV.	10:45 a.m. – 12:05 p.m. Attachments 4, 4a, 4b and 4c	**Pharmacy Services and Programs – PEBB Carriers** *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.	12:05 p.m. – 12:25 p.m. Attachment 5	**Legislative Session Budget Note: Explore Rx/Pharmacy Utilization Tools** *Robert Valdez, Mercer Health & Benefits, LLC*
VI.	12:25 p.m. – 12:30 p.m.	**Other Business/Public Comment**

Adjourn

Public Employees' Benefit Board
Meeting Minutes
September 17, 2019

The Public Employees' Benefit Board held a regular meeting on September 17, 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
Representative Andrea Salinas
Jeremy Vandehey

Board Members Excused/Absent:
Senator Betsy Johnson

PEBB Staff:
Ali Hassoun, Director
Rose Mann, Board Policy and Planning Coordinator
Rebecca Guillaume, Executive Assistant
Margaret Smith-Isa, Program Development Coordinator

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

ଔ ଔ ଔ ଔ

I. Call to order and approval of August 20, 2019 Board meeting minutes – Attachment 1

Chair Shaun Parkman called the meeting to order and introduced Representative Andrea Salinas. Representative Salinas replaced Representative Greenlick on the PEBB Board. Chair Parkman then asked for a motion to approve the August 20, 2019 PEBB Board meeting minutes.

MOTION

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

II. WW Kurbo Program Option – Attachment 2

Ashley Brown, Strategic Account Executive, WW Health Solutions presented information on WW Kurbo.

MOTION

Bill Barr moved to postpone decision on WW Kurbo until the OEBB SEOW has heard the information and made a recommendation to the OEBB Board. Dana Hargunani seconded the motion. The motion carried 7 – 0.

III. Hospital Payment Cap Rules – Request to file as permanent rules - Attachment 3

Margaret Smith-Isa, PEBB Program Development Coordinator presented information on the PEBB Hospital Cap Rules and requested the Board approval to file the rules as permanent rules with the Secretary of State.

MOTION

Jeremy Vandehey moved to approve filing OAR 101-080-0010 and 101-80-0020; Hospital Payment Cap rules as permanent rules with the Secretary of State. Bill Barr seconded the motion. The motion carried 5 – 0.

IV. Strategic Planning – Attachment 4

Michael Garrett and Trisha Tyler, Mercer, led the Board in a discussion on strategic planning.

V. Network/Access – Attachments 5, 5a and 5b

Dr. Keith Bachman, PEBB Medical Director and Sophary Sturdevant, Executive Account Manager, Kaiser Permanente

Dr. Jim Rickards, Senior Medical Director and Erica Hedberg, Manager, State Government Accounts Strategy, Moda Health Plans

Stephanie Dreyfus, Vice President of Network Development, Providence Health Plans

VI. Wellness Programs Update - HTHU – Attachment 6

Jennifer Gaffney, Staywell presented an update on Healthy Team Healthy U

VII. 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.

HEALTH WEALTH CAREER

Attachment 2

OREGON PEBB BOARD MEETING

LONG TERM STRATEGY REVIEW

OCTOBER 15, 2019

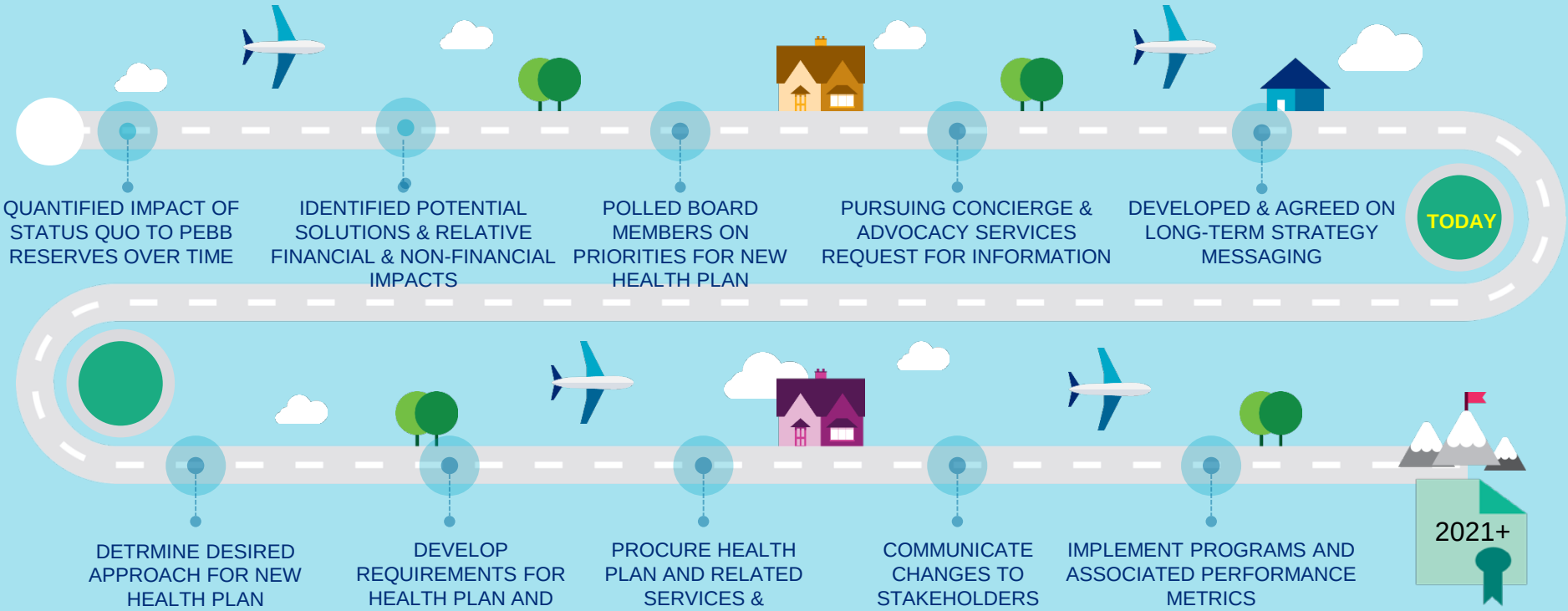
AGENDA

01 NEXT STEPS FOR NEW HEALTH PLAN

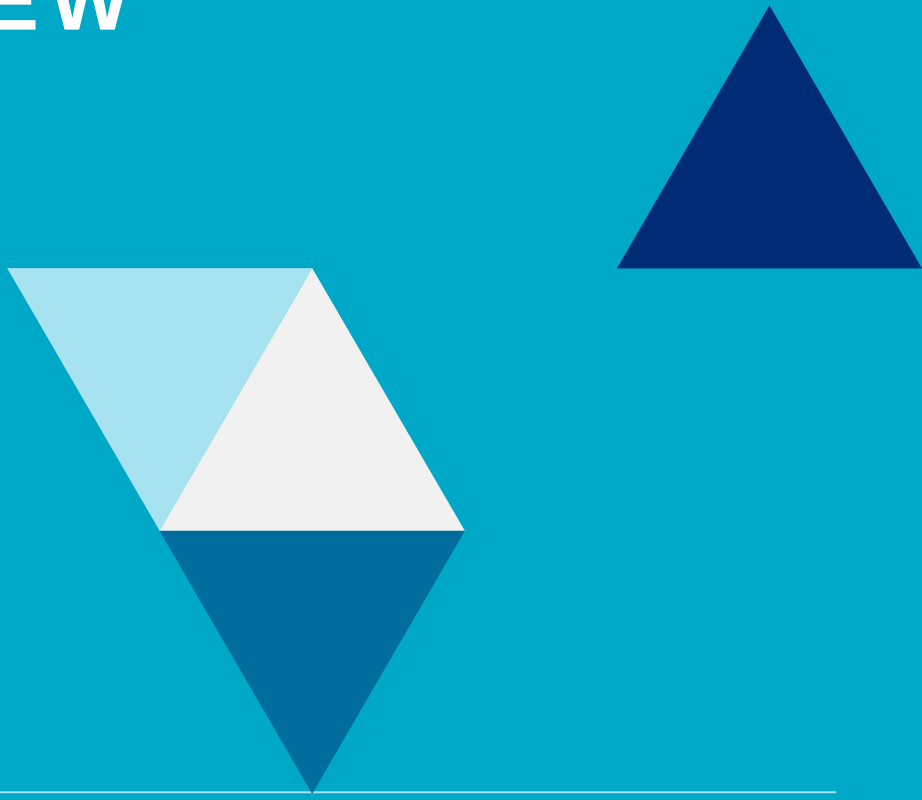
02 UPDATE ON BRIDGE STRATEGIES

03 APPENDIX

HEALTHCARE STRATEGY
WE ARE ON A JOURNEY (NOT TO SCALE!)



NEXT STEPS FOR NEW HEALTH PLAN



STRATEGIC QUESTIONS FOR THE NEW HEALTH PLAN

Integration with Medical RFP

Alignment with OEBB

oebb

Alignment with key stakeholders:

- Members
- Physicians
- Hospitals
- Administrators/Carriers
- Other Plan Sponsors

OPTIONS FOR ACHIEVING THE NEW HEALTH PLAN

1. Piggyback on existing OHA CCO arrangements

2. PEBB executes direct contracts with health systems for graduated risk-bearing entities
   - Administrator will have to pay providers according to terms based on PEBB's contract

Examples: Boeing, Washington HCA

3. Contract through carriers with health systems for graduated risk-bearing entities
   - PEBB provides contractual requirements for Health Plan arrangements, carriers will need to customize any existing arrangements

Example: Microsoft

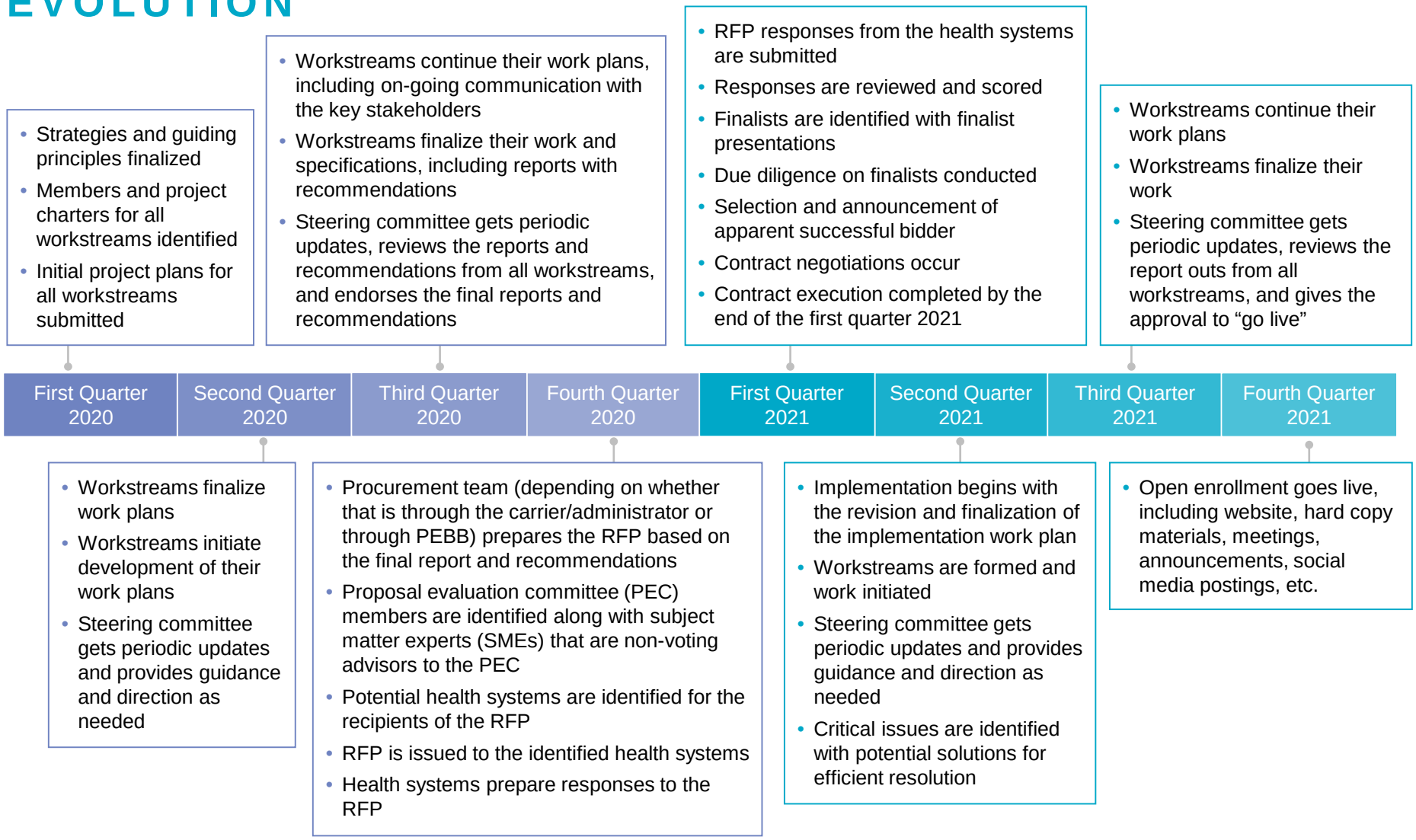
4. Require carrier to develop and administer full risk-bearing arrangement with health system

SUGGESTED STRUCTURE FOR THE HEALTH PLAN'S EVOLUTION

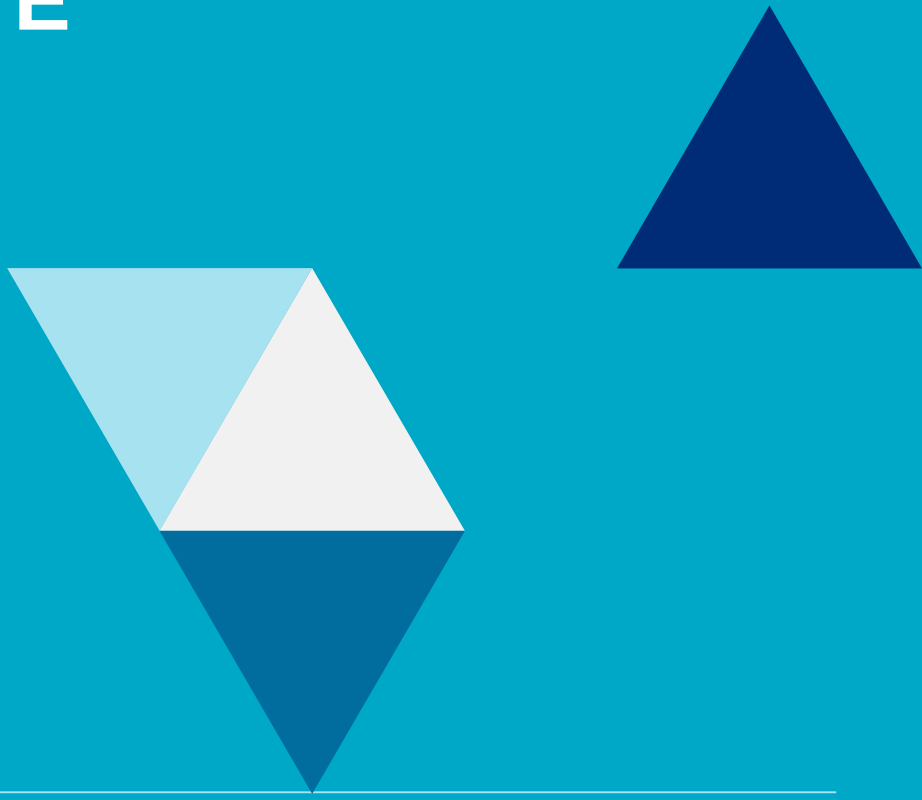
Steering Committee	• Provides leadership guidance for the developers of The Health Plan • Includes Board members, PEBB staff members, carrier/administrator, consultants, and other stakeholder leaders

Member Experience	Clinical, Quality, and Care Transformation	Integration, Data, and Operations
• Develops the communications strategies (e.g., website, open enrollment materials, etc.), benefit design, and other guiding principles for enhancing the member experience • Includes PEBB staff members, carrier/administrator, consumer representatives, consultants, and other stakeholders as necessary	• Develops the requirements for the clinical, care transformation, and quality measurements for The Health Plan • Includes PEBB staff members, carrier/administrator, medical leaders, quality directors, consultants, and other stakeholders as necessary	• Develops the protocols for integrating benefit vendors with The Health Plan, designs information sharing arrangements, and other operational aspects • Includes PEBB staff members, carrier/ administrator, information technology experts, consultants, and other stakeholders as necessary

ILLUSTRATIVE TIMELINE FOR THE HEALTH PLAN'S EVOLUTION



UPDATES ON BRIDGE STRATEGIES



BRIDGE STRATEGIES
PLAN OF ACTION

Strategies

Expert Medical Opinion

Concierge for Statewide

Bundled Payments with COE

Point Solutions

Approach

#1
Carriers build, buy, or align with the strategies

#2
PEBB Procures

Process

Incorporate questions into renewal letters

Receive responses

PEBB decides if responses are adequate, and if the carriers are not able to do it, is the idea important enough to go out to procurement

Procurement process on ideas carriers cannot administer

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 – 11/12

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

RFI RESPONDENTS

Mercer identified the following respondents based on their advancements and achievements in the concierge and advocacy space. Below outlines the respondents who have accepted, not declined or accepted and have declined to respond.

Accepted

- evive
- Accolade
- HealthAdvocate — Always at your side
- Regence
- PacificSource ADMINISTRATORS
- consumermedical℠ — Your Medical Ally®
- Quantum HEALTH
- moda HEALTH
- PROVIDENCE Health & Services

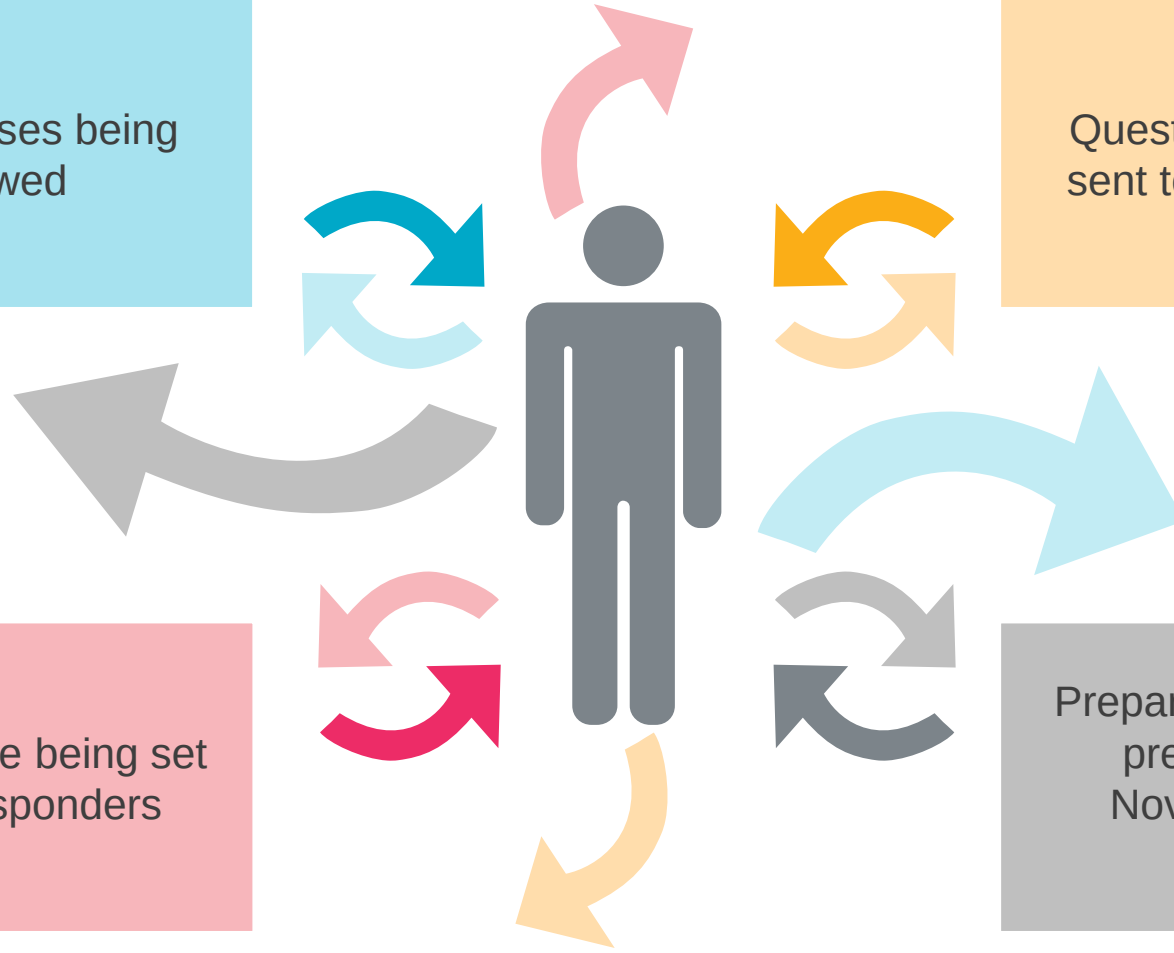
Declined

- Collective Health®
- IMA — HEALTHCARE MANAGEMENT ADMINISTRATORS

RFI CURRENT ACTIVATES

RFI responses being reviewed

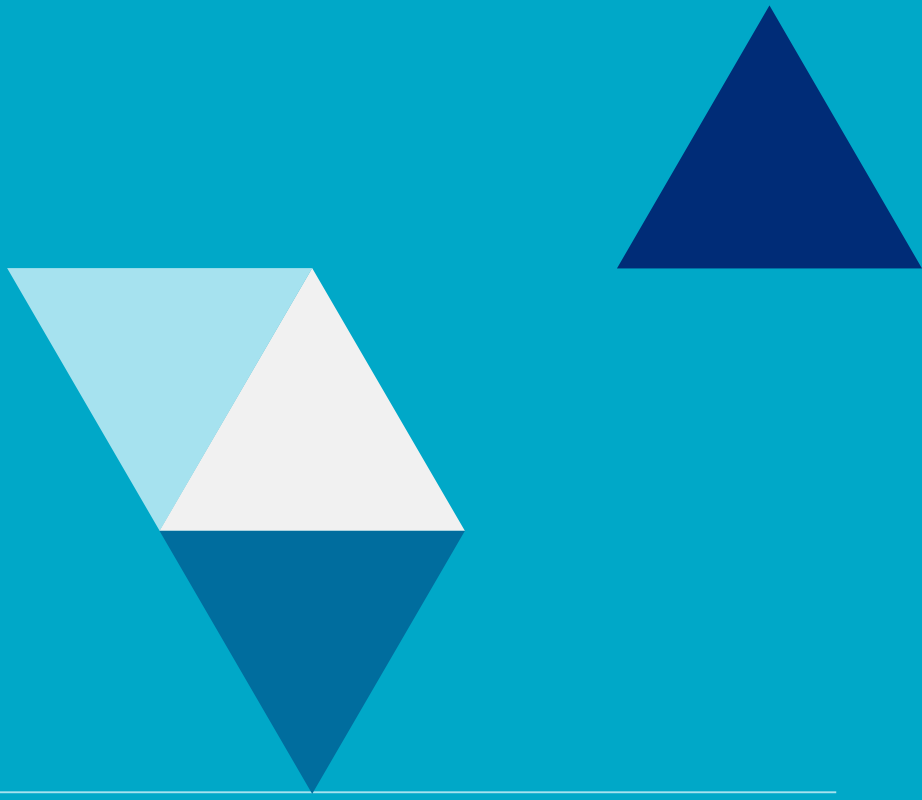
Questions have been sent to all responders



Interviews are being set up with responders

Preparing for summary presentation for November Board meeting

RECENT TRENDS



STATE AS PURCHASER AND REGULATOR

Purchaser Strategies

- **Montana**: Implemented reference-based pricing for all hospital services using 234% of Medicare inpatient and outpatient services, saving $15.6 million 2018
- **North Carolina**: Pushing for a similar reference-based pricing model using Medicare rates, but the plan has hit implementation hurdles and is being scaled back
- **Colorado**: Considering expansion of a purchasing alliance to a statewide strategy starting with state employees
- **California**: Creating a statewide purchasing system for prescription drugs

Regulatory Strategies

- **Massachusetts**: Health Policy Commission monitors spending growth and market impact of proposed mergers and acquisitions
- **Rhode Island**: Established inflation caps and DRG payments decreasing spending growth and patient cost-sharing
- **Pennsylvania**: Use of global budgets for rural hospitals and new care delivery models
- **New Hampshire**: NH Health Cost is a tool that has been rolled out for consumers to see care costs leading to modest savings and decreases in price lists

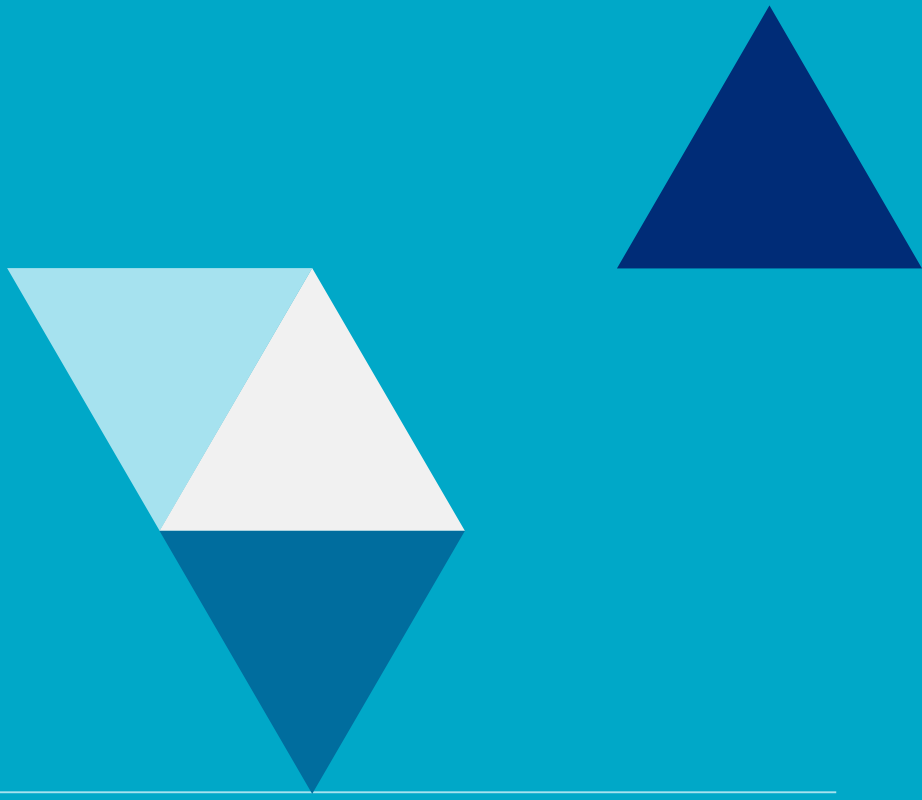
*States' Role in Combatting High Health Care Prices, The Commonwealth Fund, September 12, 2019
https://www.commonwealthfund.org/blog/2019/states-role-combatting-high-health-care-prices

MEDICARE SHARED SAVINGS PROGRAM (MSSP) RESULTS

- In 2018, MSSP generated $739.4 million in total net savings across 548 ACOs
- ACOs taking downside risk performed better than ACOs that did not take downside risk
- ACOs led by physicians perform better than ACOs led by hospital systems
- Nearly all ACOs continue to satisfactorily report quality measures and meet the quality performance standards
- Nearly all ACOs continue to satisfactorily report quality measures and meet the quality performance standards

*Verma, S. Interest in Pathways to Success grows: 2018 ACO results show trends supporting program redesign continue. *Health Affairs*. September 30, 2019. https://www.healthaffairs.org/do/10.1377/hblog20190930.702342/full/

APPENDIX



LONG TERM STRATEGY MESSAGING

APPROVED BY PEBB BOARD 8/20/2019

TRANSFORMING THE HEALTH PLAN

Approved by PEBB Board 8/20/2019

Triple Aim	**Improve the quality of care**		**Improve the patient experience**		**Deliver care more efficiently**	
STATE OF OREGON Office of the Governor KATE BROWN	**Improving Behavioral Health systems & increase value and pay for performance**		**Address social determinants of health and equity**		**Maintain a sustainable cost growth**	
OHA Guiding Principles	**Access**	**Innovation with accountability**	**Patient-centered**	**Health equity**	**Collaborative partnerships**	**Social determinants of health**
PEBB Vision	An innovative delivery system in communities statewide that uses evidence-based medicine to maximize health and use dollars wisely	A focus on improving quality and outcomes, not just providing health care	Promotion of health and wellness through consumer education, healthy behaviors, and informed choices	Accessible and understandable information about costs, outcomes, and other health data that is available for informed decision-making	Appropriate provider, health plan and consumer incentives that encourage the right care at the right time and place	Benefits that are affordable to employers and employees

Health Plan Success Measure Areas

Patients

Delivery System

Plan Sponsor and Administrator

Approved by PEBB Board 8/20/2019

PROBLEM WITH TODAY'S HEALTH CARE SYSTEM

Without change, health care costs are on the rise and expected to outpace the state's budget and wages

For all that we spend, we don't often get the quality or value that we should. Expensive care is not always the best care

We know there are opportunities to have higher quality and higher value from Health Care Systems that is financially sustainable

PEBB has a mandate to redesign the health care system to drive better value for members and help control cost

Legislative mandate to control benefit spending to no more than 3.4% per year

Approved by PEBB Board 8/20/2019

OHA'S GUIDING PRINCIPLES FOR VALUE BASED CARE

Costs

- Leverage the state's purchasing power to receive better value and drive transformative change
- Move from a fee-for-service system that rewards volume and price increases to a payment system that rewards value, quality, and financial sustainability
- Create benefits that are affordable to employers and employees
- Obtain cost reductions from improved efficiency and effective care delivery, not from cost shifting to members

Care Transformation

- Leverage data across state programs to address outlier costs, waste, and inefficiency in the system
- Engage with innovative delivery systems in communities statewide that use evidence-based medicine to maximize health and use dollars wisely
- Focus on improving quality and outcomes, not just providing health care
- Create appropriate provider, health plan, and consumer incentives that encourage the right care at the right time for the right person at the right setting of care

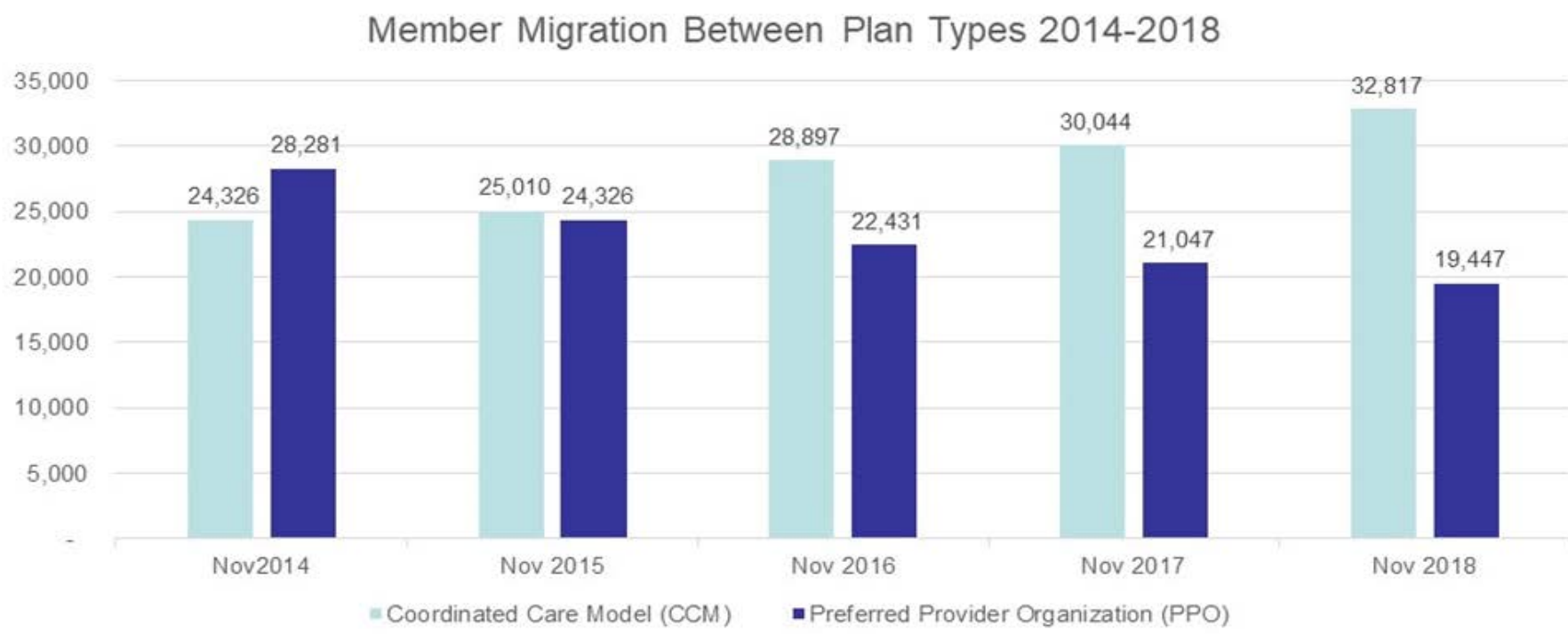
Member Experience

- Improve health equity by recognizing PEBB members are diverse and originate from racially, ethnically, culturally, gender- and ability- diverse communities throughout the state.
- Promote health and wellness through consumer education, healthy behaviors, and informed choices
- Provide accessible, understandable, and actionable information about costs, outcomes, and other health data to members, providers, and other stakeholders for informed decision-making

Approved by PEBB Board 8/20/2019

VISION
A LOOK AT THE NEW HEALTH PLAN

Oregon's coordinated care model has resulted in improved quality and reduced costs. PEBB will continue to evolve the coordinated care model building off the success to date while further advancing the model to improve health and healthcare, enhance the member experience, and lower costs.



Approved by PEBB Board 8/20/2019

ALIGNMENT WITH OHA'S KEY ELEMENTS OF COORDINATED CARE MODEL

How the Oregon PEBB Health Plan will align with OHA's CCMs:

Providing equitable, patient centered care

The Health Plan will be expected to provide care based on the member's needs and preferences

Transparency in price and quality

The Health Plan will offer tools and resources for the member about the costs and quality of care within its provider network while supporting the member's decision making about healthcare choices

Partnering with communities to support health and health equity

The Health Plan will coordinate with community resources and services to meet the member's medical and human service needs throughout the healthcare system

Measuring performance and efficiency

The Health Plan will report on key measures of health compared to targets, including member experience, care from physicians and behavioral health specialists, hospitalizations, and other quality metrics

Financial stability and strategic investment

The Health Plan will keep its annual medical trend rate at or below 3.4% with a directional decrease over time

Paying for outcomes and health

The Health Plan will incent providers to deliver care that achieves the best outcomes for the member with financial impacts based on outcomes

HOW WILL PEBB DO THIS

Approved by PEBB Board 8/20/2019

Over the next year, PEBB will establish clear requirements for future health plans that can commit to advancing the coordinated care model by improving quality, reducing costs, and improving the member experience while seeking innovative health delivery system designs and delivery models.

Value-Based Payments	Quality Metrics	Enhanced Patient Experience
Advanced value-based payment arrangements that incent the health care system to reduce unnecessary services and unnecessary costs while improving care, including alignment with CCO 2.0 expectations that 70% of payments be in an advanced value-based payment category by 2024	Set quality and performance expectations and increase the amount of payments to plans based on whether the health systems meet those expectations, including physical health and behavioral health metrics	Establish metrics to measure and improve patient experience, including health equity, social determinants of health, patient reported outcomes, and patient empowerment metrics

WHAT DOES THIS MEAN FOR MEMBERS

Approved by PEBB Board 8/20/2019

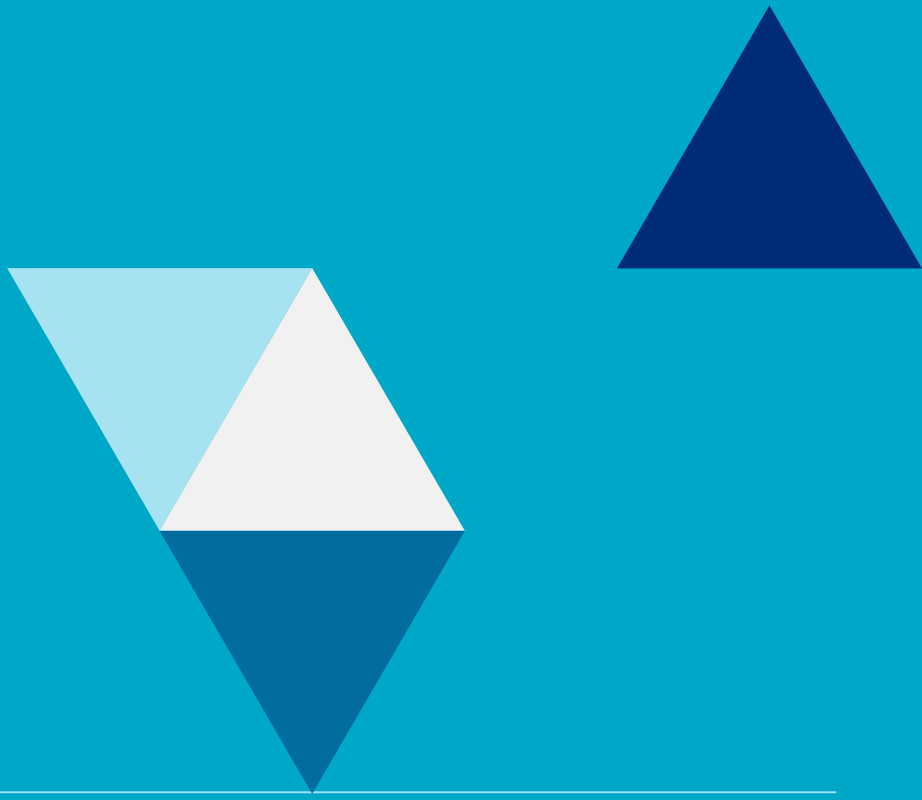
PEBB IS STILL IN THE DESIGN PHASE OF CREATING THE FUTURE VISION OF COORDINATED CARE MODEL PLANS

MEMBERS WILL RETAIN THE OPPORTUNITY TO CHOOSE WHICH PLAN THEY ENROLL IN

THE NEW HEALTH PLAN WILL OFFER THE OPPORTUNITY TO ENROLL IN HIGHER VALUE, LOWER COST PLANS FOR MEMBERS

THE NEW HEALTH PLAN WILL ALIGN AND FURTHER EVOLVE TO MEET THE GOALS OF THE TRIPLE AIM, THE GOVERNOR'S HEALTHCARE PRIORITIES, OHA'S GUIDING PRINCIPLES, AND PEBB'S VISION

ADDITIONAL LONG TERM STRATEGY INFORMATION



ALIGNING PEBB WITH CCO 2.0 GOALS

Increase Value Based Payments

Support the triple aim: better care, better health and lower health care

Reward providers'delivery of patient-centered, high-quality care

Ensure health disparities & members with complex needs are considered

Align payment reforms with state and federal efforts, where appropriate, for maximum impact and to streamline implementation for providers

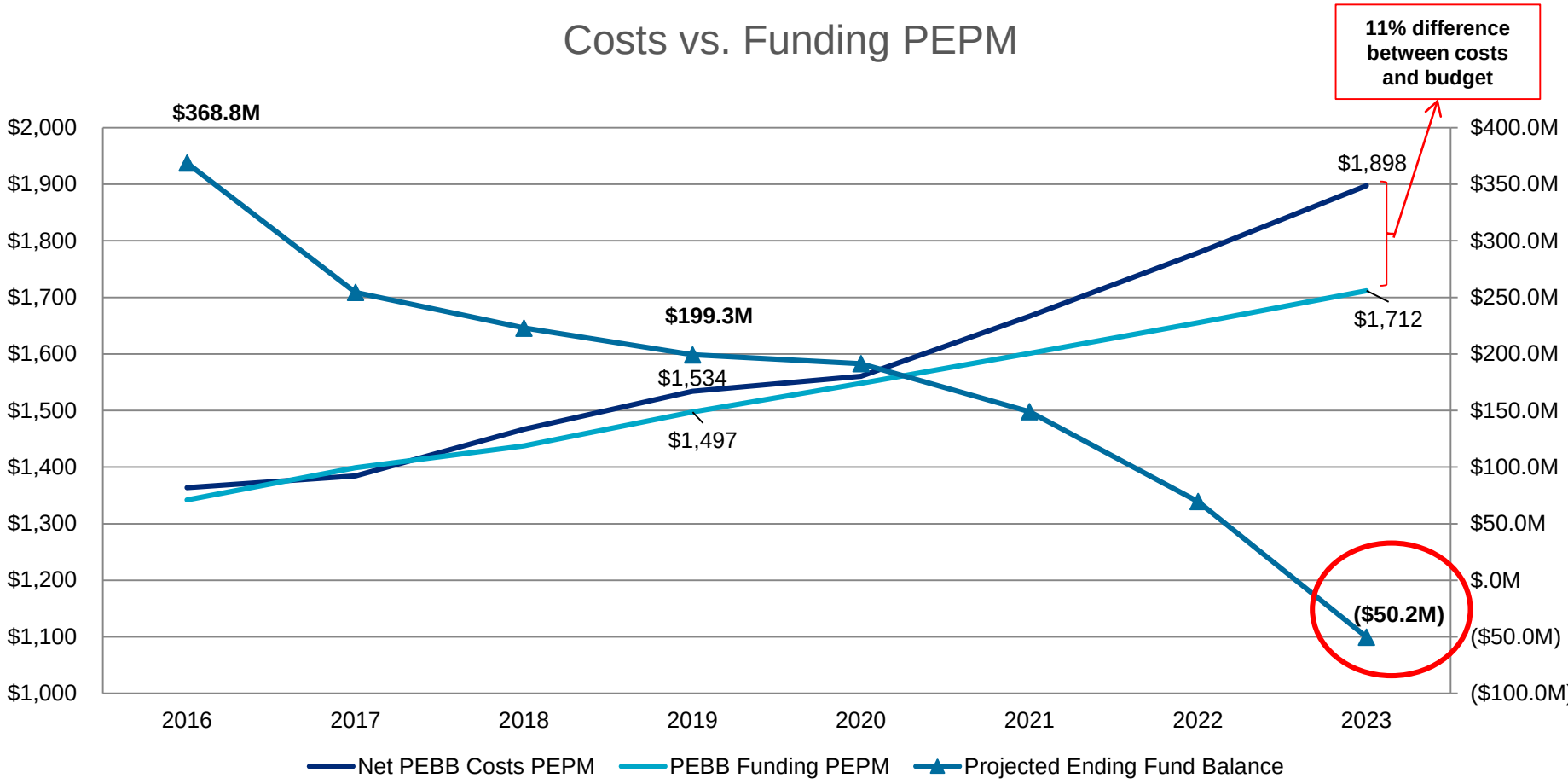
Reward CCO and provider performance

CCO 2.0 STRATEGIES FOR PAYING FOR VALUE

- Pay for outcome and value
- Shift focus upstream
- Improve health equity
- Increase access to healthcare
- Enhance care coordination
- Engage stakeholders and community partners
- Measure progress

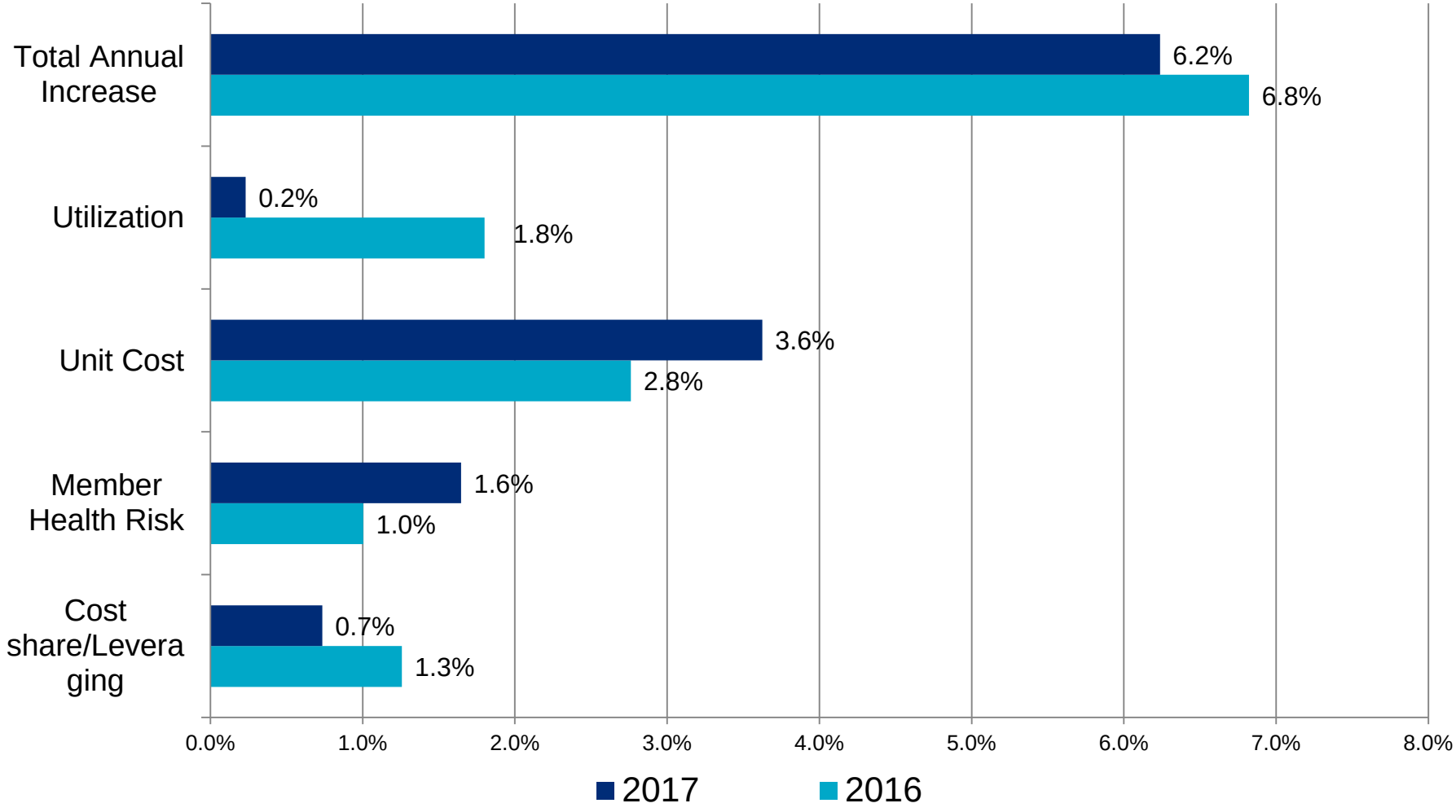
APPENDIX
PEBB'S CURRENT STATE

THE 3.4% FUNDING CAP
FUND BALANCE TURNS NEGATIVE BY 2023



Affecting positive impacts on health status, behavior change and costs can take several years

CHALLENGES OF 3.4% FUNDING CAP
HISTORICAL TRENDS REMAIN HIGH



Unit cost increases include impact of technology and service mix

PEBB CHRONIC CONDITIONS

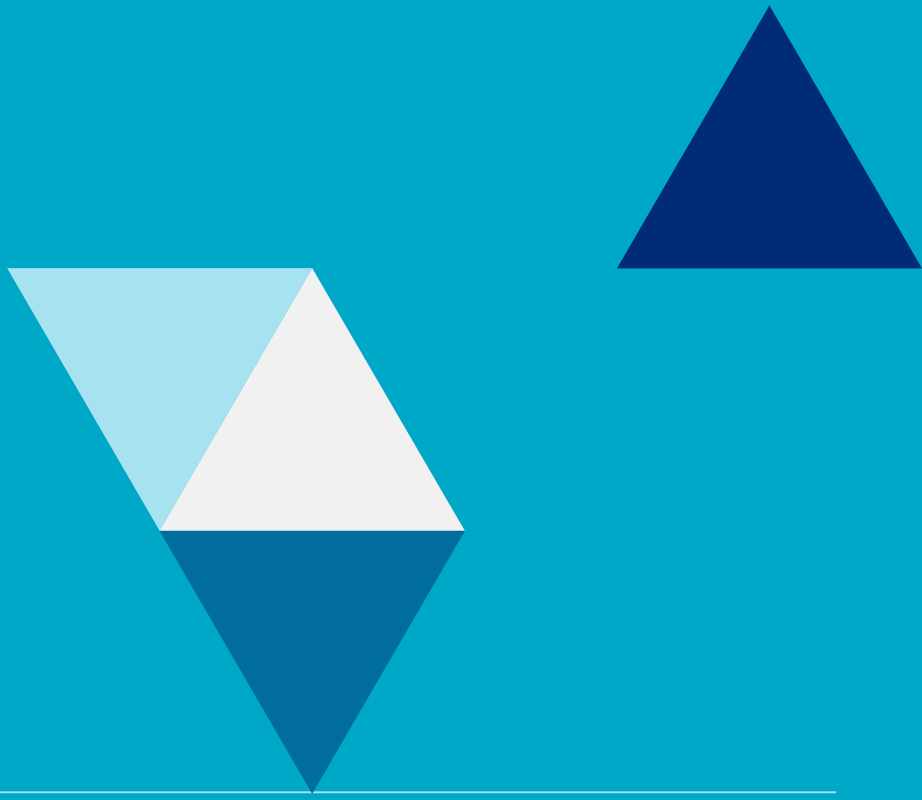
- PEBB's Chronic Condition Prevalence suggests an opportunity for specific "point solutions" aimed at improving the management of a member's condition, and ultimately saving costs

		Previous	Current	Allow Amt Med + Rx Cost Per Pat (Episode Based)
Asthma	Prevalence per 1000			$1,147 $1,164 $1,806
	Prevalence per 1000 Benchmark [4]	25.4	27.7	
	Visits per 1000 ER	N/A	21.1	
	Visits per 1000 ER Benchmark [4]	1.7	1.9	
		N/A	2.6	
	% of Total Allowed Cost	0.8%	0.6%	
Diabetes	Prevalence per 1000	59.7	63.3	$2,559 $2,894 $4,631
	Prevalence per 1000 Benchmark [4]	N/A	51.2	
	Visits Per 1000 ER	1.0	1.8	
	Visits per 1000 ER Benchmark [4]	N/A	1.7	
	% of Total Allowed Cost	3.5%	2.5%	
CAD	Prevalence per 1000	7.4	7.8	$7,578 $9,154 $10,581
	Prevalence per 1000 Benchmark [4]	N/A	9.9	
	Visits Per 1000 ER	1.2	1.2	
	Visits per 1000 ER Benchmark [4]	N/A	1.4	
	% of Total Allowed Cost	1.7%	1.6%	
Depression	Prevalence per 1000	82.9	89.6	$1,072 $1,139 $1,670
	Prevalence per 1000 Benchmark [4]	N/A	38.4	
	Visits Per 1000 ER	2.9	3.4	
	Visits per 1000 ER Benchmark [4]	N/A	2.1	
	% of Total Allowed Cost	2.1%	1.8%	
Lower Back	Prevalence per 1000	91.1	88.5	$1,405 $1,562 $1,932
	Prevalence per 1000 Benchmark [4]	N/A	64.6	
	Visits Per 1000 ER	N/A	N/A	
	Visits per 1000 ER Benchmark [4]	N/A	N/A	
	% of Total Allowed Cost	2.6%	2.2%	
Hypertension	Prevalence per 1000	62.7	61.4	$850 $1,000 $1,281
	Prevalence per 1000 Benchmark [4]	N/A	76.9	
	Visits Per 1000 ER	1.1	1.6	
	Visits per 1000 ER Benchmark [4]	N/A	1.9	
	% of Total Allowed Cost	1.1%	0.9%	

Previous Current Benchmark [3]

Previous Period: Jun 1, 2016 - May 31, 2017 (Incurred)
Current Period: Jun 1, 2017 - May 31, 2018 (Incurred)
Paid Through: Aug 31, 2018

APPENDIX
POTENTIAL STRATEGIES AND ESTIMATED COST SAVINGS



HOW DO WE HELP PEBB SOLVE FOR 3.4%?
EXPLORING THE POSSIBILITIES

CONTINUUM OF STRATEGIES TO IMPACT COSTS

Unit Prices

- Directly negotiate rural fee schedule prices
- Contract with efficient CCMs by county
- Reference based pricing
- Exclusive specialty drug vendor
- High cost claim management

Benefit Coverage

- Advocacy care management
- Stricter medical and benefit policies
- Adjust plan values to benchmark
- Risk adjust premiums for contributions
- Point solutions

Delivery and Associated Payments

- Bundled payments
- Centers of Excellence
- Health alliance to influence how providers operate
- Better integration of behavioral health and EAP with medical
- Single electronic health record provider

Payment Model with Risk Sharing

- Upside and downside risk
- Create a Health Plan
- Changing in-network to only include risk bearing providers

Patient Behavior

- Concierge vendor
- Transparency tool
- Require use of shared decision support tool
- Single telemedicine solution
- Consumer directed medical plan
- Expert medical opinion vendor
- Address social determinants of health

STRATEGY
ILLUSTRATIVE SAVINGS

	2020	2021	2022	2023	Total
Needed Savings per Year	$8 Million	$35 Million	$37 Million	$41 Million	$120 Million
Savings Opportunities					
• Concierge for Statewide	$7 Million	$11 Million	$16 Million	$17 Million	$51 Million
• Expert Medical Opinion	$1 Million	$1 Million	$1 Million	$1 Million	$4 Million
• Double Spousal Surcharge	$2 Million	$3 Million	$2 Million	$3 Million	$10 Million
• CCMs In Efficient Counties		$2 Million	$3 Million	$3 Million	$8 Million
• Bundled Payments	$2 Million	$2 Million	$2 Million	$2 Million	$9 Million
• Accountable Care Organization		$2 Million	$4 Million	$7 Million	$13 Million
Total Savings	$12 Million	$22 Million	$28 Million	$33 Million	$94 Million
Remaining Gap	None	($13 Million)	($9 Million)	($8 Million)	($25 Million)

Annual savings from members selecting CCM plans has historically been between $4M and $7M

APPENDIX
THE NEW HEALTH PLAN

TRANSFORMING THE CCM INTO THE NEW HEALTH PLAN
CRITICAL ELEMENTS

Element	Questions to Consider
Articulate the goals	• What are we trying to achieve through The Health Plan? • How do we define success? • How will we measure success?
Conduct gap analysis and identify opportunities	• What elements of the delivery system are impacted by our measures of success? • Where are the CCMs currently rated on these measures of success? • How and where can the delivery system make improvements to achieve the goals?
Evaluate The Health Plans medical Management Capabilities	For organizations that want to partner and become a high functioning Health Plan, perform a readiness assessment of the delivery system to see if the requisite population health management capabilities with the necessary tools, resources, staff, methodologies, etc. are in place in order to achieve the desired goals. • How do we know that the delivery system can perform as a Health Plan and a patient-centered medical home (PCMH)? • What accreditations or recognition can be or are obtained by the delivery system in order to ensure that it will be a highly functioning Health Plan? • Where there are gaps, what action plans are in place to eliminate those gaps?
Establish the Financial Reconciliation Methodology	• Adapt the financial measures of success to performance guarantees including upside and downside risk • Clearly articulate the financial reconciliation methodology, including outlier exclusions (if any), attribution methodology, risk corridors (if any), etc.
Patient-Centered Care and Communication	The Health Plan model needs to be patient-centered with tailored and customized communications in order to support patient enrollment and engagement • Determine gaps between current patient experience and engagement (open enrollment, standardized messaging, concierge call center, patient decision aids, etc.) and definition of success for The Health Plan • Document action steps to address gaps • Create metrics for success and methodology for calculating those metrics
Benefit Plan Design	The benefit design needs demonstrate the value to the patient in enrolling in The Health Plan • Is The Health Plan replacing the CCM or offered as an option? • Determine if the benefit design or contributions need to be adjusted to encourage enrollment into the VBC/Health Plan • Create process for obtaining a waiver to go outside The Health Plan • Will a primary care physician (PCP) designation be required?
Quality Management & Improvement	The Health Plan delivery system needs to clearly articulate how it is engaged in an on-going, systematic quality management and improvement program that delivers improved outcomes and better patient satisfaction/engagement • Clearly define success to the delivery system • Document action steps to address gaps in quality • Determine key metrics that define success and methodology for calculating those metrics
Information Sharing and Reporting	The Health Plan needs timely, accurate, meaningful, standardized, and actionable information and data in order to support proactive population health management. • Determine key stakeholders (providers, facilities, care managers, etc.) and the data required by each stakeholder • Assess current reporting capabilities and gaps • Create project plan for delivering and reviewing data with key stakeholders with timeframes for evaluating success and reassessing needs
Supplier Collaboration	There are usually a number of services and suppliers involved with an employer's overall benefit plan. There needs to be awareness and collaboration between all of the benefit suppliers when The Health Plan is launched. • How will the suppliers interact and collaborate in order to support a highly functional, integrated system?
Attribution	• What kind of providers are considered primary care providers (e.g., MDs, ARNPs, PAs, etc.)? • What type and what kind of office visits are counted (e.g., two office visits of any kind)? • What is the look-back period for counting visits (e.g., one year, two years, etc.)? • How and when would specialist visits be considered?

EVOLVING THE CCM INTO THE NEW HEALTH PLAN
SAMPLE SUCCESS MEASURES

PATIENTS

PLAN SPONSOR

- Plan design that demonstrates value and facilitates enrollment into The Health Plan
- Communicates and reinforces the model to its population
- Supports supplier integration and collaboration
- Ensures timely and accurate information and data sharing routinely occurs
- Negotiates meaningful performance guarantees (financial, clinical, and administrative)

DELIVERY SYSTEM

- Commitment from leadership with appropriate dedicated resources
- Consolidates, curates, and distributes actionable data
- Staffs primary care teams with the appropriate qualifications and infrastructure to perform proactive population health management
- Implements empowered electronic health record (EHR) that provides efficient communication, information sharing, and incorporates evidence-based guidelines
- Controls care delivery pathways and protocols
- Understands and commits to meet the needs of the patient, including service delivery and clinical delivery
- Reports measures of quality rigorously and transparently with improvement activities to address gaps

ADMINISTRATOR

- Administers value based payment methodologies
- Provides timely and accurate data between suppliers
- Vets high quality provider groups
- Establishes clear administrative processes for The Health Plan design
- Reinforces the communication regarding The Health Plan value proposition
- Provides meaningful performance guarantees (financial, clinical, and administrative)
- Transfers certain functions (e.g., catastrophic case management and utilization management) when the delivery system proves it has the capabilities to perform

SAMPLE GAP ANALYSIS AND ACTION PLAN
BASED ON HEALTH PLAN EVOLUTION

COMPETENCY EXPECTATIONS	CURRENT Years 1 to 3	INTERMEDIATE YEARS 2 to 5	SUCCESS YEARS 4+
Clinical Governance			
Provider Responsibility	Providers approve clinical and operational goals and plans	PCPs and specialists oversee quality and patient experience	Accountable for achieving sustained high performance
Network			
Primary Care (PCP)	Established	Add high-value PCPs	Optimized and refine network
Hospitals and Specialists	Identified and recruit	Add high-value hospitals and specialists	Optimized and refine network
Care Model			
Medical Home	Implementing	Established, integrating behavioral health	Optimized and complete
Risk Stratification	High-risk patients targeted	Expanded to include moderate-risk patients	All consumers targeted
Clinical Guidelines	Established for high-risk patients	EMR-based, expanded use across conditions	Complete guidelines across The Health Plan
Quality	Siloed quality efforts	Coordinated quality efforts	Continuous quality improvement
Care Coordination	Through The Health Plan	Shifting the Health Plan	Health Plan-driven
Site of Care	Adding low-cost sites of care	Refer efficient sites of care	Integrated into care model
Medication	Polypharmacy and reconciliations	Evidence-based use, adherence and efficiency	Value-based, efficient across sites
Consumer Experience			
Access	24/7 access	Expanded 24/7 and same-day urgent access	Consistent 24/7 and urgent access
Proactive Outreach	Limited to high-risk patients	Expanded for moderate-risk patients	Consistent outreach tall consumers
Satisfaction	Measured for high-risk patients	Improving for high-moderate-risk patients	Concierge model for all consumers
Portal	Basic, includes records and messaging	Addition of care plans and content	Comprehensive and mobile-enabled
Technology & Analytics			
Electronic Medical Record (EMR)	Multiple and separate EMRs	Limited data exchange between EMRs	Complete EMR interoperability
Predictive Analytics/Registries	Primary care registries only	Primary and specialty care registries	Integrated registries
Data Analytics	Limited to EMR data	Multiple data sources to identify opportunities	Use comprehensive clinical/claims data
Finance Model			
The Health Plan Risk	Gain-sharing tied to quality and cost	Gain- and loss-sharing tied to quality and cost	At risk for total cost of care
Physician Incentives	Small incentive, limited The Health Plan panel	Increased incentive, expanded The Health Plan panel, introduce downside risk	Compensation with incentives tied to performance

HEALTH PLAN BOARD INPUT
MEMBER SUCCESS MEASURES

Board was asked to rank order its top five from the following success measures from the *Member* perspective:

	POINTS
Receives comprehensive care for all physical and behavioral health needs	8.80
Less administrative hassle	8.25
Lower premium costs	8.00
Lower cost shares, such as lower co-pays, deductibles, and co-insurance	8.00
Has navigator support throughout the healthcare system	7.67
Easier access to healthcare providers	7.25
Feels respected and honored for personal preferences and values	6.75
Feels empowered and educated for self-care	5.00
Has multiple channel access to healthcare services and education	4.75
Gets whatever medication or healthcare service/procedure that is asked for	2.33
Other:	

*One abstention

THE HEALTH PLAN BOARD INPUT
PEBB'S SUCCESS MEASURES FOR A HEALTH PLAN

Board was asked to rank order the following success measures from the *PEBB Board and Staff* perspective

	POINTS
Comprehensive reporting demonstrating the positive financial, clinical, and member/patient experience outcomes	4.80
Has all performance guarantees met by The Health Plan	4.67
Meets or exceeds financial targets	4.20
Minimal or no member complaints	3.40
Able to clearly articulate the value proposition of The Health Plan to all stakeholders resulting in achieving the desired enrollment	3.00
Other:	

HEALTH PLAN BOARD INPUT
HEALTHCARE DELIVERY SYSTEM SUCCESS MEASURES FOR A HEALTH PLAN

Board was asked to rank order the following success measures from the *PEBB Healthcare Delivery System* perspective

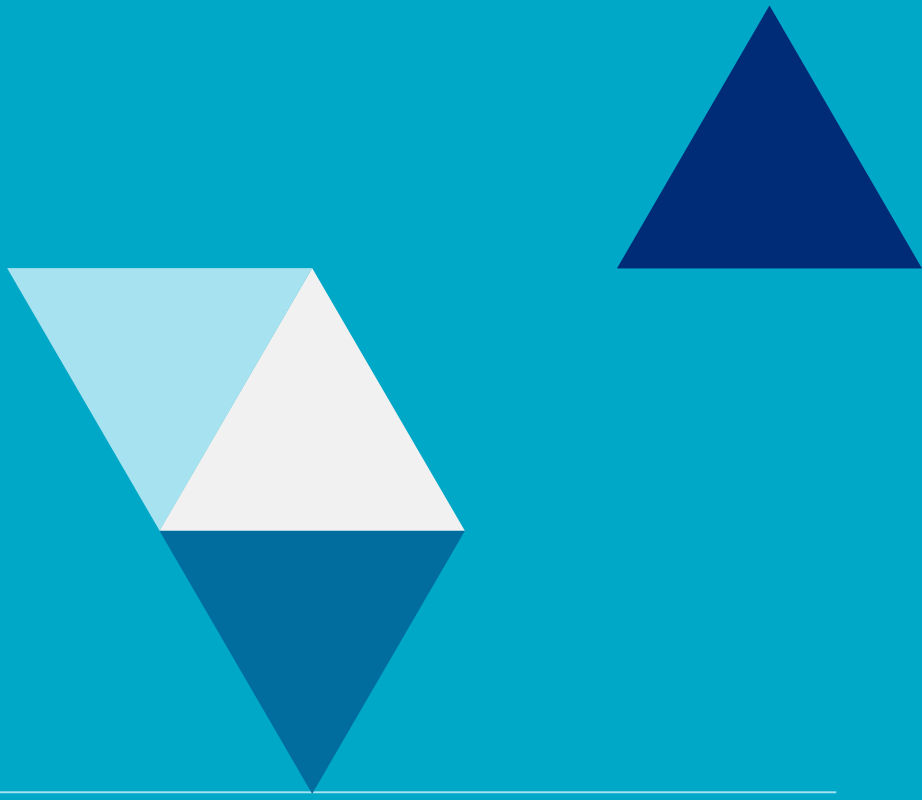
	POINTS
Demonstrated improvements in the clinical, financial, and member/patient experience outcomes	5.50
Able to meet or exceed all quality metrics and other targets while receiving the maximum financial rewards for performance	4.17
Incorporates systematic shared decision making (including patient decision aids) with patients resulting in improved clinical outcomes, empowered patients, and lower costs	4.00
Able to redesign clinical workflows with care teams and electronic health records (EHRs) to deliver efficient, effective, comprehensive, patient-centered, team-based care	3.80
Able to leverage the work with PEBB for other contracts and products with other plan sponsors	2.20
Increase volume of patients	1.75

HEALTH PLAN BOARD INPUT
CARRIER/ADMINISTRATOR SUCCESS MEASURES

Board was asked to rank order the following success measures from the *Carrier/Administrator* perspective

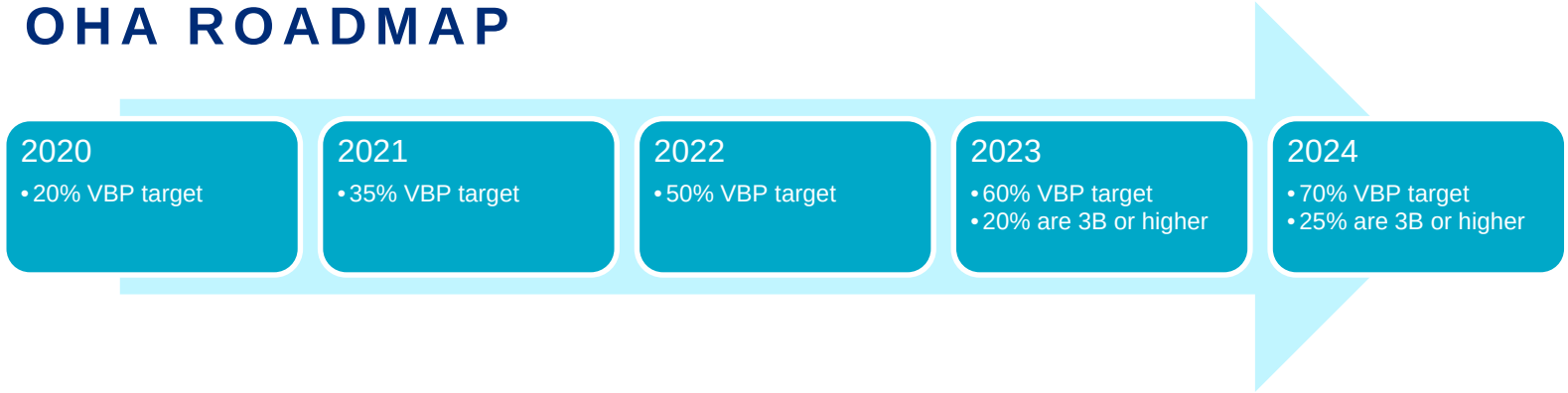
	POINTS
Able to meet or exceed all performance guarantees	4.83
Provides accurate, timely, and meaningful data with The Health Plan and all benefit vendors	4.40
Able to administer accurate, efficient, and timely value-based payments	4.25
Able to coordinate and integrate with The Health Plan for optimal and non-duplicative clinical management services	3.60
Able to leverage The Health Plan work with PEBB for other contracts and products with other plan sponsors	3.00
Provides timely and meaningful data on critical metrics	2.40

APPENDIX
ROADMAP FOR PEBB'S VALUE-BASED-PAYMENT STRATEGY



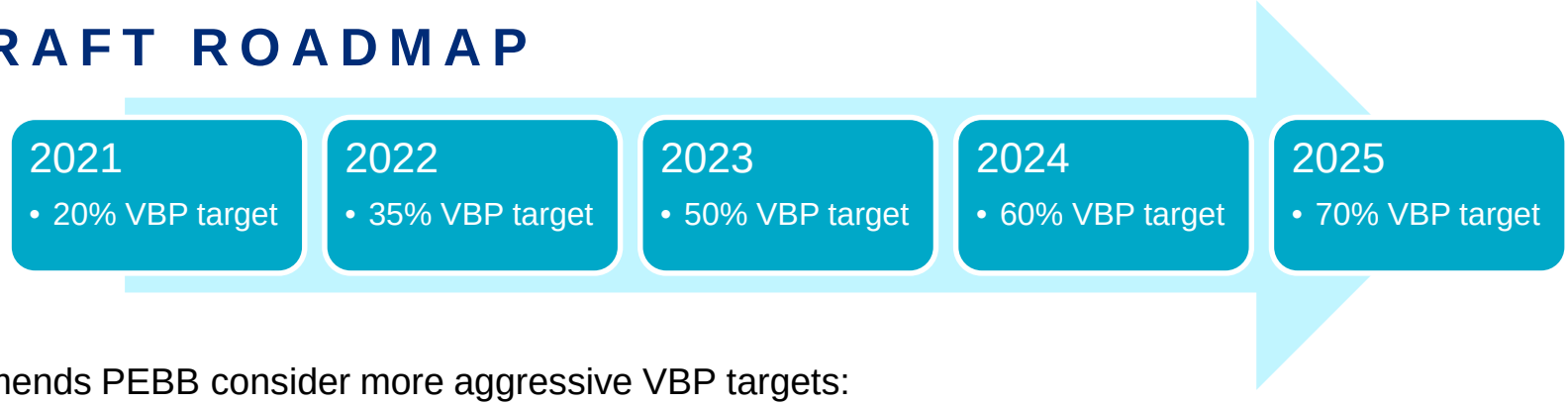
PEBB'S ROADMAP VS. OHA'S CCO 2.0

OHA ROADMAP



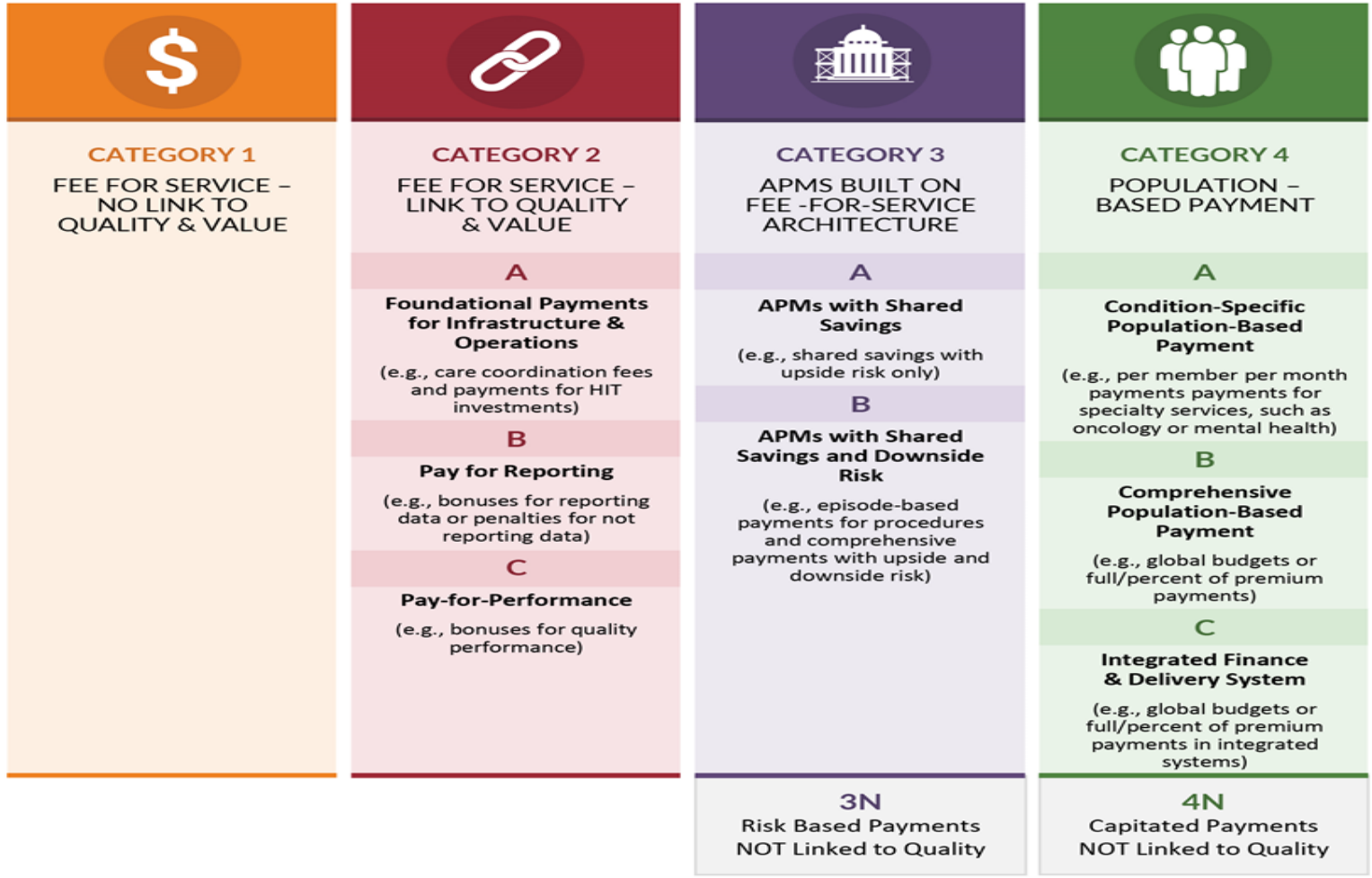
- OHA's CCO payments to providers must be in the form of a Value-Based-Payment (VBP) and fall within LAN Category 2C (Pay for Performance) or higher

PEBB DRAFT ROADMAP



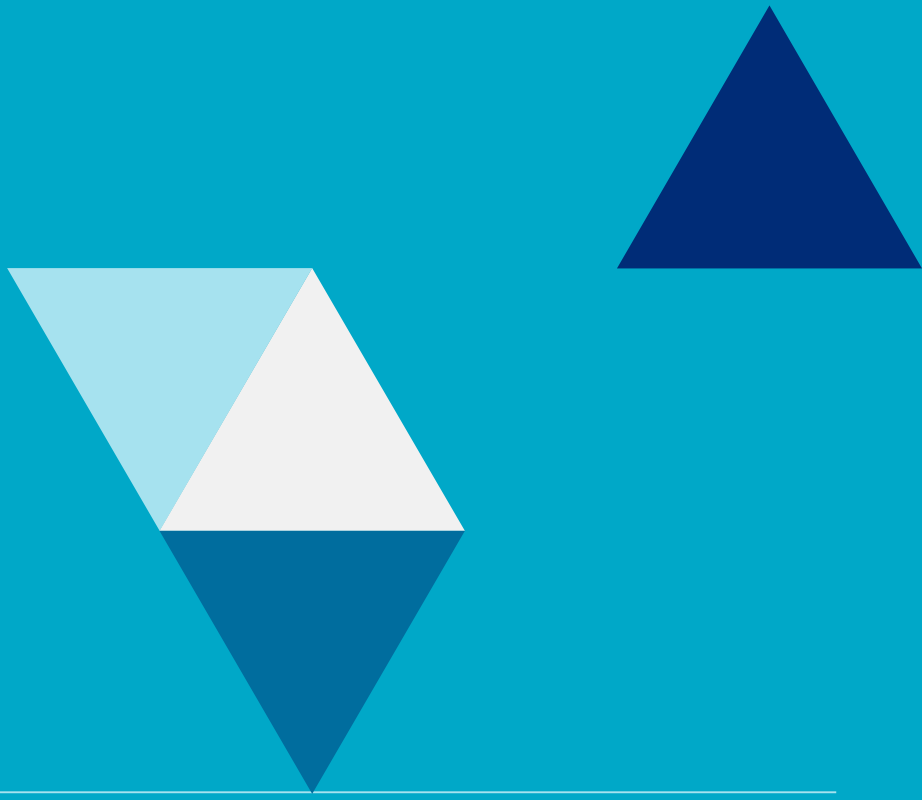
- Mercer recommends PEBB consider more aggressive VBP targets:
  - 2021-2024: Minimum of Category 2C, transitioning to Category 3
  - By 2025: Category 3B or higher (APMs with Shared Savings and Downside Risk)
  - The Health Plan will be required to have a minimum Category 4 payment model as soon as possible

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



Source: APM Framework, HCP-LAN,2017

APPENDIX
EXAMPLES OF ACO NETWORKS



MICROSOFT
THE HEALTH CONNECT PLAN

From Microsoft media release and employee newsletter:

- The Health Connect Plan, offered through Premera, provides personalized, coordinated care and cost predictability to help simplify managing your health
- Key details:
  - **The Health Connect network:** The Health Connect Plan is built around a select group of providers on the Eastside—the Eastside Health Network, which includes dozens of independent practices, EvergreenHealth, and Overlake Medical Center and Clinics; Allegro Pediatrics; and the Living Well Health Center—who share Microsoft's vision to deliver a personalized health care experience and help you achieve improved health outcomes over time.
  - **A personalized and coordinated approach to your health care:** In the Health Connect Plan, you are encouraged to work closely with a Health Connect network primary care provider (PCP) of your choice. Your PCP gets to know you and your dependents' health care needs and goals and helps coordinate your care.
  - **Predictable out-of-pocket costs and simplified administration:** You pay a convenient copay for many basic services, such as office visits and prescription medications, when you see providers in the Health Connect network, making your out-of-pocket costs predictable and potentially reducing the time you spend reviewing claims and paying bills. You also have access to Premera network providers outside the Health Connect network, although a deductible may apply and your out-of-pocket costs will generally be higher.
  - **A dedicated service center for all of your questions:** The Health Connect Navigator provides personalized help, such as finding providers, making appointments, answering plan questions, and much more

https://www.premera.com/mshealthconnectplan/

BOEING
PREFERRED PARTNERSHIP

For eligible employees in the Puget Sound region

From Boeing's Preferred Partnership website for employees:

- Overview:
  - Boeing has partnered with a leading healthcare system in the Puget Sound region — UW Medicine Accountable Care Network — to change the way healthcare is delivered. This arrangement is called the Preferred Partnership and is designed to improve quality, provide a better experience for you and your family, and be more affordable
- How the Preferred Partnership Option Works:
  - The Preferred Partnership option has a broad provider network — with primary care providers (PCPs), specialists, urgent care facilities and hospitals located throughout the Puget Sound region. To receive network benefits, generally you and your family need to use only providers in the UW Medicine Accountable Care Network. Urgent care and emergency care, however, are covered at the network level, even if the provider is not in the UW Medicine Accountable Care Network, or if you are traveling outside the Puget Sound region
  - If you otherwise receive medical services from providers not in the UW Medicine Accountable Care Network, and the services are not for urgent care or emergency care, those services would be covered at the non-network level in the Traditional Medical Plan and the Advantage+ health plan. In the Select Network Plan, non-network, nonemergency care is not covered.
  - If you cover a child under the plan who lives outside the Puget Sound region, the standard option may be a better choice for your family.
- Features:
  - **Enhanced Services**
    - Quicker access to network PCPs and specialists, and more after-hours care availability.
    - More personalized and coordinated care, especially for individuals with complex medical situations such as diabetes or a heart condition.
    - Greater use of electronic messaging with providers, and access to your electronic medical record.
  - **Affordable Coverage**
    - Lower paycheck contributions
    - Increased company contributions to the HSA if applicable

http://www.healthpartnershipoptions.com/SiteAssets/pub/fact_sheet_emp_ps.html

WASHINGTON HEALTHCARE AUTHORITY
UNIFORM MEDICAL PLAN (UMP)

From WA State HCA website

- **UMP Plus:**
  - UMP Plus has a lower deductible and monthly premiums than UMP Classic while offering most of the same benefits. The plan has no prescription drug deductible, and you pay nothing for primary care office visits with your network primary care provider. Other services received at the visit, like x-rays and labs, are covered the same as they are with UMP Classic. And all your UMP Plus network providers work together to give you the right care at the right time.
- **Employees choose between two ACO networks:**
  - UW Medicine Accountable Care Network
  - Puget Sound High Value Network
- **Advantages:**
  - Lower premiums than many other PEBB Program health plans.
  - Lower medical deductible than many other PEBB Program health plans.
  - No prescription drug deductible.
  - Lower out-of-pocket costs when using network providers.
  - Office visits with primary care providers at no charge.
  - Quick access to primary and specialty care.
  - Focus on wellness, such as screenings and preventive care.
  - Coordinated care between your providers for chronic conditions such as diabetes.
  - Providers with extended office hours.

https://www.hca.wa.gov/ump/plan-ump-plus

APPENDIX
EXAMPLES OF OTHER STATE INITIATIVES

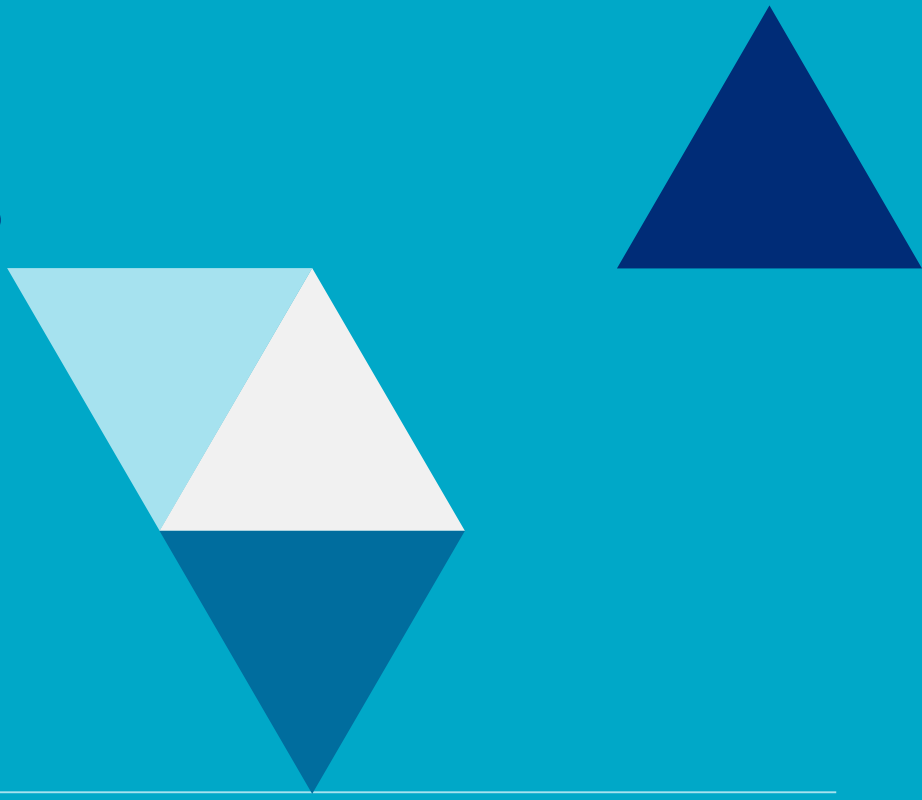
STRATEGY FOR ACTION
WHAT IS WASHINGTON DOING?
THE HEALTH PLAN AND BUNDLED PAYMENTS

	Targets / Enhances	Demonstrating Value
The Health Plan	• Shared Risk Model • Member experience • Care transformation • Timely data • Incentives with benefit designs	• 17,000 members in 9 counties representing 52% growth between 2016 and 2017 • Both networks received 100% credit in 2016 for clinical quality improvement • 19,281 PCP visits • Range of member annual savings: Premium $300-$828; deductible up to $375 • 44% premium differential for 2018 • 89% member retention
Bundled Payment	• Concierge experience for members with total joint replacements • Virginia Mason designated COE through competitive procurement • Based on Bree Collaborative recommendations	• 10-15% cost savings first year of COE • About $1,000 out of pocket cost savings to member • 100% of members would use COE again and recommend it • 23 more members currently pursuing surgeries at COE • Expansion of COE to spinal fusions

STRATEGY FOR ACTION
RURAL PAYMENT STRATEGY

Vermont ACO Model	• Limits per capita health care growth to 3.5% annually • Focuses on outcomes and quality, specifically on access to care, substance abuse disorder, suicides, and chronic conditions
Pennsylvania	• Prospectively sets global budget for participating rural hospitals, based on historical revenue • Rural hospitals will redesign delivery of care to improve quality and meet health needs of local communities
Washington State	• Patient centered solutions to reward rural providers for value of care and incent based on improved outcomes • Address access and sustainability concerns along with community needs • Integrated delivery systems and redefine primary care for rural populations • Ensure that members are engaged with local health delivery systems • Create payments based on total cost of care with encounter-based payments

APPENDIX
BRIDGE STRATEGIES



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

RFI Content

- **CAS questions** – These questions were drafted by Mercer with input from OHA
- **OHA and CAS Background** – This was developed by both Mercer and OHA
- **Attachments** sent alongside the RFI

RFI Questions

- **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.

Attachments

- **RFI Background** – The background information indicates PEBB's background and identifies the appropriate context of the RFI.
- **Summary Plan Design** – Member handbook as well as a summary of plan description for the Providence Statewide Plan.
- **Experience Report** - Prior claims history for the Providence Statewide plan with de-identified data.
- **Governor's Healthcare Strategy** - Governor Brown's vision is for all Oregonians to have quality, affordable health care, regardless of who they are or where they live.

The RFI is NOT a procurement, so no contract award will be made. The RFI was sent to a select number of organizations and is open to any responders to provide a market update on capabilities to OHA and PEBB.

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

Projected Potential Savings

2020	2021	2022	2023
$7M	$11M	$16M	$17M

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

STRATEGY: EXPERT MEDICAL OPINION

Enables employees struggling with a medical decision to have their medical case reviewed by experts to confirm the diagnosis and treatment plan, or to offer an alternative diagnosis and/or treatment approach

Projected Potential Savings

2020	2021	2022	2023
$1M	$1M	$1M	$1M

How this stacks up with key criteria

- Potentially improves outcomes with members facing complex or rare diagnoses
- Demonstrated savings per utilization but program costs are $2 to $5 PEPM
- Utilization of the program may be low unless highly communicated
- Supports Triple Aim but could fragment care
- Program requires a third party administrator
- Can be implemented in a short time frame

How this could make people happy

- Reassurance on diagnosis or treatment plan
- Concierge customer service
- Availability of top providers for rural members
- Service can be extended to non-covered family members

How this could frustrate people

- May result in a conflicting opinion with a different treatment plan than original doctor's
- Program understanding/awareness may be low unless well-communicated

TIMING

SHORT

CARRIER/VENDOR

NEW

COMMUNICATION

HIGH FOR UTILIZATION

IMPLEMENTATION

MEDIUM

STRATEGY: BUNDLED PAYMENT WITH COES

Select and implement bundled payments for high volume services with high cost variances, along with an enhanced travel benefit and Centers of Excellence

Projected Potential Savings

2020	2021	2022	2023
$2M	$2M	$2M	$2M

How this stacks up with key criteria

- Programs would be priced to provide savings off of current costs
- RFP to create bundles and determine centers of excellence would take at least a year
- Rewards providers of high quality care but potentially fragments health care delivery
- Uneven capabilities for current plans to administer
- Shifts costs from fee for service to pay for value
- Program can be disruptive but could be developed in conjunction with OEBB

How this could make people happy

- Improved benefits with warranties on outcomes of members' surgeries
- Concierge service for the member's case
- Engages members in their own treatment decisions

How this could frustrate people

- Additional requirements, including shared decision making, to access higher level of benefits
- Centers of excellence locations may require travel

TIMING

MEDIUM

CARRIER/VENDOR

CURRENT/NEW

COMMUNICATION

HIGH

IMPLEMENTATION

MEDIUM

STRATEGY: POINT SOLUTIONS

Condition/risk-specific programs to improve the health outcomes of impacted individuals

Projected Potential Savings

2020	2021	2022	2023
TBD	TBD	TBD	TBD

How this stacks up with key criteria

- Individual programs typically provide return on investment guarantees
- Each solution would likely save under $1 million per year
- Programs attempt to achieve the Triple Aim but would segment care away from current providers and vendors
- Utilization and engagement requires high level of communication
- Point solutions are delivered by outside vendors

How this could make people happy

- Targeted solutions for the members' specific conditions
- Improved care, health outcomes, and/or lower member costs

How this could frustrate people

- Care is fragmented and members and their doctors will need to interact with an outside vendor
- Solutions may be disruptive to members

TIMING

SHORT

CARRIER/VENDOR

NEW

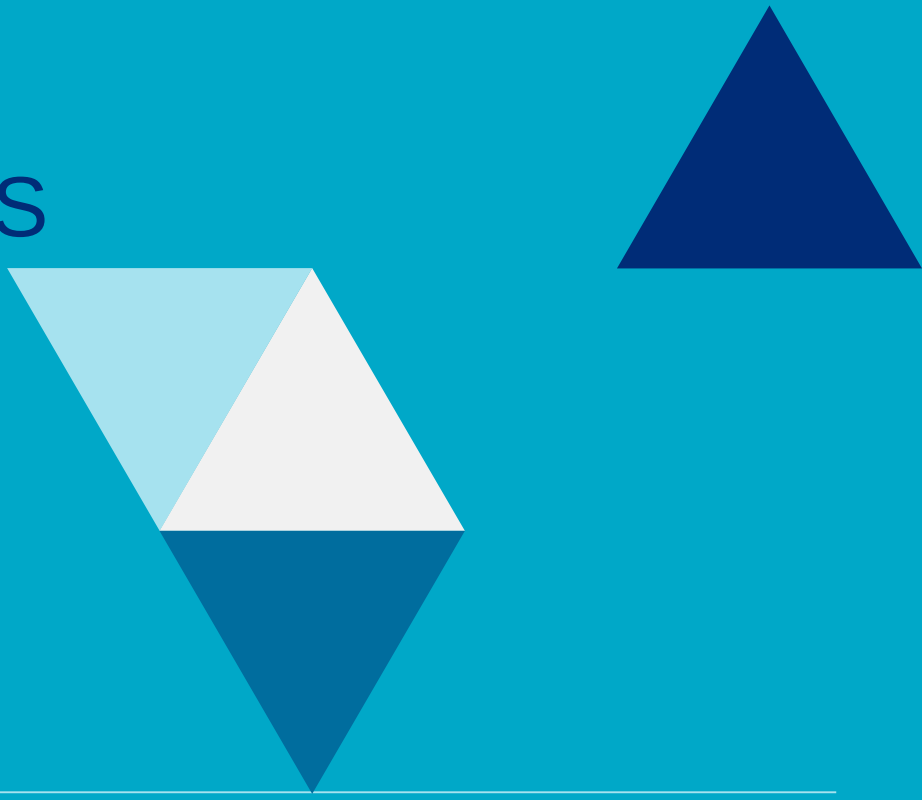
COMMUNICATION

DIRECTED AND CONTINUOUS

IMPLEMENTATION

MEDIUM

APPENDIX
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).

Attachment 3

REVIEWING THE PHARMACY LANDSCAPE

OCTOBER 15, 2019

Kendra Lofgren, R.Ph., B. Pharm.
West Market Pharmacy Lead

AGENDA

1 **PHARMACY MARKETPLACE**

2 **UPWARD PRESSURES ON DRUG PRICES & DRUG MIX**

3 **PHARMACY MANAGEMENT – BENCHMARKS & OPPORTUNITIES**

PHARMACY MARKETPLACE

MACRO TRENDS SHAPING PHARMACY TODAY

Market consolidation and expensive new drugs and treatments are driving cost

As plan designs shift cost to employees, some struggle to afford the healthcare they need

New solutions are flooding onto the market – but employee engagement remains elusive

The line between medical and pharmacy is blurring, making it imperative to manage care holistically across both benefits

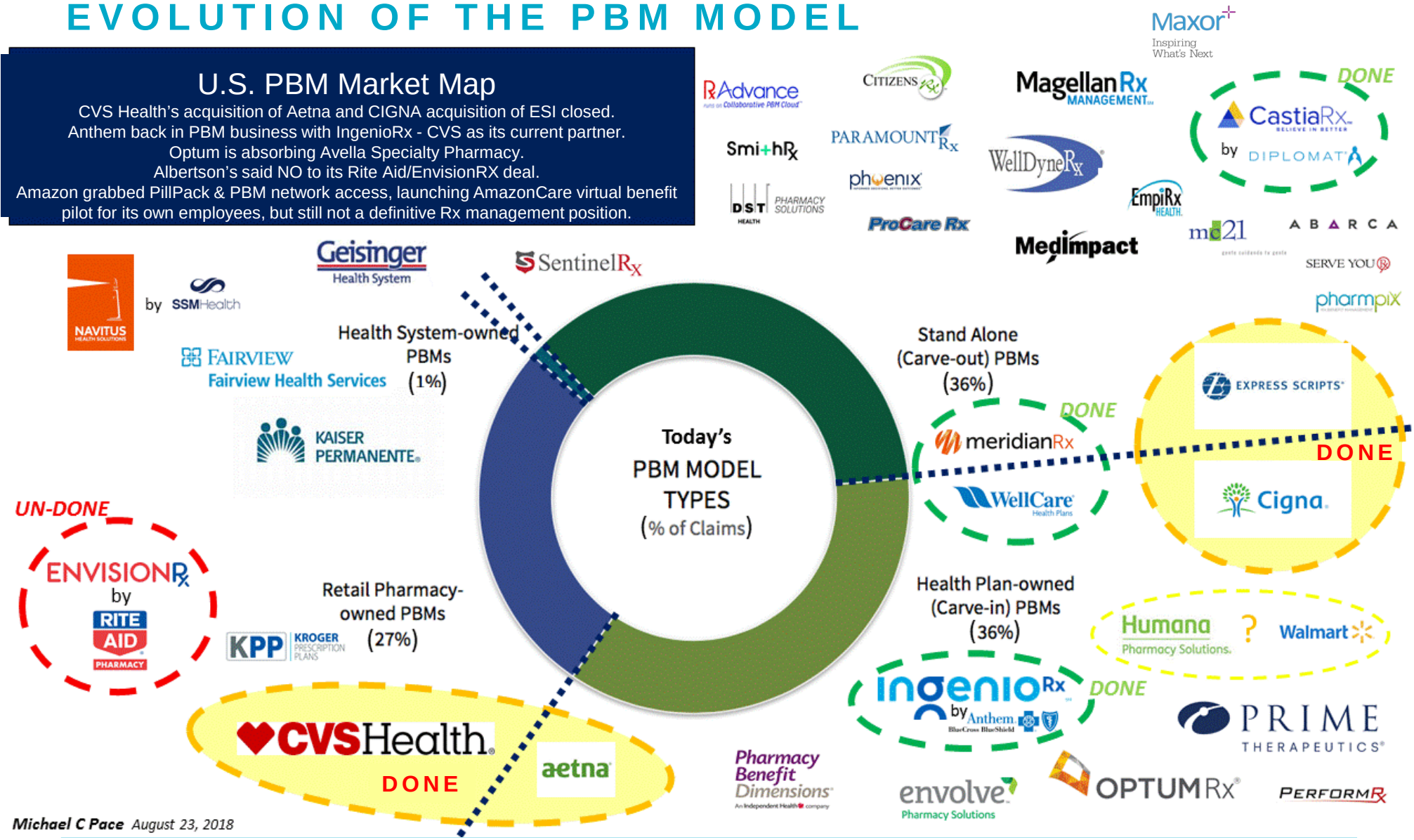
Today's on demand consumer may shift health trends towards connected care technology

Greater focus on the current rebate structure could lead to a change and may shift contract dynamics

EVOLUTION OF THE PBM MODEL

U.S. PBM Market Map

CVS Health's acquisition of Aetna and CIGNA acquisition of ESI closed.
Anthem back in PBM business with IngenioRx - CVS as its current partner.
Optum is absorbing Avella Specialty Pharmacy.
Albertson's said NO to its Rite Aid/EnvisionRX deal.
Amazon grabbed PillPack & PBM network access, launching AmazonCare virtual benefit pilot for its own employees, but still not a definitive Rx management position.



Michael C Pace *August 23, 2018*

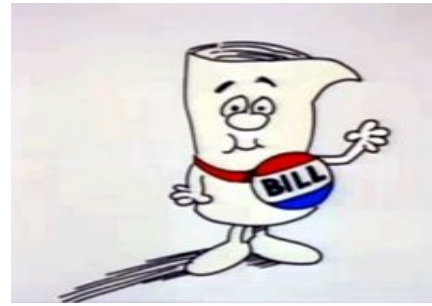
Adapted by Mercer *January 11, 2019*

KEY ISSUES IN PHARMACY TODAY

REBATE

- Scrutinizing the “Spread” model
- Rebate definition variations complicate savings interpretation
- Rebates may reduce cost but misalign incentives
- Interest to move away from rebate driven model
- Spread models do not always cost less

LEGISLATIVE



- Legislation may change the landscape
- Some bills may start a “world without rebates”
- Bills are focused on public sector but affect private as well
- PBMs responding slowly to public requests for change
- Some state Medicaid plans cancelling “spread” contracts
- Primary focus on reducing member costs

SPECIALTY

- Specialty is the biggest driver of H&B Spend
- 87% increase in claims over $1M in last 3 years
- Cost of new drugs may force a public/private partnership
- Medical Specialty Pharmacy spend and site of care aspects facing more scrutiny

HOT PHARMACY TOPICS IN THE NEWS

May 24, 2019

"FDA approves innovative gene therapy to treat pediatric patients with spinal muscular atrophy, a rare disease and leading genetic cause of infant mortality"

$2.1M drug to be launched in the United States

June 11, 2019

The United States Department of Health & Human Services' (HHS) adds HIV Pre-exposure Prophylaxis to ACA Preventive Items effective 7/1/2020.

New ACA HIV Prophylaxis coverage added for 2020

July 11, 2019

The United States Department of Health & Human Services' (HHS) proposal to restructure rebates is retracted.

No Rx rebate changes for now in the United States

August 26, 2019

Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury Dept. prepare FAQ to clarify prior policy release on Pharmacy Copay Card/Assistance Program requirements to accounting member cost share.

No enforcement of policy until 2021 NBPP ruling

THE PRESCRIPTION DRUG LANDSCAPE
MANAGING DRUG COSTS IN A DYNAMIC MARKETPLACE

KEY EMPLOYER CHALLENGES

PBM Market Consolidation

Rising Drug Costs

Specialty Pharmacy

Rebates

EMERGING TRENDS & ACTION OPPORTUNITIES

Evaluate Your Pharmacy Deal

Formulary & Utilization Management

Site of Care

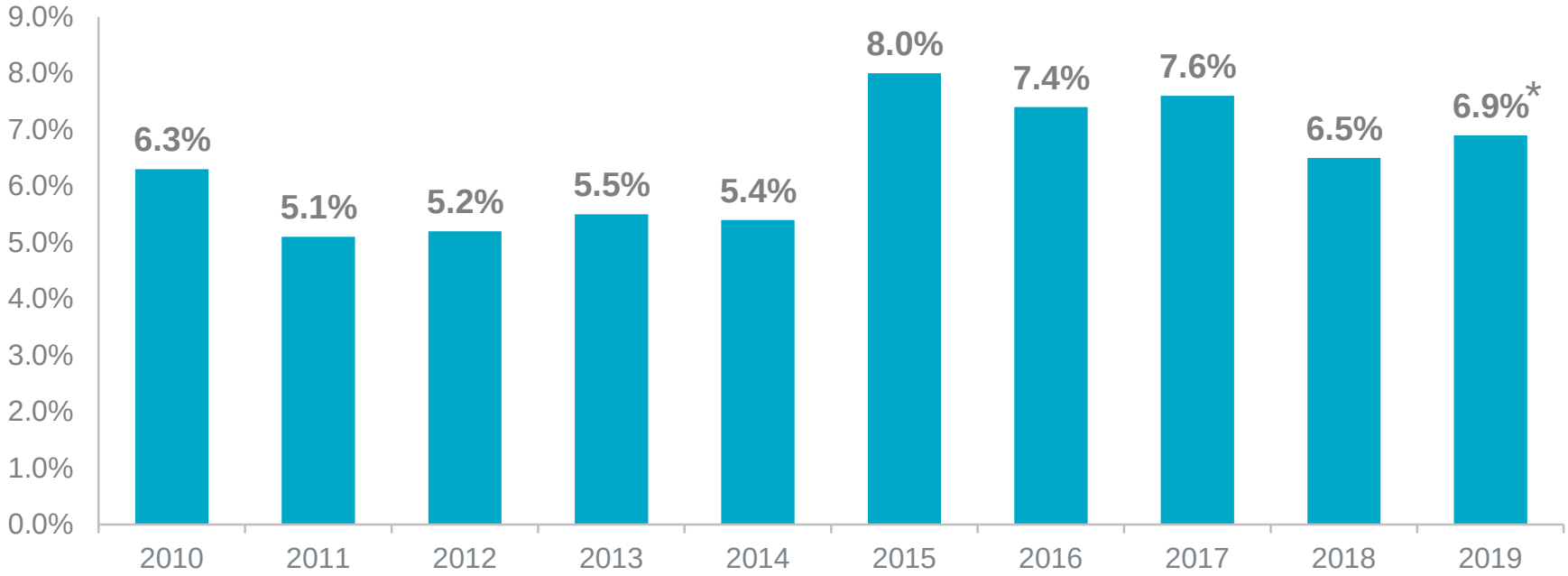
Evolving Payment Models

UPWARD PRESSURES ON DRUG PRICES & DRUG MIX

DRUG COSTS IN EMPLOYER HEALTH PLANS LOWER THAN PROJECTED FOR 2018

SPECIALTY DRUG MIX & COST IMPACT REMAINS KEY DRIVER OF EMPLOYER RX COSTS

2018 Specialty drug cost growth = 11.9%, down from 15.4% in 2017



Avg. annual change in prescription drug benefit cost per employee for employers with 500+ employees
Source: Mercer National Survey of Employer-Sponsored Health Plans

* Projected

SPECIALTY AND OTHER CHANGES DRIVING HIGH COST CLAIMANT SURGE

- ACA eliminates **lifetime maximums**

- **Rare diseases** are conditions that affect fewer than 200K people, but more than 7,000 rare conditions impact 30M Americans

  Source: National Institutes of Health

- From 2014 to 2017, 87% increase in number of members with **claims exceeding $1M** with some over $10M

  Source: Sun Life Financial, 2018 High-Cost Claims Report

- Material increase in use of stoploss coverage (including captives) to address new dynamic

INVESTMENT IN RARE DISEASES IS FUELING LARGER CLAIMS

59% Novel Drug Approval in 2018

58% **Drugs for Orphan Disease**

32% First-in-Class

24% Breakthrough Therapies

Source: FDA's Center for Drug Evaluation and Research, Advancing Health Through Innovation: 2018 New Drug Therapy Approvals Report

DRUG PIPELINE OVER THE NEXT 5 YEARS

75% Specialty Drugs

55% Biosimilar

30% Orphan Drugs

30% Priority Review by FDA

15% Breakthrough Therapy

Major Focus Areas:

- Cancer
- Hemophilia
- Alzheimer's
- Migraine Prophylaxis
- Liver
- Gene Therapy

SIGNIFICANT SPECIALTY MEDICATIONS APPROVED 2019 YTD

TREATMENT INDICATION	ANNUAL COST (EST.)
Plaque Psoriasis (Skyrizi)	$88K Year 1 $59K Maintenance
Cardiomyopathy (Vyndaqel)	$225K
Spinal Muscular Atrophy (SMA) (Zolgensma)	$2.1M No maintenance
Secondary Progressive Multiple Sclerosis (SPMS) (Mayzent)	$88K 1st oral therapy for indication
Advanced/Metastatic Bladder Cancer (Balversa)	$180K-$276K dose/duration dependent
Rheumatoid Arthritis (Rinvoq)	$59K

Annual costs based on estimated AWP and data on file

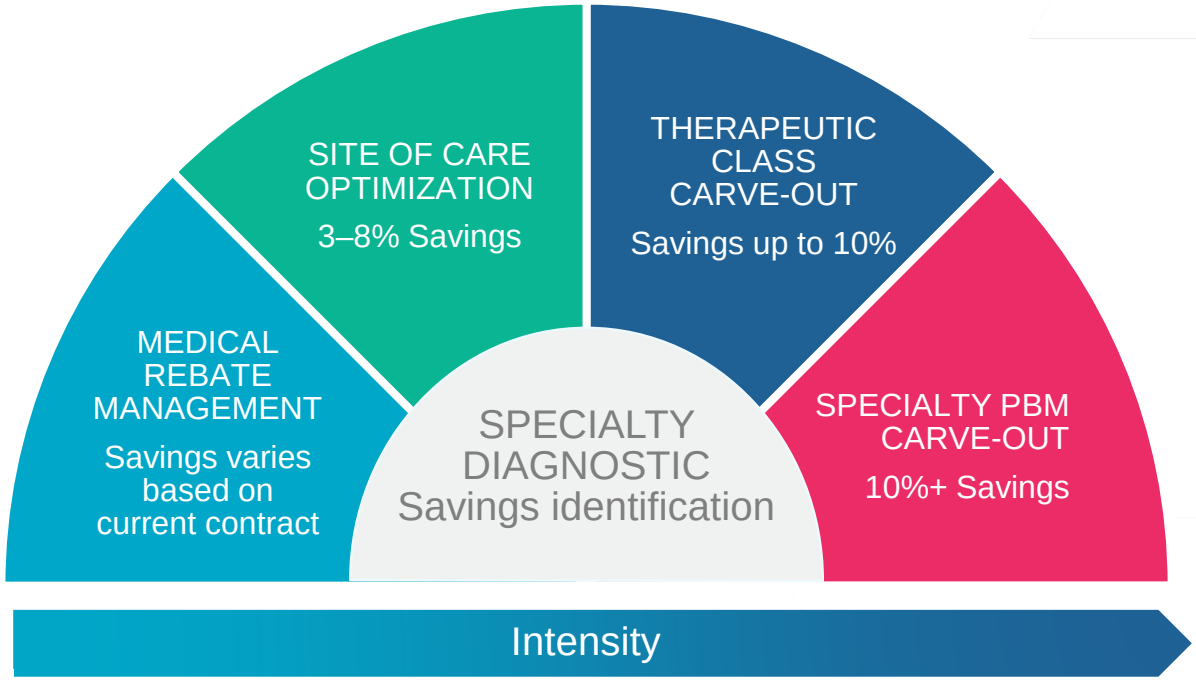
SELECTED RARE DISEASES- PIPELINE

TREATMENT INDICATION	Launch Estimate
Hemophilia A [SPK-8011]	2020
Hemophilia B [SPK-9001]	2020
Hemophilia B [AMT-061]	2020
Multiple Myeloma [bb2121CAR-T antiBCMA02 CAR]	2020
Hemophilia A [SB-525]	2022
Hemophilia A [SHP-654]	2022
Sickle Cell [LentiGlobin for SCD]	2022

ARE CARRIERS MORE AGGRESSIVELY MANAGING MEDICAL SPECIALTY DRUGS?

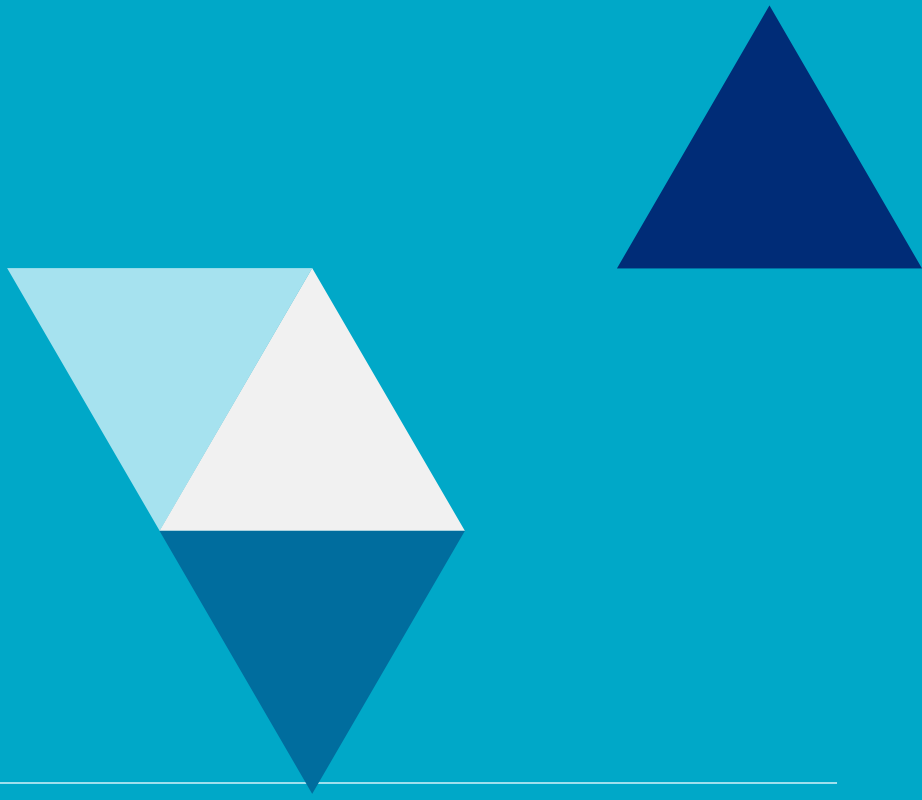
- Excluding drugs most appropriate for the pharmacy benefit
- Increased utilization management rules available
- Developing medical formulary
- Developing preferred specialty pharmacies to source certain drugs
- Implementing exclude at launch for new to market drugs
- Site of care management

MANAGING SPECIALTY PHARMACY SPENDING: A CONTINUUM OF APPROACHES

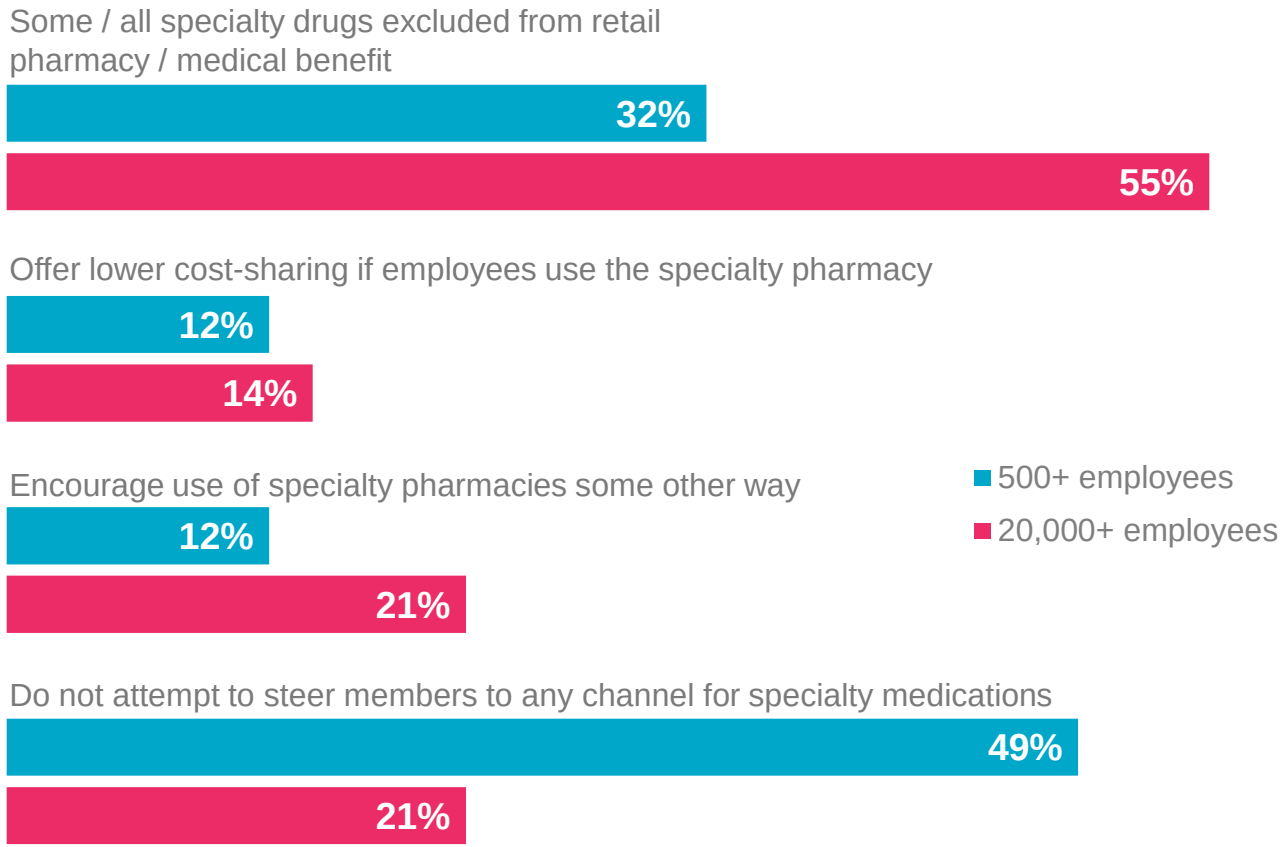


MERCER NATIONAL SURVEY OF EMPLOYER-SPONSORED HEALTH PLANS

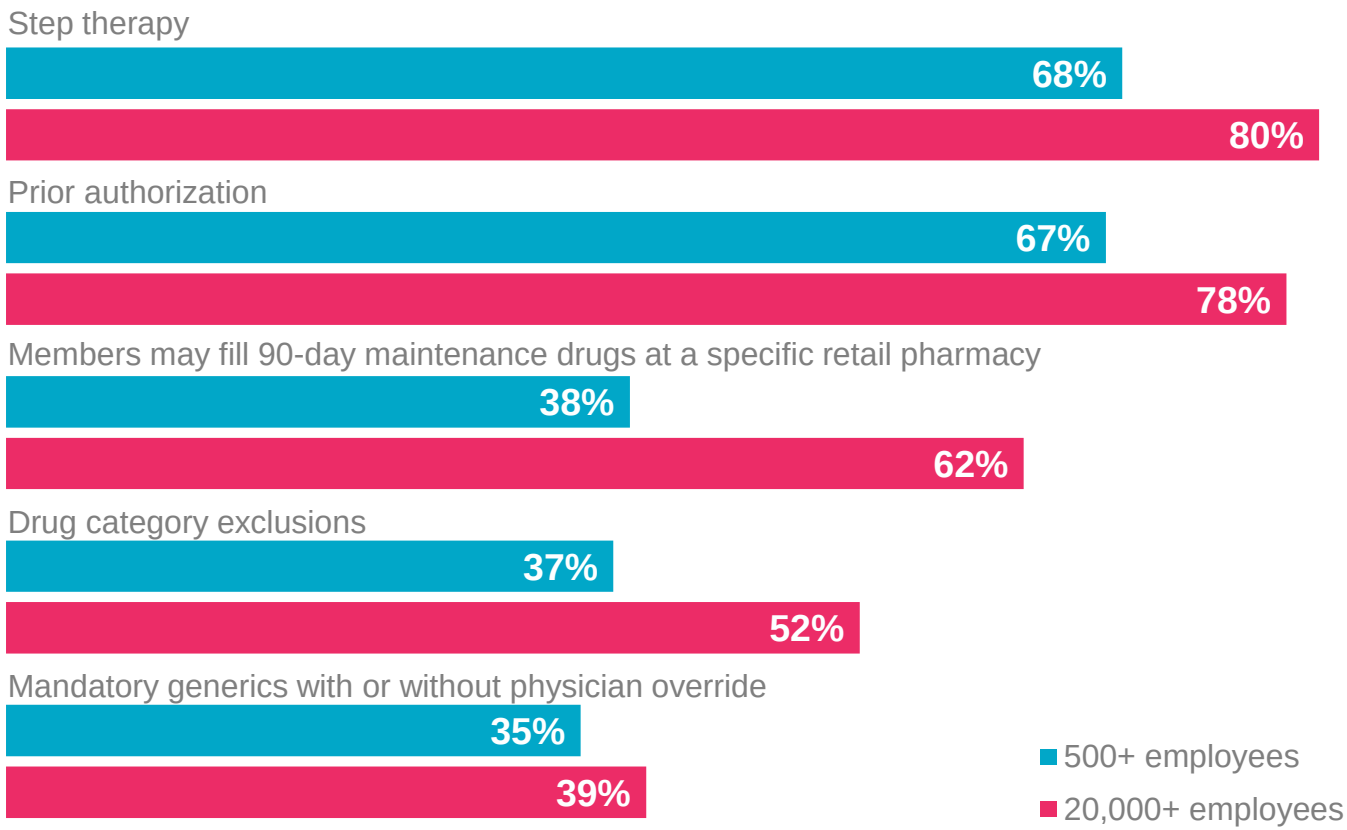
PHARMACY MANAGEMENT BENCHMARKS & OPPORTUNITIES



PLAN MEMBERS ARE ENCOURAGED TO USE A SPECIALTY PHARMACY



PRESCRIPTION DRUG PLAN COST MANAGEMENT FEATURES



STRATEGY FRAMEWORK
HOW TO ADDRESS THE ISSUES

FOCUS ON YOUR BIGGEST ISSUE

	OPPORTUNITIES	POTENTIAL SAVINGS
Supplier	• Pricing / Market Checks • Rebates	$ $ $
Drug	• Formulary • Utilization Management	$ $
Channel	• Site of Service Steerage • Coordination of Care	$ $ $ $
Care	• Benefit Design • Patient Assistance/Coupons	$ $


MERCER
MAKE TOMORROW, TODAY

KAISER PERMANENTE NORTHWEST

Pharmacy Services and Programs

PEBB Board Attachment 4

Tuesday, October 15, 2019

Presented by:
Keith Bachman, MD, PEBB Medical Director
Elizabeth Bentley, MSJ, PharmD, BCPS, Director, Clinical Pharmacy Services
Sunshine Sommers, MS, RPh, Manager, Clinical Pharmacy Services

KAISER PERMANENTE®

Agenda

Program Overview
Responses To Your Questions

KAISER PERMANENTE®

Program Overview

KAISER PERMANENTE®

Overview – Pharmacy Program

CLINICAL COORDINATION

Pharmacist clinical care team partners with physicians to maximize evidence-based care through direct patient interactions and clinical management

STRATEGIC PURCHASING & FORMULARY ALIGNMENT

Pharmaceutical contracting, benefit design and formulary alignment across all regions promotes quality outcomes and affordability

SEAMLESS MEDICATION MONITORING

Pharmacy and electronic health record integration allows seamless medication monitoring and tracking

EVIDENCE-BASED PRESCRIBING

Evidence-based guidelines and disease management protocols built into the HER to guide optimal prescribing

EXPERT FOCUS ON SPECIALTY DRUGS

National Specialty Pharmacy and subspecialist pharmacist and physicians leverage contracting and clinical monitoring to maximize outcomes and affordability

NATIONALLY RECOGNIZED LEADER
for quality, safety and service

Awarded Pharmacy
QUALITY ALLIANCE AWARD
8 years in a row

Named **TOP MAIL ORDER PHARMACY**
in J.D. Power Customer Satisfaction survey
8 times since 2009

Responses To Your Questions

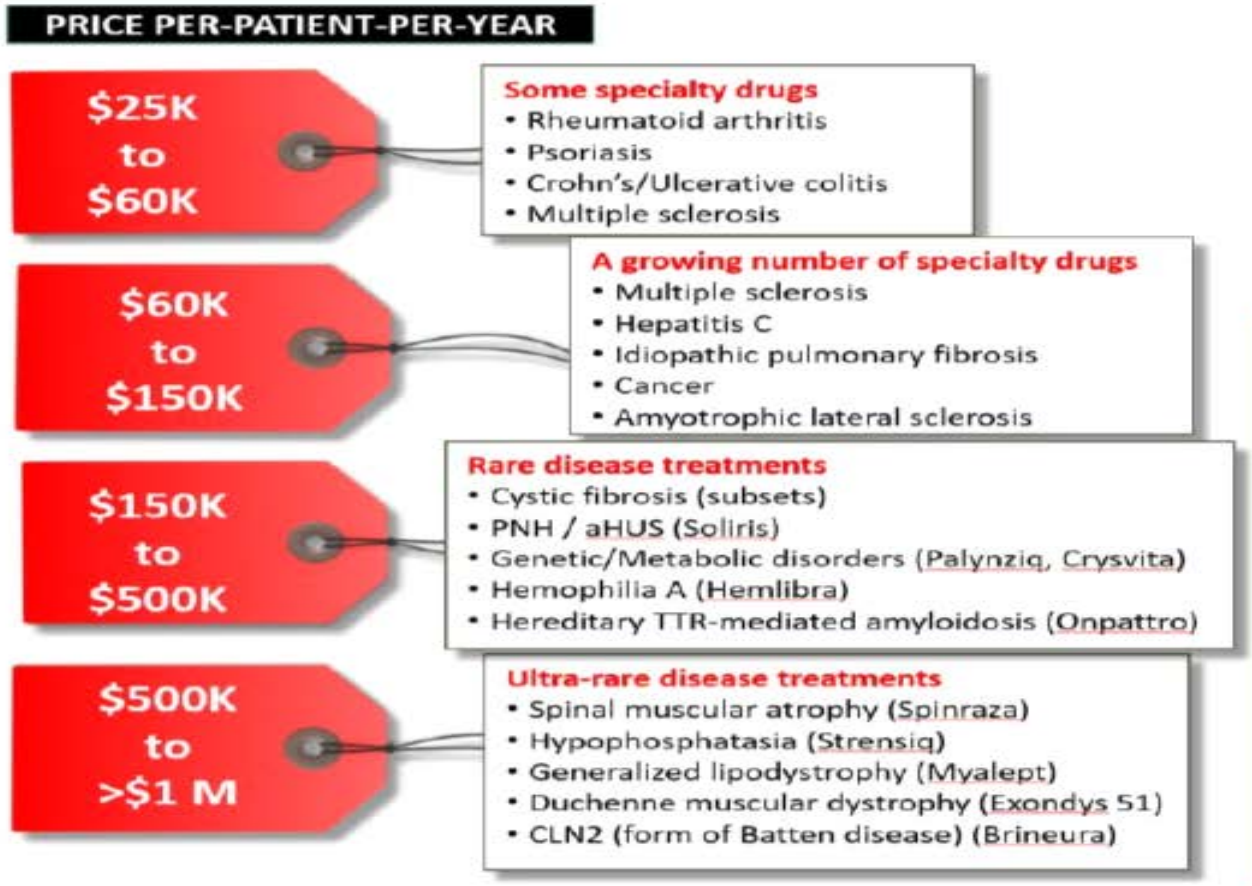
KAISER PERMANENTE®

1) Rx plan/program changes for 1/1/2020, as applicable

- No changes

Plan benefits	Traditional Plan	$250 Deductible Plan
Prescription drugs and supplies	$1 generic $15 preferred brand $50 specialty Mail order (31–90 day), $1 generic, $15 brand	$5 generic $25 preferred brand $50 specialty Mail order (31–90 day), $5 generic, $25 brand

2) Gene therapy coverage: medical vs. pharmacy considerations (e.g., member experience/cost share, patient assistance implications, etc.)



2017-2018 Gene Therapy Approvals

- **CAR-T therapy for cancer**
  - Kymriah: $475K + hospitalization costs
  - Yescarta: $373K + hospitalization costs
- **Gene therapy for rare inherited vision loss**
  - Luxturna: $850K + surgery costs

Gene Therapy Pipeline for 2019+

- Onasemnogene abeparvovec : Spinal muscular atrophy
- Lisocabtagene maraleucel: CAR-T therapy/cancer
- LentiGlobin: transfusion-dependent beta-thalassemia
- Lenti-D: cerebral adrenoleukodystrophy

PNH = paroxysmal nocturnal hemoglobinuria; aHUS = atypical hemolytic uremic syndrome;
CAR-T = chimeric antigen receptor T-cell ; CLN2 = late infantile neuronal ceroid lipofuscinosis type 2

KAISER PERMANENTE®

3) New ACA preventive HIV treatment coverage requirements for 7/1/2020

- Program is available through physician or self referral
- Managed through our HIV clinic
- Shared decision making is used to discuss risk vs benefits
- Rx: Truvada and Descovy (brand medications)
- Cost: $45 - $50/day

4) Opioid management—strategies, aligning treatment options, etc.

Proactive opioid management powered by integration

Care teams work together to provide effective pain relief without putting our members at risk for opioid-related complications.

KAISER PERMANENTE®

4) Opioid management—strategies, aligning treatment options, etc.

Opioid management policies protect members

- Limit opioid prescriptions overall
- Provide pain management alternatives
- Prescribe lower doses and shorter courses of opioid
- Help patients on opioid medications taper their use

Coordinated actions reduce risk

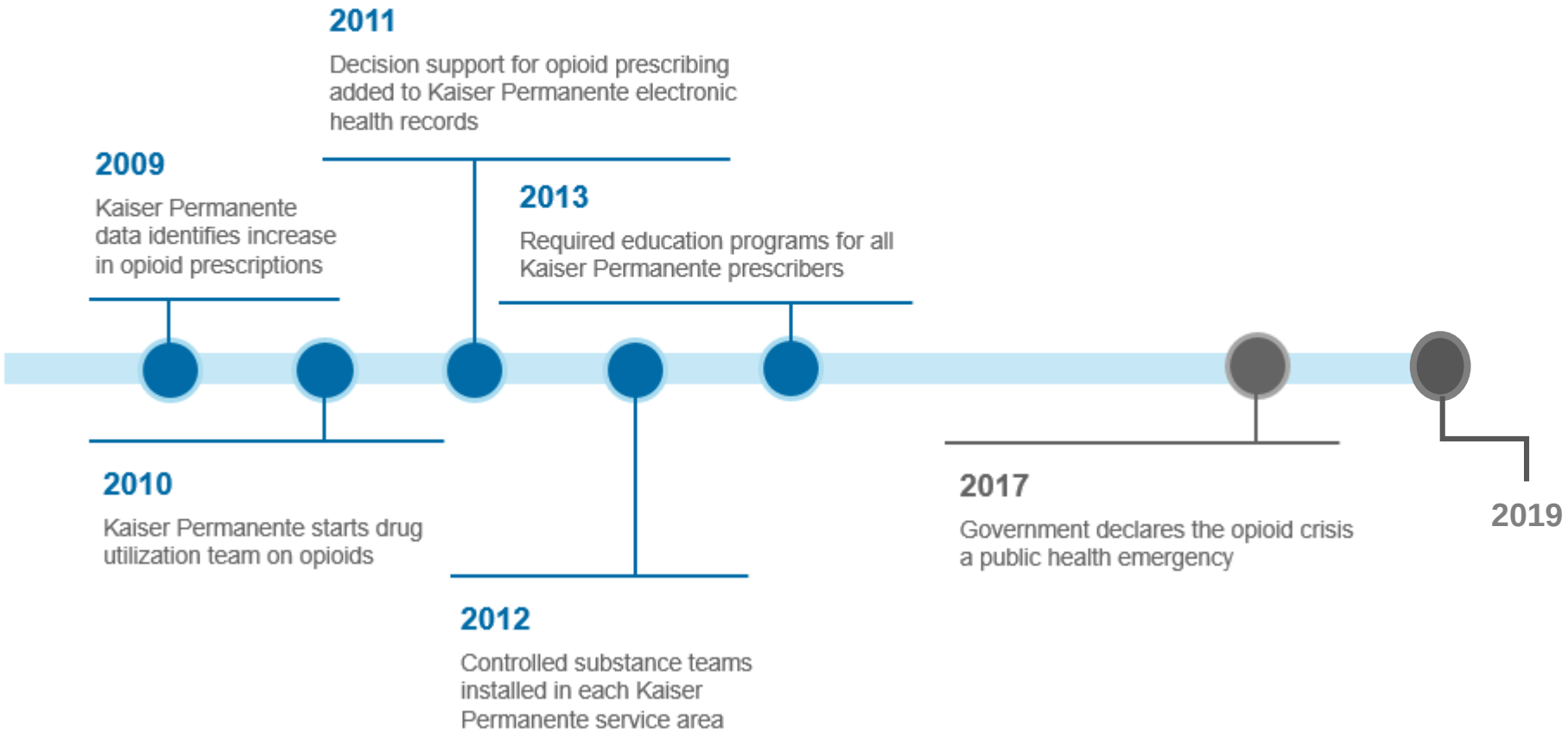
- Provider education
- Tapering programs
- Patient therapy plans
- Digital safety nets

Effective pain management alternatives

- Acupuncture
- Cognitive behavioral therapy
- Lifestyle changes (diet/exercise)
- Mindfulness, meditation and deep breathing
- Non-opioid pain medications
- Physical therapy

4) Opioid management—strategies, aligning treatment options, etc.

Early detection, fast implementation



KAISER PERMANENTE®

5) Member-facing programs to support appropriate utilization/site of care for PEBB

- Managed through our care model
  - ✓ Home Infusion
  - ✓ Outpatient Clinic
  - ✓ Nurse Treatment Room
- Protocols are built into our system

6) Managing specialty Rx cost and pipeline for PEBB

Evidence-based guidelines

Physician and pharmacist leadership

Team-based, coordinated approach

Proactive member education and support

Cost-effective purchasing and distribution

Benefit design and pricing – Maximize Use of **Biosimilars**

Outcomes measurement

Integrated pharmacy management

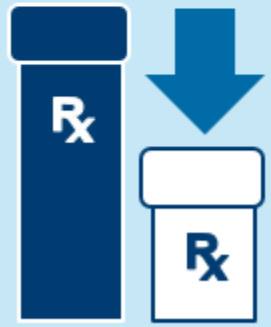
KAISER PERMANENTE®

6) Managing specialty Rx cost and pipeline for PEBB: Biosimilars

Biosimilars maintain quality while managing specialty drug costs

<2% of the U.S. population is treated with a specialty drug each year.[1]

50% of U.S. prescription drug spending is on specialty drugs.[2]



Biosimilars present an opportunity to cut specialty drug costs.

They cost up to

40% less

than the specialty drugs they mimic.[3]

[1]Mulcahy et al., *RAND Perspective*, 2017. [2]IQVIA Institute, May 2019. [3]Hayes, *Pharma Intelligence*, April 4, 2017.

KAISER PERMANENTE®

6) Managing specialty Rx cost and pipeline for PEBB: Biosimilars

Kaiser Permanente's fast implementation and high utilization of biosimilars

Nationwide, biosimilars are used less than 30% of the time when they're available.[1]

Our system enables us to have far better results — and the cost savings add up quickly.

Zarxio

More than **95% adoption** within 3 months vs. **60%** national average[2]

Inflectra

Approximately **80% adoption** in less than a year vs. **8%** national average[3]

Fulphila

Approximately **65% adoption** after 2 months

[1]IQVIA Institute, May 2019. [2]Statista, 2019. [3]Symphony Health, 2018.

6) Managing specialty Rx cost and pipeline for PEBB

Supporting the fight against high drug costs

We advocate on behalf of our 12.3 million members for government policies that drive down drug prices and bring new biosimilars to market.

> **"High drug prices impose a crippling burden on our members and our ability to carry out our mission. … It is past time for a new policy framework that fosters competition and prices patients can actually afford, while still rewarding innovation."**
>
> — Anthony Barrueta, Kaiser Permanente senior vice president of Government Relations, testimony to the U.S. House of Representatives, March 13, 2019.

KAISER PERMANENTE®

7) How drug manufacturers' coupons from the annual limitation on cost sharing is being handled

- Not applicable in our system

Thank you!

Moda Pharmacy Program

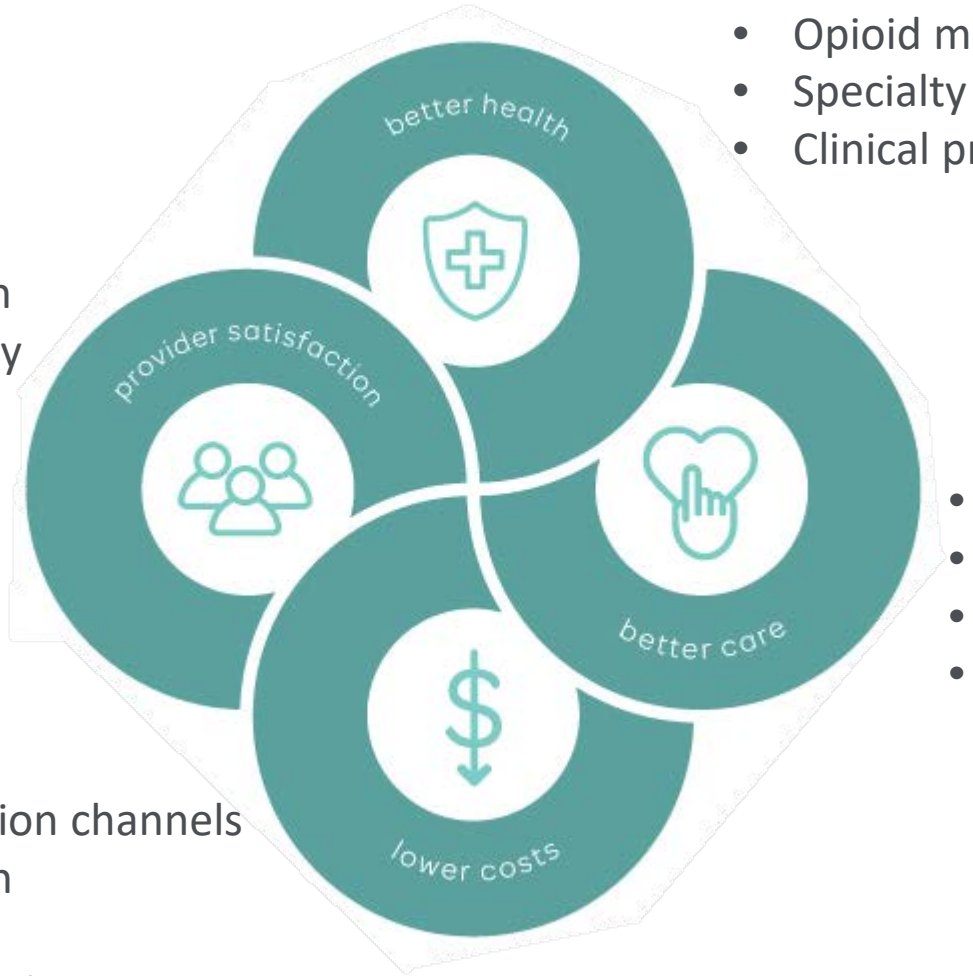
Carly Rodriguez, PharmD, FAMCP
Pharmacy Director, Clinical Innovation

moda

Program objectives

- High Performance Formulary
- Opioid management
- Specialty management
- Clinical programs

- Provider education
- Reduced administrative burden
- Coverage and cost transparency



- Member empowerment
- Member education
- Reduce barriers to care
- Coverage and cost transparency

- Preferred distribution channels
- 100% pass-through
- Group purchasing
- Annual market checks

High Performance Formulary update

Effective January 1, 2018

- Limits spending on low-value drugs that have less costly, but equally safe and effective alternatives
- The Moda P&T Committee reviews and determines which medications are included on formulary based on clinical evidence
- Projected **10% savings** on drug spend in 2019

Opioid management – state efforts

- Oregon Health Authority
  - Performance Improvement Project (PIP) for Opioid Safety
    - Reduce prescribing of high morphine equivalence dosing (MED)
  - Health Evidence Review Commission (HERC)
    - Opioids for conditions of back and spine
    - Manage day supply for acute use and implement taper plan for chronic use
  - SUPPORT Act
    - Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment
    - Opioid prescription limits for quantity and MED prescribed for acute treatment; concurrent use of opioid with benzodiazepine or antipsychotic
- Washington Healthcare Authority
  - Clinical policy
    - Opioid prescription limits quantity of opioids prescribed for acute and chronic treatment of non-cancer pain

Opioid management – Moda approach

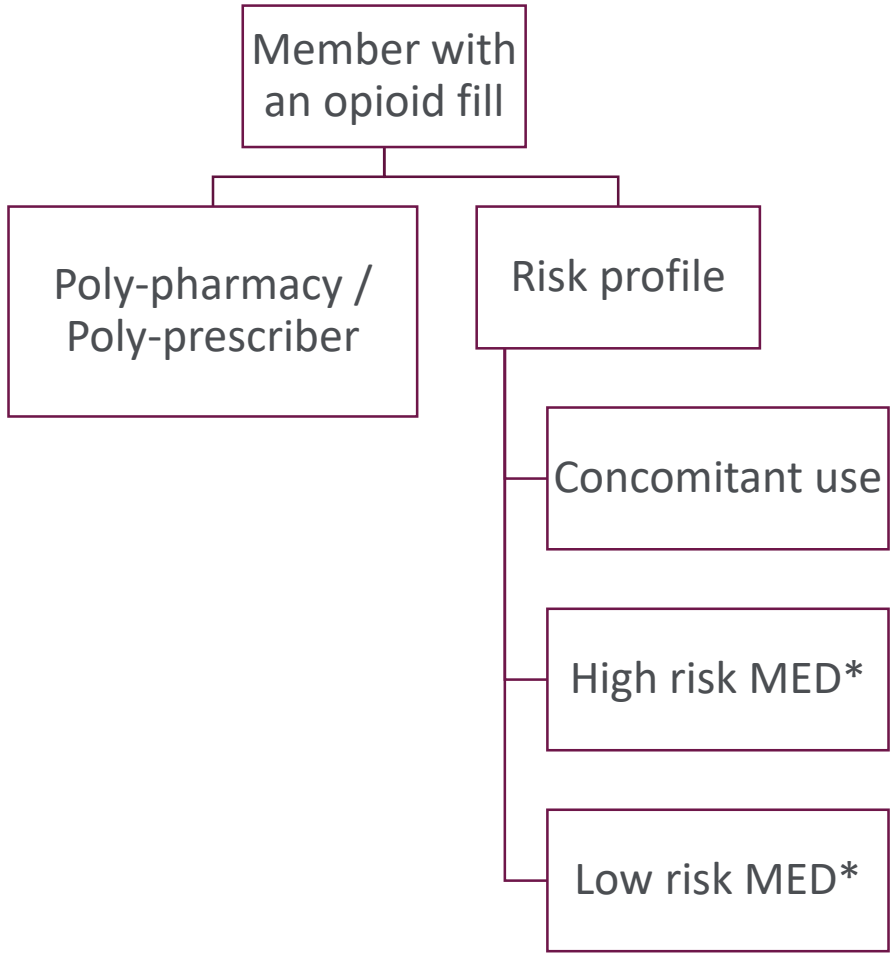
- Members are stratified based on risk level. High risk categories include:
  1. Poly-pharmacy/poly-prescriber: increased risk factors of diversion
  2. Concomitant use with benzodiazepines: 3.7 fold increase in overdose compared to opioid alone
  3. High MED (90+ morphine equivalence dose): 30-fold increase in opioid use disorder compared to no opioid utilization

Year	Acute	Concomitant Use	High MED*	Low MED*	Poly – Pharmacy Poly – Prescriber
2017	94.62%	2.28%	1.55%	0.93%	0.62%
2018	95.26%	1.77%	1.20%	1.45%	0.24%
Jan – Aug 2019	94.96%	1.50%	1.33%	2.12%	0.00%

All data is specific to OR PEBB members.
**MED: Morphine Equivalence Dose*

Opioid management – Moda approach

- From 2017 to 2019, OR PEBB:
  - **100% decrease** in poly-pharmacy and poly-prescribing (4+ pharmacies and 4+ prescribers)
  - **34% decrease** in concomitant opioid and benzodiazepine utilization
  - **15% decrease** in high risk opioid prescribing (90+ MED)
  - **128% increase** in low risk opioid prescribing (< 90 MED)
  - **0.4% increase** in acute opioid prescribing (< 90 days of use)

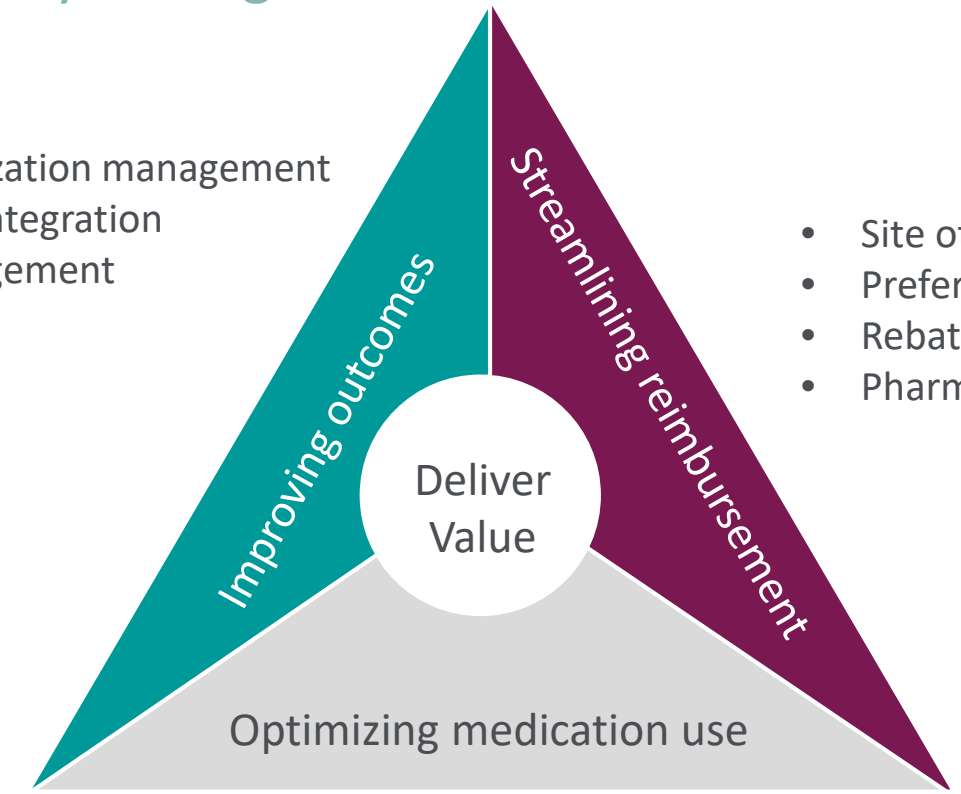


**MED: Morphine Equivalence Dose*

Specialty management – clinical programs

Medical pharmacy management model

- Evidence-based utilization management
- Medical-pharmacy integration
- Key condition management



- Site of Care program
- Preferred distribution channels
- Rebate management
- Pharmacy Benefit Optimization program*

* 1/1/2020 implementation

- Medical Dose Optimization program
- Drug Wastage program
- IVIG Weight Based Dosing program

Specialty management – cost and pipeline

- Pre-approval clinical review
- Embrace biosimilars
- Gene therapy: Centers of Excellence, utilization management, outcomes-based agreements with manufacturers
- Partnership with Ardon Health, our preferred specialty pharmacy
  - Financial assistance programs applied once prior authorization is approved, based on medical necessity
  - Accumulators: Automated Accumulator and Variable Copay programs
  - Clinical and medication support

Specialty management – Ardon Health

Operational excellence

- Integrated & invested relationships
- Experienced benefit investigation
- Quick therapy starts

Financial assistance*

- 90.4% of specialty fills
- Average assistance per fill: $98
- Average member cost per fill: $4

*Once PA approval is granted based on medical necessity, financial assistance provided

Medication support

- Adherence management
  92% vs. 80% standard
- Proactive refill calls
- Replacement support

Clinical support

- Integration into care delivery team
- NW provider insight and coordination
- Clinical intervention for 1 in every 2.2 fills
- Side effect management

Future considerations

- Implementation of pre-exposure prophylaxis (PrEP) as a preventative service
  - Required for plan years beginning on or after 7/1/2020
- Expand Site of Care scope to include oncology and supportive oncology medications
- Hemophilia strategy: Centers of Excellence, dose assessment, preferred products
- > 30 day fills for select specialty medications
- Rheumatoid Arthritis Dose Optimization pilot program
  - TNFα inhibitor (e.g., Humira, Enbrel) dose reduction for members in remission
- Opioid point-of-service dose limits

Questions?

PROVIDENCE Health Plan

PEBB Pharmacy Update

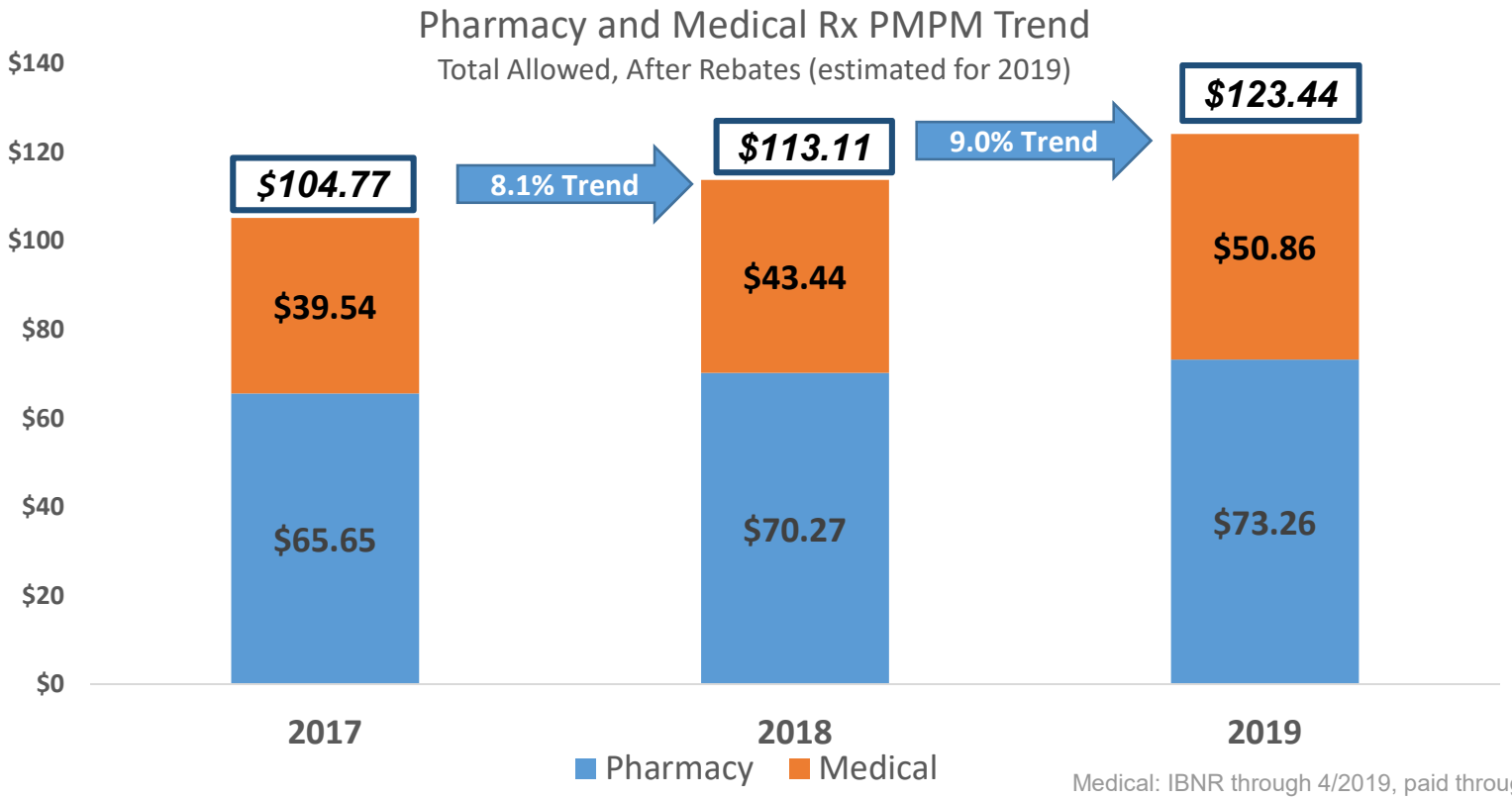
October 15, 2019

Helen Noonan-Harnsberger, PharmD, AVP Pharmacy Division
Heidi Chinwuba, PharmD, BCPS, BCACP, Clinical Pharmacy Manager

Today's Discussion

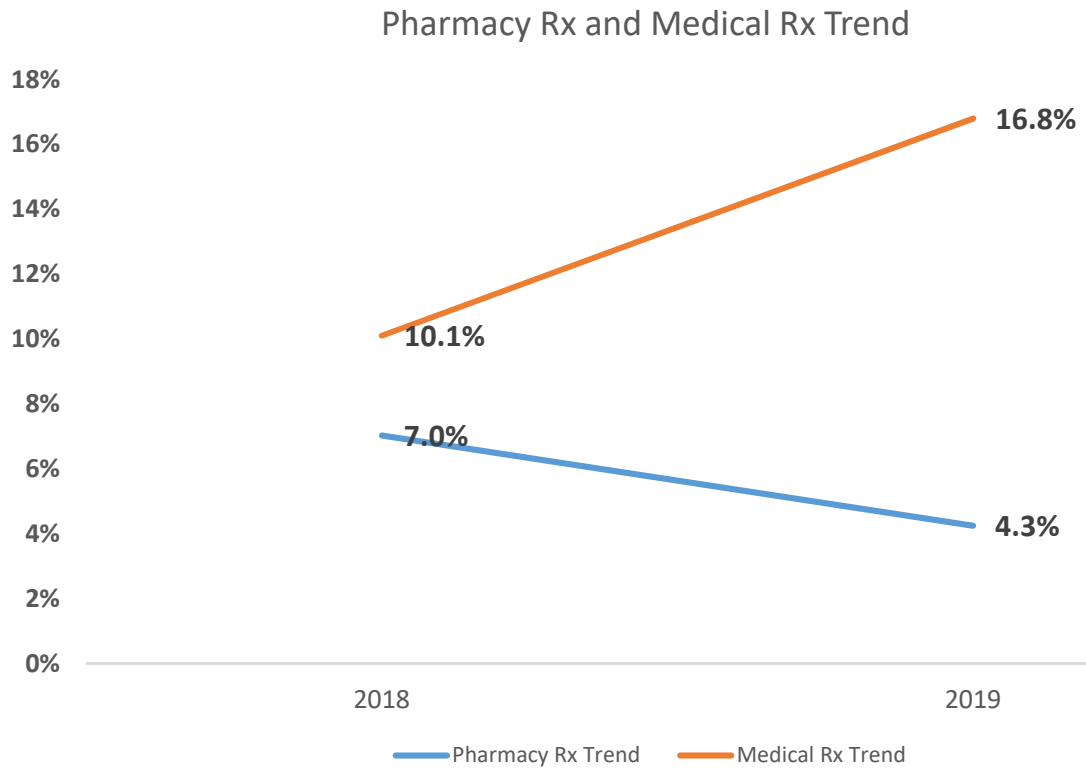
1	• Plan Performance
2	• Site of Service
3	• Specialty: Gene Therapy, Pipeline
4	• Opiates
6	• HIV PrEP
7	• Co-pay coupons & Accumulators
8	• 2020 Program Changes

Combined pharmacy and medical Rx trend



Medical: IBNR through 4/2019, paid through 6/2019
Pharmacy: Incurred and paid through 6/2019

Medical Rx trend driving costs

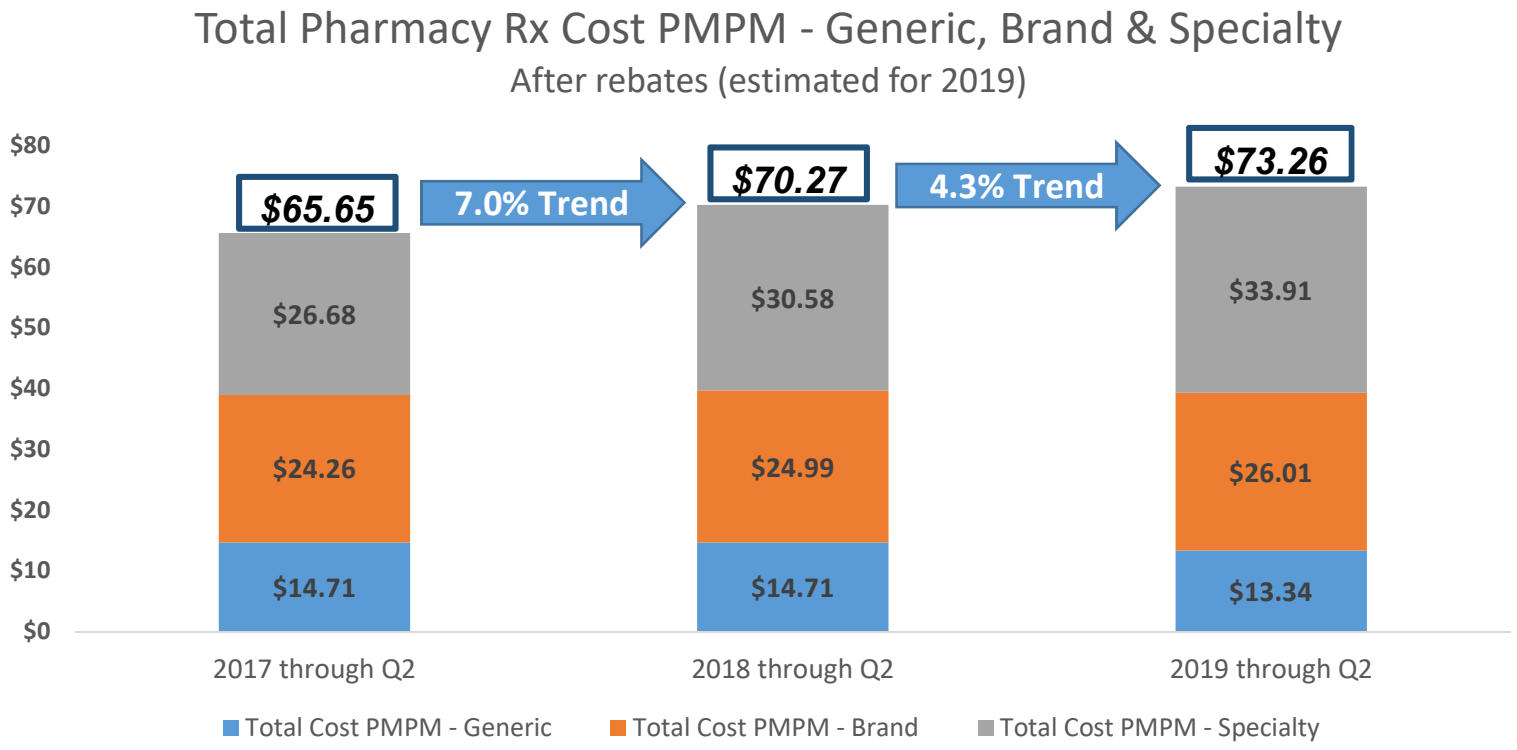


Outlook

Majority of new medications in the pipeline are medical drugs used to treat (and possibly cure) rare conditions.

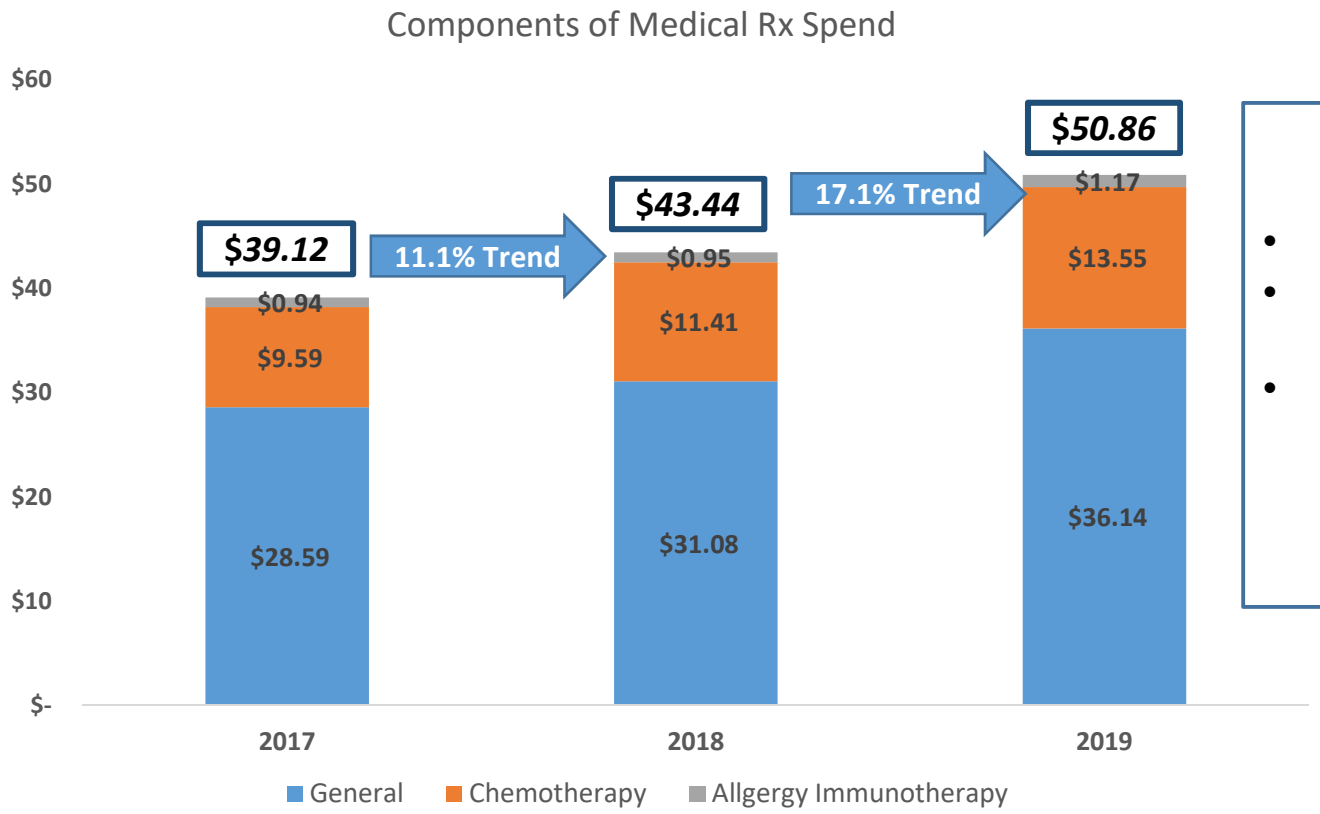
PHP has developed programmatic solutions to ensuring access at an affordable price for these novel therapies

2019 Pharmacy Rx trend with slower growth as compared to 2018



Incurred and paid through 6/2019

Medical Rx trend driving majority of cost increases for PEBB

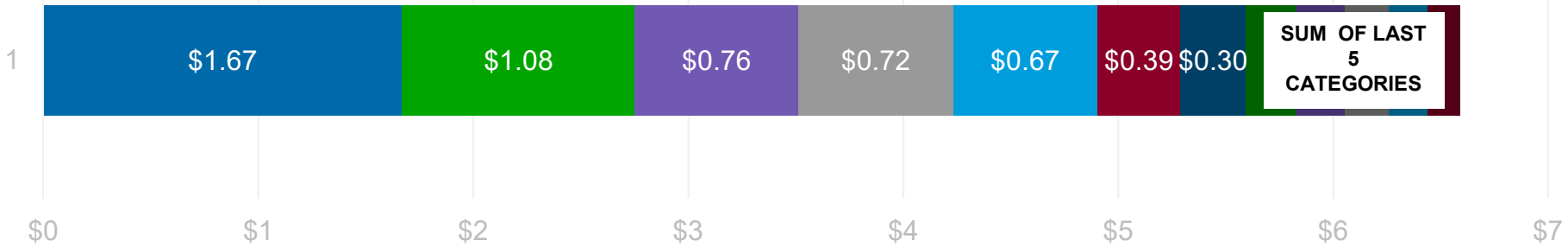


Medical Rx Trend Management

- Dose optimization
- Unit cost management
  - Carve out contracts
- Site of care
  - Provider office *vs.*
  - Outpatient infusion center *vs.*
  - Home infusion

Primary drivers of medical Rx trend

PMPM costs for MS drugs represents 18% of the overall increase in medical Rx trend, and is driven primarily by increased utilization of newer agents for primary progressive MS.



- Ocrelizumab (MS)
- Idursulfase (Hunter's Syndrome)
- Vedolizumab (Crohn's Disease, Ulcerative Colitis)
- Pegfilgrastim (neutropenia - CA care)
- Rituximab (Cancer, RA)
- Lumizyme (Pompe disease)
- Hizentra (primary immunodificiency)
- Aflibercept (macular degeneration)
- Natalizumab (MS)
- Tocilizumab (RA)
- Golimumab (PsA, UC, Crohn's, AS)
- Omalizumab (Asthma)

Chart represents drugs driving 90% of medical cost increases
IBNR through 4/2019, paid through 6/2019

Member Facing Programs: Site of Care

Site of Care

- **Voluntary Program**
  - Transition to lower cost site of care, such as home infusion when clinically appropriate
    - High cost infusions
    - Hemophilia
  - All eligible members and providers are contacted by specialty team, personally
- **Mandatory Program – 2020**
  - Prior Authorization on site of care
  - Expansion of home infusion network to support

If the medication is administered by a healthcare provider, it falls to the medical benefit, even if dispensed by specialty pharmacy. PHP always ensures procurement via lowest net cost channel.

Member Facing Programs

Tailored clinical case review

- May involve medical director, clinical pharmacist specialist, prescriber, care management, and specialty pharmacy

- High cost or high clinical touch cases

- Review for optimizing dose and/or opportunities for lower cost therapeutic alternatives
    - Clinical intervention to improve outcomes

Managing Specialty Pharmacy Cost

2019 PEBB Savings (new interventions through 8/2019): $1.55 million

- **Population Management**
  - Evidence-based policy development
    - Prior auth
    - Quantity limits
  - Disease specific management programs
- **Member Specific Management**
  - Site of Care
  - Tailored clinical case review
  - Dose Optimization
  - Carve Outs
  - Alternative Procurement
  - Adherence

Pipeline Management

PROVIDENCE Health Plan

- Forecasting & modeling
  - Development of UM strategies prior to product market launch
- Manage both pharmacy and medical benefit - integration
  - Prior Authorization
  - System edits
  - Medical rebates
  - Site of Service
- Unique reimbursement strategies
  - Carve out contracts/single case agreements
  - Value based agreements
  - Close alignment with providers

FDA STATEMENT

Statement from FDA Commissioner Scott Gottlieb, M.D. and Peter Marks, M.D., Ph.D., Director of the Center for Biologics Evaluation and Research on new policies to advance development of safe and effective cell and gene therapies

Share | Tweet | LinkedIn | Email | Print

For Immediate Release: January 15, 2019

Statement From: Commissioner of Food and Drugs - Food and Drug Administration
Scott Gottlieb M.D.

The FDA is witnessing a surge of cell and gene therapy products entering early development, evidenced by a large upswing in the number of investigational new drug (IND) applications. Based on this activity, we anticipate that the number of product approvals for cell and gene therapies will grow in the coming years, reflecting significant scientific advancement and the clinical promise of these new innovations.

We anticipate that by 2020 we will be receiving more than 200 INDs per year, building upon our total of more than 800 active cell-based or directly administered gene therapy INDs currently on file with the FDA. And by 2025, we predict that the FDA will be approving 10 to 20 cell and gene therapy products a year based on an assessment of the current pipeline and the clinical success rates of these products. During this period without a FY19 appropriation for FDA, we've been focused on making sure that we continue critical aspects of our work, to the extent permitted by law. At this time, for products covered by a user fee program, including cell and gene therapy products, our review of existing medical product applications and associated policy development is funded by limited carryover user fee balances. We'll continue to update the public on how we're approaching our work.

We're working to expand our review group dedicated to the evaluation of these

Jan. 15th 2019

PROVIDENCE Health Plan

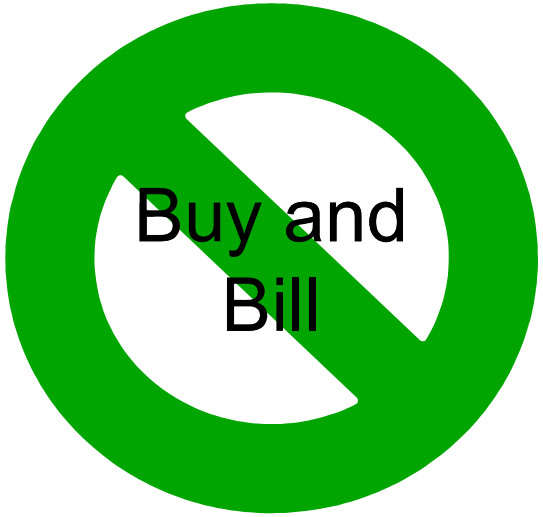
"We anticipate that **by 2020 we will be receiving more than 200 INDs per year**, building upon our total of more than 800 active cell-based or directly administered gene therapy INDs currently on file with the FDA."

"…By 2025, we predict that the **FDA will be approving 10 to 20 cell and gene therapy products a year** based on an assessment of the current pipeline and the clinical success rates of these products."

Gene Therapy

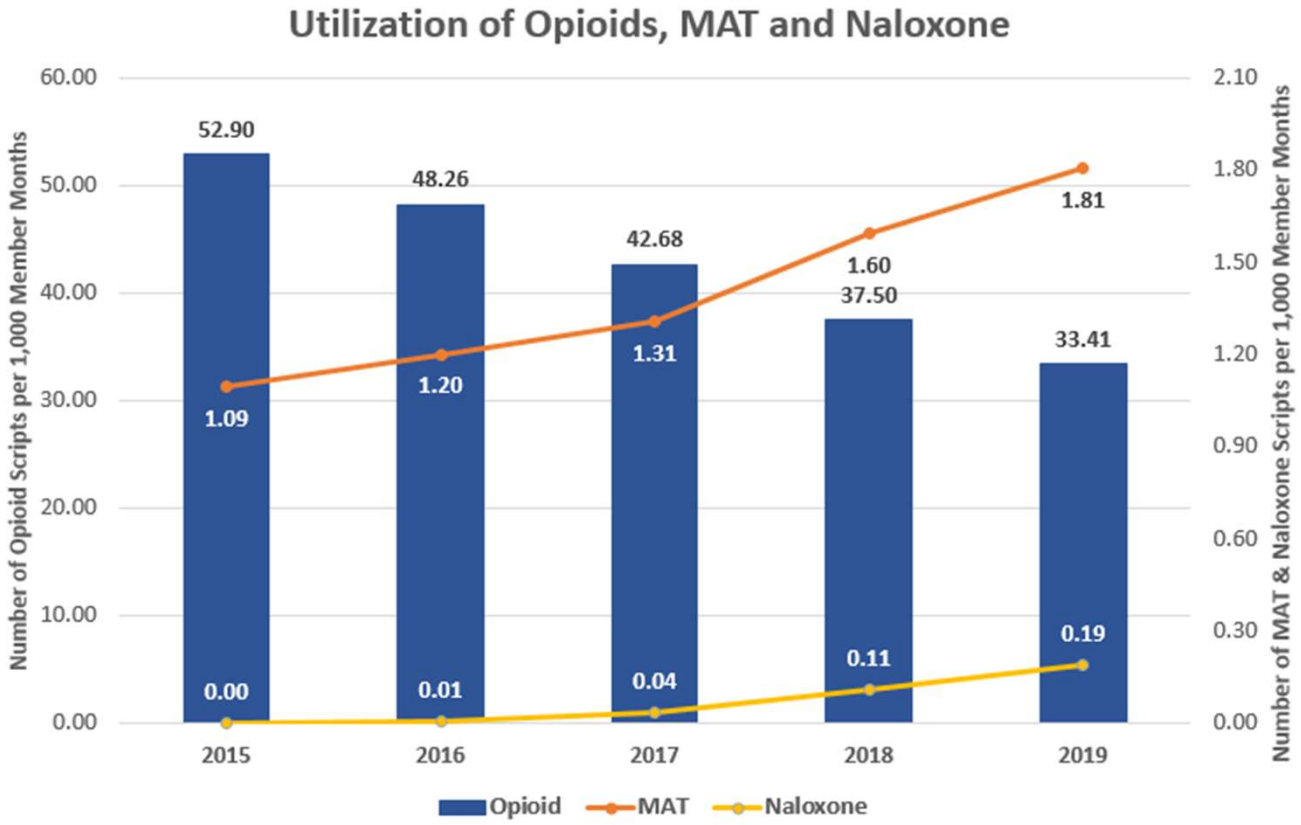
Hemophilia and spinal muscular atrophy treatments could be impactful for the PEBB population

- Pre-launch planning
- Rigorous, evidence based clinical criteria for approval
- Alternative payment methodology
  - Carve out contracts
  - Annuity payments
  - Outcomes based agreements
- Healthcare provider administered = medical benefit



Opiate trends over time

PEBB Choice + PEBB Statewide combined



Opiate management

PROVIDENCE Health Plan

Utilization Management Tools	Member and Provider Outreach	Safety
• Duplicate therapy edit • Opiates + benzodiazepines • Cumulative dose > 90 MME • Quantity limits • Prior Authorization	• Targeted member and provider letters • Individual case management upon provider request	• 7-day initial supply limit • Overdose: unrestricted access to preferred naloxone products • MAT: Unrestricted access to preferred buprenorphine products • Pharmacy lock-in program • FWA monitoring and detection

Pain Education, Behaviorists, Social support, Team Approach

HIV Pre-exposure Prophylaxis (PrEP)

PrEP added to ACA preventive list

- PrEP covered 100% under ACA preventive benefit
- PrEP has substantial benefit for decreasing risk of HIV infection in persons at high risk of HIV infection
  - Sexual acquisition
  - Injection drug use
- Implementation across all commercial lines of business by 6/1/2020
- Truvada and Descovy FDA approved for PrEP; Viread (generic) is CDC-recommended alternative.
- Generic Truvada (single source) launch projected for 9/30/20 with multiple generics launching 3/29/21.
- Descovy and Viread have some limitations for patient selection.

HIV Pre-exposure Prophylaxis (PrEP) – cont.

PEBB - current use and 2020 projected use/cost of PrEP

		# PEBB patients (est)	% total population	PEBB PMPM cost
	Total PEBB population 2018	101,500	---	---
	PEBB use and cost of PrEP 2018 (Truvada, no HIV dx) - **actual**	108	0.11%	$ 0.68
2020 PROJECTIONS	If PEBB USE matched CDC estimated PrEP treatment in US, 2016	132	0.13%*	$ 0.91^
	If 30% increase PEBB (increased rate of use measured by CDC 2017 to 2018)	140	0.14%	$ 1.00^
	If PEBB use rate at CDC estimated total PrEP opportunity in US population, 2015	426	0.42%	$ 2.19^

* Estimated age >/= 15

^ 2020 projected cost: Truvada w/ 9% inflation over next 12 months and 20% generic discount starting 10/2020; excludes Descovy

Drug manufacturer coupons and copay cards

PROVIDENCE Health Plan

PHP is generally

neutral regarding Rx coupons and copay savings cards

- PHP accepts and applies coupon/savings cards for out-of-pocket costs for patients in commercial plans.
- PHP has not deployed and has no plans to deploy copay accumulators or maximizers.
  - Federal law has some restrictions on accumulators; recent guidance from HHS conflicts with IRS guidance for HDHPs
  - HHS will issue updated guidance this fall

Program Changes

- Formulary Removals
  - Oxycontin®
- Opiates
  - 90 MME hard edit at point-of-sale
- New UM programs in development
  - Diabetes
  - Psoriasis

OPDP
Oregon Prescription Drug Program

PEBB Board Meeting

10/15/2019

Oregon Health Authority

Trevor Douglass; Heidi Murphy; Chandra Wahrgren

Outline

- Historical roadmap of OPDP
- Our Commitment to Excellence
- Success
- The Details
  - Market Check
  - Transparency
  - Pricing Models
- What has OPDP done for PEBB lately?

History

2003

OPDP was established – Oregon's only prescription drug purchasing pool.

2006

OPDP joined with the Washington Prescription Drug Program (WPDP) to form the Northwest Prescription Drug Consortium to pool drug purchasing and bring the best price to participants.

2007-08

Moda Health selected to administer the Consortium program and expand participation. Consortium launches with Washington's Public employees and Oregon's Educators Benefits Board.

2010

Consortium expands scope of services with new RFP to include Medicaid, Medicare, GPO and 340B programs. Moda Health selected to administer program.

2013

OPDP launches GPO program to include Traditional and Non-Traditional non-profit entities.

2015

Through passage of Oregon House Bill 2638, Medicaid received authorization to join OPDP. Any Medicaid Health Plan can elect to use OPDP's programs and contracts to better manage their program costs.

2016

Consortium extends current agreement with Moda through 2021.

2017

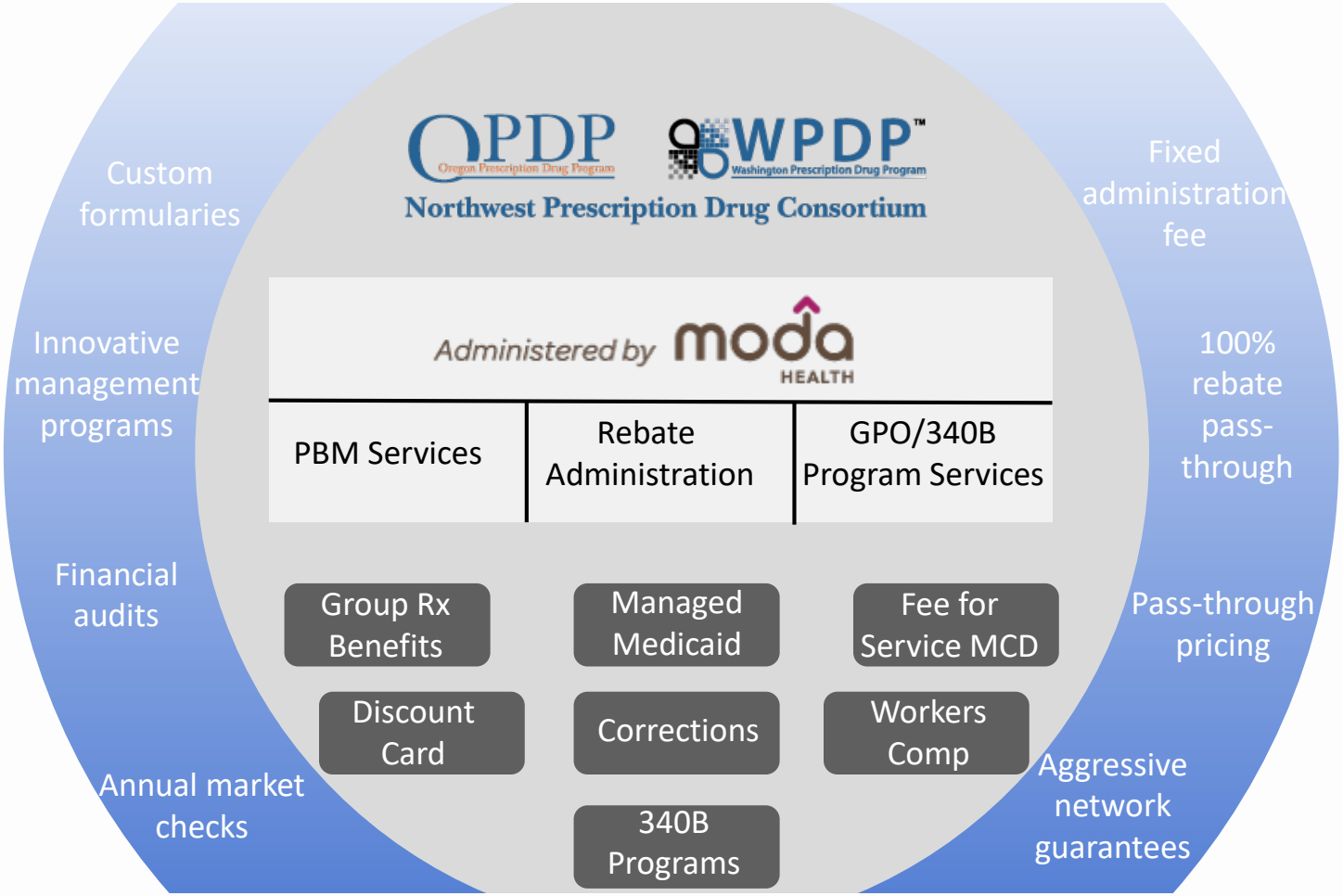
Eastern Oregon CCO joins Consortium, adding Managed Medicaid as a participant in program.

2018

Consortium facilitates more than $800 million in annual drug purchases for over 1 million people in participating groups and facilities.

Northwest Prescription Drug Consortium

Over 1 million lives enrolled



Success

1. For the past three years we have solidly out-performed our already competitive contracted rate guarantees.
2. We conduct a third-party market check and benchmarking to ensure the delivery of a competitive product.
3. We require verifiable transparency for our participating programs.
4. We remain committed to delivering innovative solutions across our program offerings.

Market check-overview

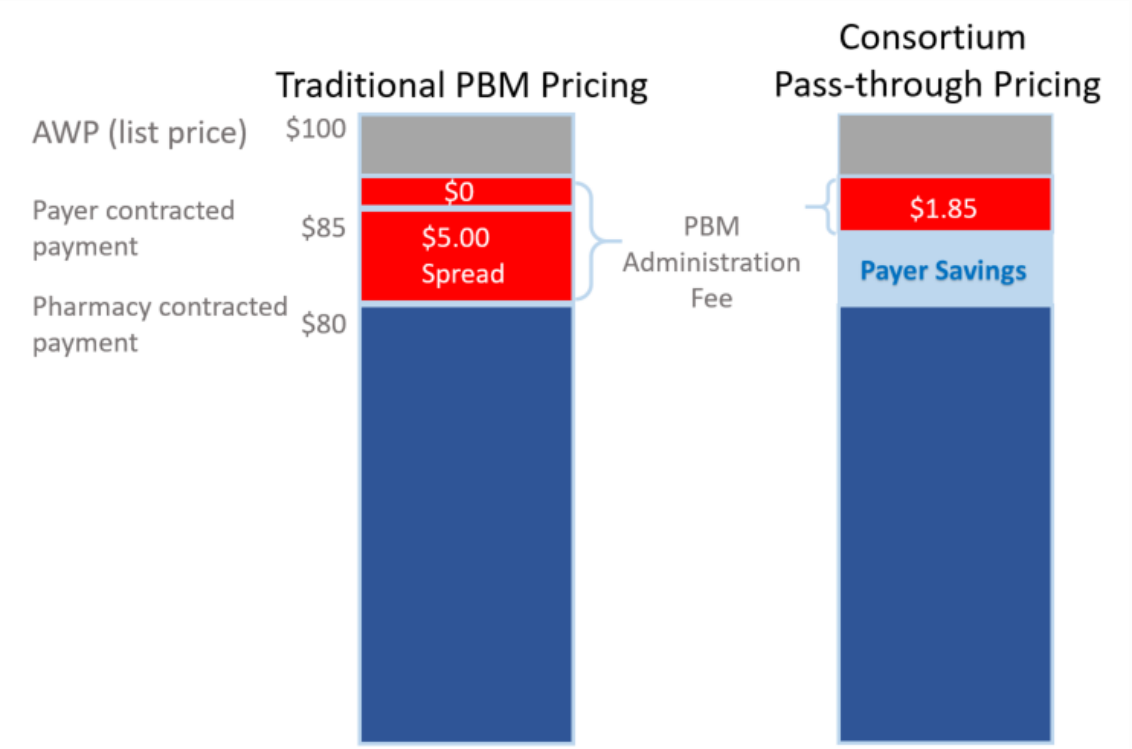
1. Annual market check (current and future performance benchmarks)
2. Comprehensive evaluation
    1. Financial guarantees
    2. Channel rates & performance
    3. Dispensing fees
    4. Administrative fees
3. Market comparators
4. Market competitiveness (0.75-1.0%)

Transparency and pass-through

- Clarity in PBM contracting
- 100% pharmacy pass-through
- 100% Rebate pass-through
- Fixed per claim fee
- Annual market check
- Performance above guaranteed rates

Pricing models

Pass-through vs. traditional pricing models

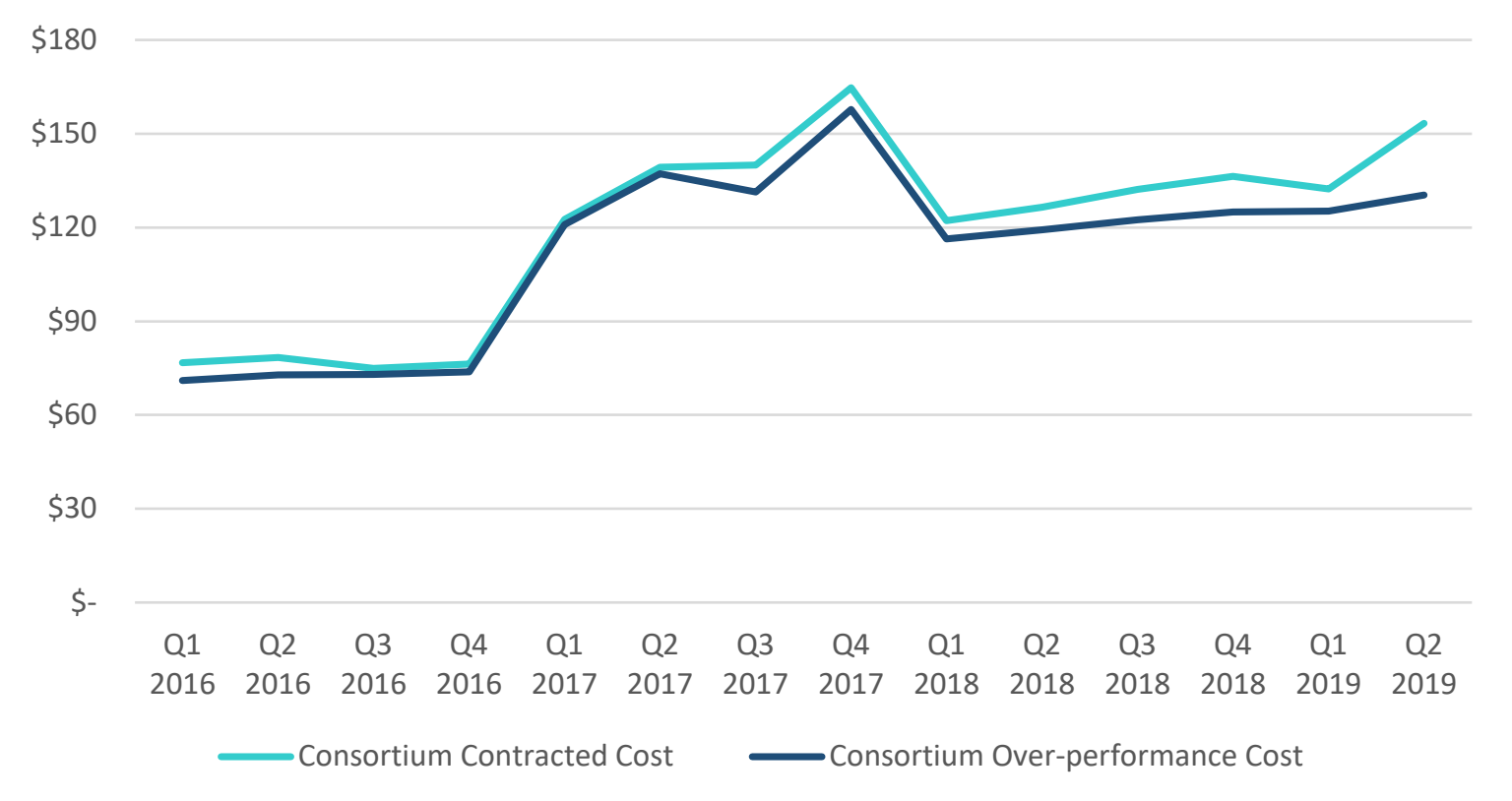


- Pass-through Admn fee is fixed vs variable with traditional
- Pass-through Admn fee is known and verifiable vs unknown and non-discoverable with traditional
- Pass-through Admn fee includes many PBM services that are available for an additional fee with traditional

NW Prescription Drug Consortium

Value through over performance

Over $99.4 million in additional savings through network over-performance since 2016



PEBB Network Performance Summary[1]

Value through over performance

$797 thousand in additional savings through network over-performance since 2017

Rx Type	Over performance 2017	Over performance 2018	Over performance 2019 (thu Jun 2019)
Retail, Choice 90, Mail Order & Specialty	$201,913	$326,705	$229,760
Dispensing Fee	$11,396	$14,796	$3,295
Total over performance	**$213,309**	**$341,501**	**$233,055**

- Annual market checks ensure continuous network performance
- Clinical initiatives minimize waste and ensure appropriate utilization
- Value formulary (implemented in 2018) directs use to most cost effective medications

In closing

OPDP continues to innovate and adapt to health system changes and seeks out opportunity to explore how we can synergistically deliver exceptional care at reduced costs while promoting the health and well-being of all Oregonians.

Questions?

More information:

http://www.opdp.org

Trevor Douglass, OPDP and Pharmacy Purchasing Director
Oregon Prescription Drug Program (OPDP)
Trevor.Douglass@state.or.us
971-209-8491

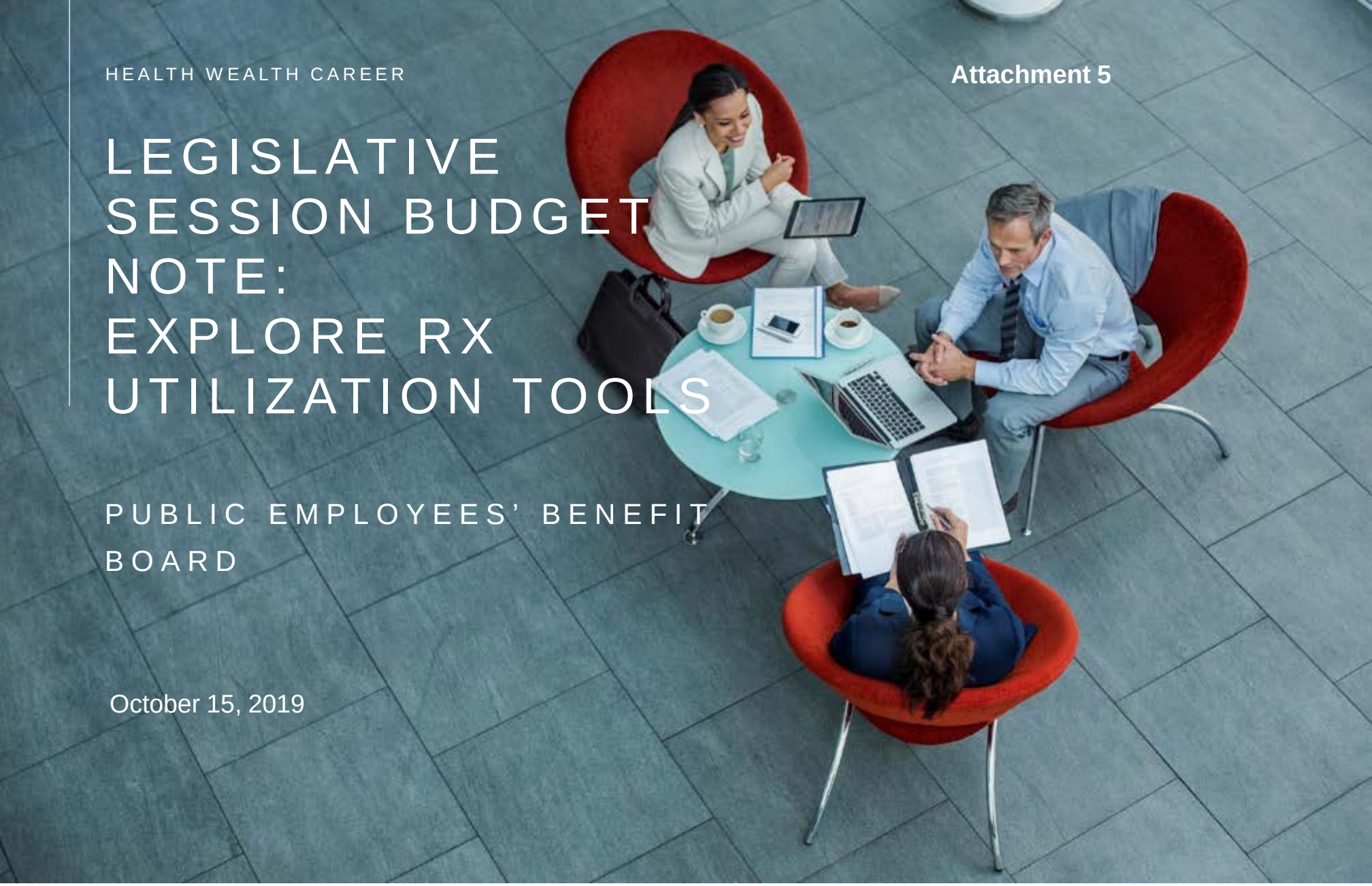
HEALTH WEALTH CAREER

Attachment 5

LEGISLATIVE SESSION BUDGET NOTE: EXPLORE RX UTILIZATION TOOLS

PUBLIC EMPLOYEES' BENEFIT BOARD

October 15, 2019



MAKE TOMORROW, TODAY MERCER

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

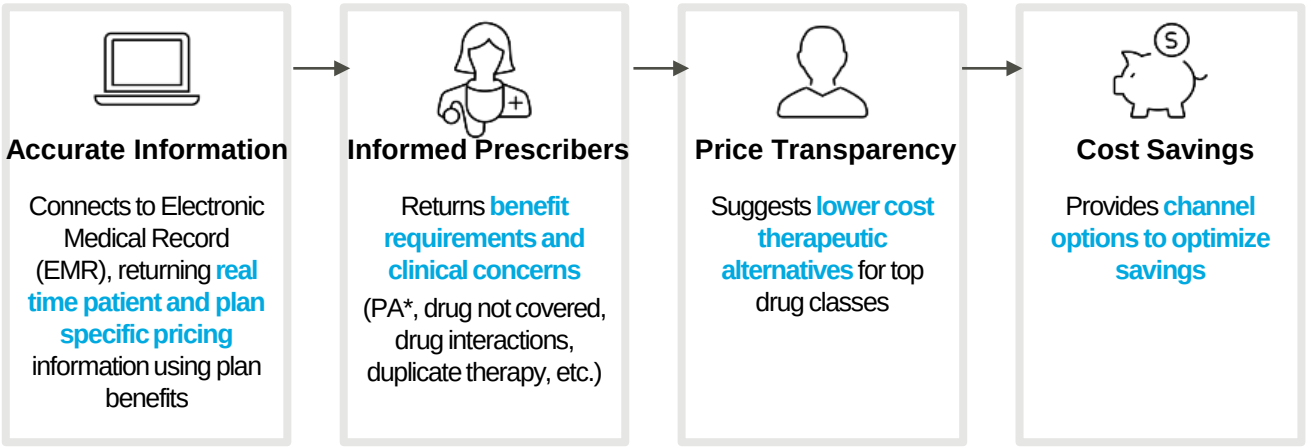
REAL TIME BENEFIT CHECK (RTBC)

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.



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
MAKE TOMORROW, TODAY