

State of Oregon
Request for Proposals (RFP)
RFP #OHA-1049-15



Oregon Educators Benefit Board

Comprehensive Medical, Pharmacy and Vision Services

Issue Date: *July 8, 2015*

Due Date for Submitting All Required Responses and Documents: *September 2, 2015 by 3:00 PST*
Hard Copies due to OEGB: September 9, 2015 by 3:00 PST

RFP Contact: Claudia Grimm, Contracts Coordinator
Oregon Educators Benefit Board (OEGB)
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Proposal Tech Electronic Submission Address: Vendors must formally post their responses to the questionnaire through the Proposal Technologies online platform. The login page is located at <http://www.proposaltech.com/app.php/login>. ****Please Note:** Vendors will need to register in accordance with the instructions listed in Section 3.6 in order to receive their login credentials.

Hard Copy Mailing Address:
Oregon Educators Benefit Board
Attn: Claudia Grimm
1225 Ferry Street SE, Suite B
Salem, Oregon 97301-4285

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SECTION 1 – GENERAL INFORMATION

1.1 Introduction and RFP Resources

The State of Oregon, acting by and through the Oregon Educators Benefit Board (OEBB) is issuing this Request for Proposals (RFP) for medical, pharmacy management and vision services. This RFP is being conducted pursuant to Oregon Revised Statutes (ORS) 243.061 – 243.302, which can be found at: <http://www.leg.state.or.us/ors>.

Per OAR 111-005-0010, the policy of the Oregon Educators Benefit Board (OEBB) is to select contractors and consultants in an expeditious, fair and efficient manner that is consistent with the goal of delivering high-quality benefits and other services at a cost that is affordable to the Employees, Early Retirees and their Dependents of the Entities we serve and meets the requirements of ORS 243.866. The Board may enter into more than one contract for each type of benefit plan or other service sought.

A description of OEBB, its Vision and Guiding Principles; its Board and Committee structure; and the Healthy Futures program can be found in **Exhibit 1**.

The Scope of Work includes the work that, at minimum, Contractors will be required to perform under the Contracts should they be awarded a Contract. The Scope of Work can be found in **Part D, Attachment 3** of this RFP.

Definitions governing this RFP are described in **Exhibit 5, RFP Definitions**. In the event that a term included in this RFP is not defined in **Exhibit 5**, Proposers will refer to OEBB’s administrative rules.

The Oregon Educators Benefits Board’s (OEBB) administrative rules are Oregon Administrative Rules (OAR) **111-001-0000**, which can be found at:

http://arcweb.sos.state.or.us/pages/rules/oars_100/oar_111/111_tofc.html

1.2 RFP Schedule

The table below provides key dates related to the release of this RFP, review of proposals, and award of Contracts.

| Activity | Date |
|---|------------|
| RFP Issued | 7/8/15 |
| Pre-Proposal Conference (attendance not mandatory) | 7/15/15 |
| Deadline for Request for Change or Clarification, or for Protest of RFP Specifications Due by 3:00 PST | 7/29/15 |
| Requests and Protests Answered by OEBB | 8/12/15 |
| RFP Closing Date: <u>All</u> Required Proposal Responses and Other Documents Due to Proposal Tech by 3:00 PST | 9/2/15 |
| Hard Copies of Proposals due to OEBB | 9/9/15 |
| OEBB Review of Proposals | 9/ 2-16/15 |

| Activity | Date |
|---|-------------------|
| Selection of Proposers in the Competitive Range – Interviewees Selected | 10/15/15 |
| Deadline for Protests of Competitive Range | 10/20/15 |
| OEBB Sends Interviewees Interview Questions | 10/21/15 |
| Protests of Competitive Range Answered by OEBB | 10/27/15 |
| Deadline for Interviewees to Provide Written Responses to Interview Questions to OEBB | 10/28/15 |
| Proposer Interviews | 11/3/15 – 11/5/15 |
| Selection of ASP(s) | 12/2/15 |
| Notice of Intent to Award | 12/2/15 |
| Award Protest Deadline | 12/10/15 |
| Final Award After Protest Period | 12/16/15 |
| Complete Final Contract Negotiations | 5/14/16 |
| Contract Execution date (on or before) | 5/28/16 |
| Insurance & Open Enrollment Meetings Planning | 2/26/16 – 7/30/16 |
| Open Enrollment | 8/15/16 –9/15/16 |
| Contract Initial Plan Year Begins | 10/1/16 |

OEBB reserves the right to modify, alter or extend any of the dates listed above. Proposers will be notified of any changes to the proposed schedule through ORPIN. Proposers are responsible for ensuring that their registration information is current and correct. OEBB accepts no responsibility for missing or incorrect information contained in the Proposer’s registration information in ORPIN. The ORPIN web site is at: <http://orpin.oregon.gov/open.dll/welcome>

1.3 Single Point of Contact

Proposers should direct any questions about this RFP, including questions relating to contractual requirements, clarification of specific information requested, the procurement process, or any other aspect of the project or needed services to the Single Point of Contact listed on the front page of this RFP, except for technical assistance questions related to the Proposal Submission Website. Technical questions related to the Proposal Submission Website must be sent to: www.proposaltech.com/app.php/register.

1.4 Funding Arrangements Considered Under this RFP

Under this RFP, OEBB will accept the following types of proposals that are in compliance with Oregon law and from Proposers that satisfy insurance licensure requirements:

- Comprehensive fully-insured Benefit Plans; and,
- Other alternative funding and risk arrangements* that meet the Triple Aim, including but not limited to minimum premium arrangements.

*Risk arrangements are between the carriers and their contracted Providers as OEBB cannot take on any risk.

1.5 Contract Term

Contracts awarded under this RFP will begin when fully executed by the parties and after receiving all necessary approvals from the State of Oregon, including legal sufficiency approval from the Oregon Department of Justice (the “Effective Date”). As described in *Part D, Attachment 1, Legal Terms and Conditions, Section A* and *Part D, Attachment 3, Scope of Work* and other parts of this RFP, OEGB expects that Contracts will be fully executed by April 30, 2016 for the 2016 plan year that starts October 1, 2016. Selected Proposers will be required to, at no additional cost to OEGB, dedicate resources to program implementation, open enrollment, member communications, information system updating and interfacing, and other critical planning activities prior October 1, 2016.

The initial Contract term will be for three Plan Years, beginning when the implementation work for the first Plan Year, or April 30, 2016 at the latest (*see Exhibit 6, Part C* of this RFP as an example of work beginning prior to the first Plan Year). OEGB expects that the initial term of the Contracts will be from October 1, 2016 to September 30, 2019 (including any applicable run out periods). Following the initial term of the Contracts, OEGB has the option to renew Contracts for as many years as the Board determines is in the best interest of the State. Termination and renewal of the Contracts are dependent upon performance, OEGB’s specific needs, and the specific provisions of the Contracts. Furthermore, termination and renewal decisions are made at the Board’s discretion. Generally, renewal requests will be sent to carriers not later than January for the following Plan Year.

Nothing in this RFP limits the Board’s discretion and ability to change benefits at a Plan Year renewal, which may include, but is not limited to, removing existing pharmacy coverage or adding pharmacy coverage if provided by the Oregon Prescription Drug Plan (OPDP).

1.6 Geographic Area for Proposals

Proposals to this RFP may be submitted to offer coverage on a statewide basis, to provide coverage within any region of the state, or to offer multiple options that include statewide as well as regional coverage options.

OEGB will divide proposals into two categories for review and scoring: proposals offering statewide coverage and proposals offering coverage within any region of the state, but not including the entire state. For example, if a proposal contains both a statewide offer and one or more regional offers, the statewide offer will be reviewed and scored to compare it against all other statewide offers and, likewise, the regional offer(s) will be reviewed and scored to compare it against other regional offers in the same or similar regional areas.

Upon review and scoring of qualifying proposals received, OEGB may select one or more statewide and two or more regional plans to offer member choice in counties across Oregon to the extent possible and practical. Accordingly, both one or more statewide proposals and one or more regional proposals may be selected for the same geographic region.

1.7 Combined Medical and Pharmacy and Stand-Alone Medical Proposals Requested

Proposers are asked to provide proposals for:

- 1) Combined medical, pharmacy and vision coverage on a fully-insured basis;
- 2) Medical and pharmacy only on a fully-insured basis;
- 3) Vision coverage only on a fully-insured basis; and,
- 4) Medical coverage only on a fully-insured basis.

Proposals comprised only of pharmacy coverage will not be accepted; however, OEGB reserves the right to contract directly with the Oregon Prescription Drug Program (OPDP) for pharmacy coverage pursuant to ORS Chapter 190.

1.8 Plan Designs

Under this RFP, OEGB will accept proposals that offer a Benefit Plan design consistent with that in ***Exhibit 3*** for ***OEGB Medical, Pharmacy and Vision Plan Designs***.

A proposal will be deemed non-responsive by OEGB if it does not include a Benefit Plan design consistent with the plan designs described in ***Exhibit 3***.

Section 2: Expectations of Proposers

2.1 Part D: Final Submission Requirements

All Attachments in **Part D** must be completed in addition to the appropriate Questionnaires in **Part B** and the appropriate Financial Proposals in **Part C** as described on the proposal submission website. Proposers are required to check each applicable item or box on the forms indicating that Proposers agree to the mandatory minimum requirements, representations, warranties, tax certifications, in addition to the Legal Terms and Conditions and the Reporting & Performance Requirements and have provided all required responses and documents pursuant to this RFP. Proposers must submit this form with the required electronic signature as instructed on the proposal submission website. There are also two checklists, the attachments checklist and the proposal checklist that should be completed and submitted with your Proposal.

In order to be deemed responsive, Proposers must complete the following forms in Part D on the Proposal Submission Website:

- ***Legal Terms and Conditions-Attachment 1***
- ***Reporting and Performance Requirements-Attachment 2***
- ***Scope of Work-Attachment 3***
- ***Insurance Requirements-Attachment 4***
- ***Mandatory Minimum Requirements - Attachment 5***
- ***Proposer Certifications-Attachment 6***
- ***Designation of Confidential Materials-Attachment 7***
- ***Proposer Information & Signature-Attachment 8***

Failure to complete any item in **Part D, Attachments 1-8**, along with required electronic signatures, will result in the proposal being deemed non-responsive. Specific instructions for completing these forms, can also be found on the Proposal Submission Website. **Part D Attachments 9 & 10 are Checklists** that may be helpful in assuring you have completed all the necessary requirements. Please include the Checklists in your submission.

2.2 Legal Terms and Conditions

This RFP requires Proposers to: (1) indicate which terms and conditions in **Part D, Attachment 1, Legal Terms and Conditions**, they would like to negotiate in the event they are selected as an Apparent Successful Proposer (ASP); and (2) provide alternative language or a clear explanation of how they would like to change the term or condition. Proposer will lose the right to negotiate that term or condition if selected as an ASP, if Part D, Attachment 1 is not completed on the Proposal Submission Website. **NOTE:** Certain terms and conditions will not be subject to negotiation as indicated in **Part D, Attachment 1, Legal Terms and Conditions**.

2.3 Reporting and Performance Requirements

This RFP requires Proposers to: (1) indicate which reports in Part D, Attachment 2, Reporting and Performance Requirements they are unable to provide or which performance requirements they agree (or don't agree) to put fees at risk and would like to negotiate in the event they are selected as an Apparent Successful Proposer (ASP). Proposer will lose the right if selected as an ASP to negotiate any reporting and performance requirement, if Proposer does not complete **Part D, Attachment 2, Reporting and Performance Requirements** on the Proposal Submission Website.

2.4 Scope of Work

OEBB and any ASP selected under this RFP will negotiate a Statement of Work for the Contract based on this RFP's Scope of Work and the contents of the ASP's proposal.

Part D, Attachment 3, Scope of Work, includes the work that, at minimum, Contractors will be required to perform under the Contracts should they be awarded a Contract. **Part D, Attachment 3**, together with the ASP's proposal and the final Board-approved plan design(s), will be the basis for negotiating the Contract's Statement of Work and other Contract exhibits. OEBB expects to include more administrative and operational requirements in the final Contracts. These additional requirements will be based on, at minimum, the ASP's proposal and the final Board-approved plan design(s).

This RFP requires Proposers to: (1) indicate which requirements in **Part D, Attachment 3, Scope of Work** they would like to negotiate in the event they are selected as an Apparent Successful Proposer (ASP); and (2) provide alternative language or a clear explanation of how they would like to change that particular requirement. Proposer will lose the right to negotiate a requirement if selected as an ASP if **Part D, Attachment 3, Scope of Work** is not completed on the Proposal Submission Website.

2.5 Insurance Requirements

This RFP requires Proposers to: (1) indicate which coverages in **Part D, Attachment 4, Insurance Requirements** they are unable to provide and would like to negotiate in the event they are selected as an Apparent Successful Proposer (ASP); and (2) provide alternative language or a clear explanation of how they would like to change the language or requirement. If a Proposer does not adhere to the foregoing requirements, the Proposer will lose the right to negotiate that item if selected as an ASP. Proposers must indicate which coverage or terms they would like to negotiate, if any, by completing **Part D, Attachment 4, Insurance Requirements** form on the Proposal Submission Website.

2.6 Mandatory Minimum Requirements

In addition to responding to all questionnaire items in Part B, Proposers must confirm their compliance with the **Mandatory Minimum Requirements provided in Part D, Attachment 5**.

Part of the **Mandatory Minimum Requirements** includes a confirmation of the use of the **Sample Form of Group Benefits Contract** in **Exhibit 4**. **Exhibit 4** illustrates how the Contracts will be structured. Some aspects of the general structure of the group benefit Contracts as well as some of the specific content therein will be subject to negotiation based on the specific contents of the ASP's proposals. This RFP requires Proposers to agree to the use of the sample group benefit Contract format by completing the **Mandatory Minimum Qualifications form in Part D, Attachment 5** on the Proposal Submission Website.

2.7 Proposer Certifications

In addition to responding to all questionnaire items in Part B, Attachments 1-4 in Part D, the **Mandatory Minimum Requirements provided in Part D, Attachment 5**, Proposers must confirm their compliance with the **Proposer Certifications in Part D, Attachment 6**.

Proposers will confirm their compliance with the by completing the form in **Part D, Proposer Certifications, Attachment 6** on the Proposal Submission Website at: www.proposaltech.com/app.php/register (the "Proposal Submission Website"). Website

2.8 Designation of Confidential Materials

Proposers will designate any materials they wish to be deemed Confidential by completing the required checklist in ***Part D, Attachment 7***, which can be found on the proposal submission website at: www.proposaltech.com/app.php/register (the “Proposal Submission Website”). Further information on designating material as Confidential can be found in **Section 3.8** of this RFP.

OEBB REQUIRES PROPOSALS TO BE COMPLETE AND COMPLY WITH ALL RFP SPECIFICATIONS. ANY MISSING INFORMATION COULD DISQUALIFY A PROPOSAL.

Section 3: RFP Process

3.1 How to Obtain RFP Documents

The RFP, including all Addenda and all questionnaires, exhibits, and attachments, is posted on the ORPIN web site as the solicitation document. OEGB is not required to mail hard copies of the RFP, its Addenda, Exhibits or Attachments. Notification of any substantive clarifications provided in response to any question will be provided and published at the ORPIN website below.

For complete RFP documentation please go to the ORPIN website: <http://orpin.oregon.gov/open.dll/welcome> and view Agency Opportunity number **OHA-1049-15**

ORPIN Usage: Proposers unfamiliar with the ORPIN system may contact the State Procurement Office at 1225 Ferry St., SE-U140; Salem, Oregon 97301-4285. The telephone number of the State Procurement Office is (503) 378-4642. The State Procurement Office hours are 7:30 am to 4:30 pm Pacific Standard Time, Monday through Friday.

For complete RFP documents, the RFP, including Exhibits, Addenda, and Attachments will also be posted on the proposal submission website at: www.proposaltech.com/app.php/register. For all official RFP documents, except for detailed proposal submission instructions, Proposers should regularly check the ORPIN website.

3.2 Proposer Responsibilities

Proposers should read all RFP documents very carefully, as OEGB will not be responsible for errors and omissions on the part of Proposers. Proposers will be responsible for following the RFP proposal submission instructions in **Part E Exhibit 2** in addition to all instructions located on the proposal submission website. It is the responsibility of all Proposers to make sure that they have responded to all required questions, completed all required forms, submitted all required representations, warranties, and certifications, and provided electronic signatures where required. Proposers should carefully review final submissions to avoid ambiguity, vagueness, and errors in calculations and responses. Each Proposer shall be responsible for making all investigations and examinations that are necessary to ascertain conditions and requirements affecting its proposal.

Proposers are responsible for meeting the deadlines described in **Section 1.2**. OEGB takes no responsibility for submissions that are not delivered timely or are otherwise not received by the proposal submission website or, for clarifications and protests, received by the RFP's Single Point of Contact.

3.3 Pre-Proposal Conference (Attendance is Not Mandatory)

OEGB will hold a pre-proposal conference to receive general questions and, where appropriate, provide clarification on any requirements of the RFP. The pre-proposal conference will be recorded by OEGB. Verbal comments made by OEGB at the pre-proposal conference are not binding. Should there be a need to communicate information to all Proposers as result of the pre-proposal conference, an Addendum will be issued and posted on the ORPIN website so that Proposers may download it. Addenda are issued and posted as described in Section 3.6.

Pre-Proposal Conference:

Date: **July 15, 2015**

Time: **10:00 a.m. to 12:00 noon**

Place: **General Services Building, OEBC/OEBC Board Room (1st Floor)**
1225 Ferry Street SE
Salem, Oregon 97301-4285

Attendance at the pre-proposal conference is optional. Persons or organizations that are considering submitting a proposal are encouraged to attend and ask questions of OEBC staff and Towers Watson, OEBC's consultant.

3.4 How to Submit Responses

The RFP process is being conducted both electronically and by paper submission. Electronic submission is being managed via the Internet using the Proposal Technologies Network, Inc. (Proposal Tech) application. Responses to the questionnaire and supporting documents **must be submitted via Proposal Tech**. The proposer's submission must include uploads of all requested reference documents and attachments:

- **Part B**
 - *Administrative Questionnaire*
 - *Medical, Pharmacy and/or Vision Questionnaire*
- **Part C**
 - *Medical, Pharmacy and/or Vision Financial Proposals*
- **Part D:**
 - *Legal Terms and Conditions-Attachment 1*
 - *Reporting and Performance Requirements-Attachment 2*
 - *Scope of Work-Attachment 3*
 - *Insurance Requirements-Attachment 4*
 - *Mandatory Minimum Requirements - Attachment 5*
 - *Proposer Certifications-Attachment 6*
 - *Designation of Confidential Materials-Attachment 7*
 - *Proposer Information & Signature-Attachment 8*

The Proposal Technologies (Proposal Tech) software will be open starting the end of the day this RFP is issued. Unless otherwise announced by addendum to this RFP, the Proposal Tech software will not be open for submissions after the date and time shown in Section 1.2. The person who registered with ORPIN and who downloaded the RFP and attachments **must** register for proposal access on the Proposal Tech website using **Passcode OEBC2014**. The person registered in ORPIN may also have a designee register with Proposal Tech. The following is the website location for Proposal Technologies, Inc.: **<https://www.proposaltech.com/home/app.php/register>**. For technical problems only, Proposers may contact Proposal Technologies at **877-211-8316 option 4**. Do not contact Proposal Tech regarding the specific content of this RFP.

For any organization that may be unfamiliar with this web-based tool, Proposal Tech representatives will schedule training sessions at your convenience on the Proposal Tech website. Proposers may view an online training demonstration of the system and its functionality. The online demonstration takes

approximately five minutes and will improve your understanding of the system. Paste the following link below into your browser to view the demonstration:

http://www.proposaltech.com/help/docs/response_training_798x599.htm

Five (5) paper hard copies and a thumb drive containing the original Proposal Tech submission (including all exhibits and attachments) must also be submitted to the mailing address on the front of this proposal by the date and time indicated in Section 1.2. **The official proposal submission process is via Proposal Tech and hard copy/thumb drive.** All questionnaire responses and uploaded documents referenced in this Section 3.6 must also be included as attachments to the hard copies of the Proposal submitted to OEGB. Proposer is responsible for assuring that the Proposal hard copies of its questionnaire responses and uploaded documents are the same as its Proposal Tech submissions.

OEGB may reject Proposals that do not meet both these criteria pursuant to OAR111-005-0040. In the event of a discrepancy between the hard copy and Proposal Tech submissions, the electronic version shall be considered the official submission of record.

3.5 Closing Date for Submittal of Proposals

Electronic Proposals must be entered into Proposal Tech by **3:00 pm (PST) on Wednesday, August 5, 2015**. Proposals received after closing date and time are late and will not be considered. Electronic Proposals shall be considered to be the official submission.

The five (5) hard copy submissions must be received in OEGB's office by **3:00 pm (PST) on Wednesday, August 12, 2015** at the address on the front of this document. Hard copy Proposals must also be submitted in order to be considered a responsive Proposer. Hard copies must also include a time and date stamp from Proposal Tech demonstrating that the electronic Proposal was submitted prior to **3:00 pm PST on August 5, 2015**. OEGB will consider hard copy Proposals not received by this date and time to be incomplete.

3.6 Requests for Change or for Clarification

Notwithstanding the process for meeting minimum qualifications described in **Section 2.1** through 2.7 of this RFP the appropriate means of seeking modifications to provisions of the RFP are through (a) written request for clarification (this section); (b) formal submittal of requests for changes to the RFP, contractual terms or specifications (this section); or (c) formal submittal of protests of the RFP, contractual terms or specifications (**Section 3.6**).

OEGB will respond to each properly-submitted written request for clarification, request for change, and protest. Where appropriate, OEGB will issue revisions and clarify RFP provisions via Addenda posted on ORPIN. OEGB may also informally respond to Proposer questions through the RFP's Single Point of Contact. Informal responses, however, do not affect the provisions of the RFP. The RFP, contractual terms and specifications can only be changed via formal Addenda issued by OEGB.

All requests for change of the RFP or requests for clarification of the RFP must be submitted in writing and received by the RFP Single Point of Contact shown on the front page of this RFP no later than 3:00 p.m. Pacific Standard Time on the date as listed in **Section 1.2** of this RFP.

All requests for change of the RFP must be consistent with OAR 111-005-0040(3)(b). All requests for clarification of the RFP must be consistent with OAR 111-005-0040(3)(c). To be considered by OEGB, requests for change or clarification must meet the following requirements:

1. Requests must be by an identified entity that expects to be a Proposer;
2. Requests must be signed by the entity's authorized representative;
3. Requests must reference this specific RFP by number; and,
4. Requests for change must state the reasons for the request and specify the exact alternative language proposed to any requested changes to the RFP provisions, specifications, or Contract Legal Terms and Conditions that would resolve or address the reasons for request.

To ensure the integrity of the RFP process, no requests for change or clarification will be accepted by any OEGB representative other than the RFP Single Point of Contact as described in **Section 1.3** of this RFP. Furthermore, the following requests for change or clarification will be considered void and not responded to:

1. Requests submitted by phone;
2. Requests that do not comply with the deadline listed in **Section 1.2** of this RFP;
3. Requests that do not identify the person or party requesting the information;
4. Requests to amend or negotiate Terms and Conditions identified as "non-negotiable"; or,
5. Requests that are not relevant to the awarding of the Contract(s).

3.7 Protest of RFP

All RFP protests are due to OEGB in writing no later than the due date listed in Section 1.2 of this RFP and must be consistent with OAR 111-005-0040(3)(a). Protests must be submitted in writing and addressed to the RFP's Single Point of Contact.

To be considered by OEGB, RFP protests must also:

1. be submitted by an identified entity that expects to be a Proposer;
2. be signed by the entity's authorized representative;
3. Reference this specific RFP by number; and
4. Specify with exact alternative language any recommended changes to the RFP provisions, specifications, or Contract Legal Terms and Conditions that would resolve or address the reasons for the protest.

To ensure the integrity of the RFP process, no protests will be accepted by any OEGB staff other than the RFP Single Point of Contact. Furthermore, protests will be considered void and not responded to in the following events or situations:

1. Protests submitted by phone;

2. Protests that do not comply with the deadline listed in **Section 1.2** of this RFP;
3. Protests that do not identify the person or party requesting the information;
4. Protests of the Terms and Conditions that this RFP states are “non-negotiable”; or,
5. Protests that are not relevant to the awarding of the Contract(s).

Consistent with OAR 111-005-0040(11), OEGB has wide discretion in determining how to respond to protests. Potential responses include, but are not limited to, responding to the protester in writing, delaying or modifying the RFP process in order to rectify or address issues raised in the protest, or continuing to proceed with the RFP process as originally planned and outlined in **Section 1.2** of this RFP. Protests will be resolved in accordance with OEGB’s rules. OEGB intends to respond in writing to properly filed RFP protests. Any response provided by OEGB, however, is not intended to, and may not in and of itself constitute, confirmation that the protester is in fact entitled to protest the RFP.

3.8 Addenda

Any amendment to the RFP specifications or the solicitation document process will be made in the form of an Addendum to the RFP and will be issued by OEGB in accordance with OAR 111-005-0040(4). Addenda, as they pertain to this RFP, will be posted and available for downloading or on-line viewing from the Addenda Menu on ORPIN.

Proposers should consult the ORPIN system regularly to become aware of any Addenda announcements concerning this RFP. Proposers are exclusively responsible for keeping apprised of Addenda and similar developments by using the ORPIN system. Any postings to ORPIN made by OEGB will have the effect of putting all Proposers for this RFP on notice of such changes or amendments to this RFP. In other words, any such Addenda will have the same binding effect as if it were contained in the main body of the RFP. OEGB reserves the right to modify the RFP at any time prior to the RFP closing date. Any oral communications will be considered unofficial and non-binding. Proposers will rely only on written statements issued by OEGB and posted on ORPIN.

3.9 Key Person Identification and Qualifications

Proposals must identify a key person(s) who is qualified to represent the Proposer (and, if selected, the Contractor), holding the expertise, experience, judgment and personal attention necessary to complete tasks and to act as a contact between OEGB and the Proposer. After the Contract is signed, the Proposer will not be allowed to delegate performance of the powers and responsibilities of such key person unless the Proposer provides OEGB with the suggested new Key Person’s resume of experience as it relates to the services to be provided under the Contract and obtains approval from OEGB staff to delegate the powers and responsibilities of the key person to the new suggested person. OEGB reserves the right to refuse such delegation requests.

3.10 Trade Secrets and Oregon Public Records

A. **Oregon Public Records Law.** By submitting proposals, Proposers acknowledge that all proposal documents and responses, including requests for clarification and protests, are subject to the Oregon Public Records Law (*see* ORS 192.410-192.505) and are subject to disclosure unless a legal exemption from disclosure is claimed by the Proposer and agreed to by the State of Oregon. Copies of public information may be requested by any person.

The non-disclosure of documents or any portion of a document submitted by a Proposer to OEGB may depend upon official or judicial determinations made pursuant to the Oregon Public Records Law. If OEGB receives a request under the Oregon Public Records Law for the disclosure of information designated by Proposer as being exempt from disclosure, OEGB will notify Proposer within a reasonable period of time of the request, and Proposer will be exclusively responsible for defending Proposer's position concerning the confidentiality of the requested information. Neither the State of Oregon nor any of its agencies is or will be obligated to assist in Proposer's defense. If any requests for disclosure of such information are made to OEGB, OEGB intends to make a disclosure only consistent with and to the extent allowable under law. The State will not be liable for release of any information when required by law or court order to do so, whether pursuant to the Oregon Public Records Law or otherwise and will also be immune from liability for disclosure or release of information under the circumstances set out in ORS 646.473(3).

For a description of Oregon's Public Records Law, including the legal exemptions from disclosure, refer to the Oregon Attorney General's Public Records and Meetings Manual at:
http://www.doj.state.or.us/public_records/pages/index.aspx

- B. Trade Secrets.** OEGB agrees that it will, to the extent allowed by Oregon Public Records Law, make reasonable efforts to maintain the confidentiality of any information received from a Proposer that is considered exempt from disclosure under Oregon's Public Records Law. One exemption that may apply to responses and documents submitted in response to this RFP concerns Trade Secret information, as defined in ORS 192.501(2) or under Oregon's Uniform Trade Secrets Act. Please note that it is Proposer's responsibility to identify the specific information that is being provided that constitutes Trade Secret information by explicitly labeling it "**Trade Secret Information**" per the instructions in *Part D, Attachment 7, Designation of Confidential Materials* and on the proposal submission website. OEGB may evaluate the Proposer's characterization of material as "Trade Secret" under applicable legal standards and is not obligated to accept Proposer's characterization.
- C. Exceptions.** The confidentiality obligations imposed by this subsection of the RFP do not apply to the following:
1. Information that becomes part of the public domain through lawful means and without breach of any confidentiality obligation by the recipient;
 2. Information subsequently and rightfully received from third parties who have the necessary rights to transfer said information without any obligation of confidentiality;
 3. Information that was known to the recipient prior to initially receiving the proposal containing information claimed by Proposer to be confidential;
 4. Information that is independently developed by recipient and documented in writing without use of, or reference to, any Confidential Information of the other party; and,
 5. Information required to be disclosed by compulsory judicial or administrative process or by law or regulation.

If OEGB is required to disclose information that constitutes Trade Secrets in this subsection, OEGB will first give the particular Proposer notice and will provide such information as may reasonably be necessary to enable the Proposer to take action to protect its interests.

D. Redacted Proposal Information. Instructions for completing questionnaires, including providing redacted responses, can be found in *Part D, Attachment 7, Designation of Confidential Materials* and on the proposal submission website.

In providing redacted responses to this RFP, Proposers must include the following information:

1. A general description of the information that has been redacted for each specific redaction;
2. The basis, or bases, under Oregon Public Records Law for making each specific redaction (i.e. information described above in this Section labeled “Trade Secret Information” or other applicable exemption); and,
3. The specific Proposer contact person OEGB should contact in the event a public records request has been made that may include information that has been redacted by Proposer or in the event that OEGB has any questions related to information redacted.

3.11 Modification or Withdrawal of Proposal

Prior to the due date and time designated for receipt of proposals, any proposal response may be modified or withdrawn on the proposal submission website according to the instructions therein and in **Part E, Exhibit 2.**

3.12 Validity of Proposal

Proposals will remain valid and binding on the Proposers from the date of submission through September 30, 2016, or the Contract execution date, whichever occurs first.

3.13 Grounds for Rejection

In addition to the criteria provided in OAR 111-005-0040 (7), OEGB may reject a proposal if:

1. It does not meet due dates and deadlines imposed in **Section 1.2** of this RFP;
2. It takes exception to the *Sample Group Benefits Contract format in Exhibit 4*, and the Proposer did not timely submit a request for change or protest of the Contract forms;
3. It takes exception to the *Legal Terms and Conditions in Part D, Attachment 1* and the Proposer did not timely submit a request for change or protest of the terms and conditions at issue or did not indicate on the Legal terms and Conditions form on the proposal submission website that it would like to negotiate a specific legal term or condition;
4. It takes exception to the *Scope of Work in Part D Attachment 3*, and the Proposer did not timely submit a request for change or protest of the Scope of Work;
5. It fails to agree to the Proposer Certifications in *Part D, Attachment 6*;
6. OEGB deems it non-responsive to the RFP in whole or in part;
7. OEGB deems the Proposer not to be a Responsible Proposer as described in OAR 111-005-0055(5);
8. It contains false or misleading statements or references;
9. OEGB determines that it is in the state’s interest to obtain the services proposed through another kind of contract or procurement;
10. OEGB decides to cancel the RFP with respect to the services proposed;
11. OEGB takes any other action with respect to this RFP which is inconsistent with further consideration of the proposal; or
12. The Proposer attempts to improperly influence a member of the Selection Committee, the Board, OEGB staff or Towers Watson during the proposal review and evaluation process.

3.14 Rights of OEGB with Regard to this RFP

OEGB reserves all rights regarding this RFP without liability including, without limitation, the rights to:

1. Amend, delay, or cancel this RFP in any or all service areas at any time prior to execution of the Contract;
2. Reject any or all proposals received;
3. Waive any minor informality or non-conformance with the provisions or procedures of this RFP, and seek clarification of any proposal, if required;
4. Reject any proposal that fails substantially to comply with all prescribed RFP procedures and requirements;
5. Negotiate a Statement of Work based on the *Scope of Work* described in **Part D, Attachment 3** and the specific contents of the proposal and to negotiate separately in any manner necessary to serve the best interest of the public;
6. Amend any Contracts that are a result of this RFP; and
7. Extend any Contracts that result from this RFP without an additional RFP.

Furthermore, OEGB possesses considerable discretion in making decisions concerning the provision of healthcare related services to Participants, including decisions regarding this RFP. This RFP does not create any obligation on the part of OEGB to enter into any Contract or undertake any financial obligation with respect to the operations set forth in this RFP. Each Proposer that responds to this RFP does so solely at the Proposer's cost and expense.

OEGB may introduce benefit changes or other programs while the Contracts are being negotiated as well as during the term of the Contracts. In addition, Proposers should recognize that the State Legislature may pass benefit mandates affecting OEGB, or approve revisions to the OEGB statutes or other statutes that may affect OEGB. In the event of such changes, the Contract will be negotiated as necessary.

3.15 References

By submitting a proposal, a Proposer consents to OEGB investigating the references submitted by a Proposer as well as those current or former customers not disclosed by a Proposer and to discuss subject matter such as the Proposer's past performance, its compliance with certain specifications and contractual obligations, its payment history regarding suppliers, sub-contractors, and workers, and any other information that may be helpful in choosing an ASP.

As part of the proposal submission process on the proposal submission website, Proposers will be asked to provide names, addresses and contact information for three references for which the Proposer is currently providing similar services as those requested by OEGB and three references of recently terminated customers who the Proposer provided group coverage to.

3.16 Collaboration and Subcontractors

Proposers may collaborate or subcontract with other entities to propose quality and cost-effective responses to the RFP's requirements. The proposal must incorporate all essential areas of service. OEGB will hold the successful Proposer solely responsible for managing the work, costs, quality and compliance of any and all subcontractors it intends to use in the full performance of all contractual duties assigned to the Proposer.

OEBB is looking for innovative approaches that strive to achieve the Triple Aim and will successfully engage members and their families in their own health in their own communities. OEBB will be looking for how Proposers will work with state, regional and local community health and other partners to promote best practices and evidence-based care that will result in better health, better care and lower costs.

OEBB will accept proposals that make use of innovative collaborations with delivery systems or other forms of subcontracts for specific aspects of the Contract that achieve the Triple Aim through the coordinated care model attributes. Proposers must clearly identify the collaborator, the tasks the collaborator would perform and the expertise that the collaborator can offer OEBB. Proposers will assume sole responsibility for the actions of the subcontractor or collaborator, pursuant to the subcontracting clause of the Contract. Any subcontractors or collaborators included in the proposal and retained in the Contract shall be deemed approved by the OEBB Board.

Section 4: Review, Scoring, Selection and Award

4.1 *Review for Responsiveness*

Upon receipt of all properly submitted proposals on or before the due date listed in **Section 3.1** of this RFP, OEBB and Towers Watson will determine whether each proposal is responsive or non-responsive and whether each proposal meets minimum requirements before the proposals are scored. In order to be responsive, a proposal must answer each question provided in the RFP and furnish all information required in this RFP. If a proposal is determined to be non-responsive, in whole or in part, it will be instantly rejected and will not be further evaluated.

When a proposal is determined to be non-responsive, notification will be sent to the Proposer's key contact person, as identified in the Proposer's response to this RFP. Notification of non-responsiveness shall either be sent to Proposer via email or through the United States Postal Service. A copy of all non-responsive proposals will be retained for OEBB's records.

Consistent with OAR 111-005-0050, OEBB reserves the right to determine if an error or omission is minor or substantial. If the error or omission is minor, the proposal may not be disqualified and may be further evaluated; however, please refer to **Section 4.3** for information regarding the Clarification Process that may apply. If an error or omission is determined to be substantial, the proposal shall be disqualified and will not be further evaluated.

4.2 *Minimum Requirements*

Once a proposal has been determined to be responsive, OEBB and Towers Watson will then proceed to determine whether the minimum requirements have been met. The minimum requirements required for this RFP are those requirements described in **Part D, Attachment 4** in addition to those listed in **Section 2.6** of this RFP.

4.3 *Clarification Process*

OEBB may seek clarification from a Proposer for any portion of the proposal even if the proposal in question has been determined to be responsive. If a clarification is sought, the Proposer must reply with a written and signed clarification that will become a part of its proposal and is submitted in a timely manner, as determined by OEBB. In response to OEBB's request for clarification, no new information or documentation may be submitted except as OEBB requests, and clarifications may not be used to rehabilitate a non-responsive proposal. Failure to provide clarification may result in a lower score. As OEBB's consultant, Towers Watson may, at OEBB's direction, request a Proposer submit a clarification through the proposal submission website.

4.4 *Questionnaire Review and Scoring*

Proposals that are submitted in a timely manner, are responsive, and that meet the minimum requirements described in this RFP will be reviewed and scored.

Responses to questionnaire items on the proposal submission website will be reviewed and scored prior to interviews. Individual questionnaire items will be weighted differently based upon the Board's priorities and goals. The total points possible for questionnaire responses under this RFP are described in Section 4.6.

Furthermore, questionnaires will be reviewed and scored by the Selection Committee, OEBB staff, Towers Watson and other Board-approved Subject Matter Experts within or contracted by OHA. The Board will

approve the overall weighting of points given to each section of the RFP as well as who will be responsible for scoring.

4.5 Proposer Interviews

The Selection Committee intends to interview Proposers whose proposals are submitted in a timely manner, are responsive, that meet the minimum requirements described in this RFP, and that the Selection Committee determines to be in the Competitive Range for the proposed service area and coverage type.

In determining which proposals are in the Competitive Range and which Proposers will proceed to the interview portion of the RFP, the Selection Committee will consider recommendations from Towers Watson that are based on the aggregate scoring for each Proposer, other relevant information contained in the proposals, the number of proposals, natural breaks in scoring, interrelationships among proposals, and regional considerations. In making a determination of which Proposers fall within the Competitive Range, the Selection Committee may consider a proposal in whole or in part, as well as considering which proposals or portions of proposals are in the State's best interests in order to deliver high quality benefits at a cost that is affordable to Members and the state.

In the event that OEBB receives more proposals in a region or service category than OEBB can feasibly interview within the time available, OEBB reserves the right to interview only those Proposers in a region or service category whose preliminary scores from their questionnaire responses exceed a threshold that OEBB may establish at its discretion as described above in this Section 4.5. Proposals of the Competitive Range will be subject to the protest requirements in Section 3.6 and according to the due dates listed in Section 3.1.

General interview questions will be sent to interviewees in advance. Proposer-specific questions and follow up questions will be asked during the Interviews. Furthermore, OEBB may require Proposers to submit written answers to some of the interview questions prior to the interview. Refer to Section 1.2 for the due dates associated with Interview questions and Proposers' subsequent written responses. The interview questions will be based in part by information provided by the Proposer to more fully explain their response or reasoning. Each interview will consist of both general questions that are common to all interviewees as well as questions that are specific to the interviewee.

The interviews will be held in public meetings; however, the Selection Committee may go into executive session to safeguard information that is exempt from disclosure under the Oregon Public Records Law. Following the interviews, the Selection Committee may discuss as a group their general impressions of the content of each interview; however, each Selection Committee member will independently provide a score for each Proposer interviewed and submit these scores to Towers Watson. Interview scoring will be based solely on information shared by the Proposer during the course of the interview. Towers Watson will average Selection Committee members' scores and add the interview score to the questionnaire score.

Following the interview process, the Selection Committee may do one or more of the following:

1. Request clarification from any or all of the Proposers,
2. Make changes or modifications to the RFP that apply only to the Proposers determined to be in the Competitive Range; or
3. Accept multiple proposals as more fully described in Section 4.7 of this RFP.

4.6 Final Proposal Scoring

All scoring by Selection Committee members will be performed on an individual basis. While the Selection Committee may discuss certain information in public meetings, scoring of actual proposals and interviews are done individually. A final score for each proposal will be determined by adding the final score received on the questionnaire items and the final score received on the interview.

After the Selection Committee determines which Proposers are in the Competitive Range, an additional 500 points will be possible based on the subsequent interviews. Therefore, the Proposers who are determined to be in the Competitive Range and are subsequently interviewed will have up to XXXX points possible for their proposals if they bid on Medical, Pharmacy and Vision:

To Be Determined by Towers Watson After their Review of the RFP

4.7 Selection and Intent To Award

The Selection Committee, OEBB Staff, and Towers Watson will review the scoring of Proposals in each region and coverage type as well as analyze system considerations including, but not limited to, network coverage, comparison between Proposers' access and networks, natural breaks in scoring, number of qualified proposals, interrelationships among proposals, regional coverage considerations, and Proposers' support of healthcare transformation. Based on this review, the Board will develop a list of ASPs to provide services. In the event negotiations are unsuccessful, or in the event the Board decides to choose an alternate Proposer, these ASP's will be identified.

For statewide proposals, the Board will use the highest aggregate score to determine the Statewide proposal ASP. For regional proposals, Towers Watson will develop regions based on the regional proposals received and their respective proposed service areas. The Board will use the aggregate scores of each Proposer within a region to determine the list of ASPs for each region. In regions with more than one Proposer, the Board may select a lower scoring proposal over a higher scoring proposal as an ASP if the following conditions are met:

1. The Board determines, based on Towers Watson's analysis, that the specific region cannot support both the higher scoring proposal and lower scoring proposal based on OEBB's covered lives in that service area;
2. The lower scoring proposal offers something different or unique from the higher scoring proposal as evidenced by at least one of the following:
 - a. The lower scoring proposal's selection would result in less network disruption and greater OEBB Member continuity of care;
 - b. The lower scoring proposal includes a care delivery model that the Board thinks is important to offer to its Members in that region and that the higher scoring proposal does not offer; or,
 - c. In light of the Statewide proposal(s) selected, the lower scoring proposal's selection is in the state's and OEBB Members' best interests.
3. The lower scoring proposal's aggregate score based on the questionnaire items and interview is no more than 400 points less than the higher scoring proposal.

The Board's decision to issue Intents to Award the ASPs will be made at public meetings, as described in **Section 1.2.**

OEBB Staff and Towers Watson may negotiate the Statements of Work, cost proposals, and other principal business terms and conditions with the ASPs and alternate Proposers. **THE CONTRACT'S LEGAL TERMS AND CONDITIONS SPECIFIED IN THIS RFP ARE NEGOTIABLE ONLY TO THE EXTENT THAT**

THIS RFP DOES NOT INDICATE THAT THEY ARE NON-NEGOTIABLE AND THE PROPOSER TIMELY SUBMITTED A REQUEST FOR CHANGE OR PROTEST OF THE TERMS AND CONDITIONS AT ISSUE AND INDICATES ITS INTENT TO NEGOTIATE A SPECIFIC TERM OR CONDITION ON THE LEGAL TERMS AND CONDITIONS FORM (see Part D Attachment 1) ON THE PROPOSAL SUBMISSION WEBSITE.

4.8 Responsible Proposer

OEBB reserves the right, pursuant to OAR 111-005-0055, and following the standards described in ORS 279B.110, to investigate and evaluate, at any time prior to award and execution of the Contract, the ASPs responsibility to perform the Contract. Submission of a signed proposal shall constitute approval for OEBB to obtain any information OEBB deems necessary to conduct the evaluation, including contacting Proposers' current and former customers even if not listed as a reference in Proposers' proposals. OEBB may notify a Proposer, including an ASP, in writing, of any other documentation required, which may include, but is not limited to, recent financial performance, current balance and income statements, assets-to-liabilities and other financial ratios, availability of short and long-term financing, credit information, facility and personnel information, performance record of contract performance, and resolved or unresolved governmental investigations. Failure to promptly provide this information will result in a proposal being rejected.

OEBB may postpone the award of a Contract after announcement of the ASPs in order to complete its investigation and evaluation. Failure of an ASP to demonstrate responsibility shall render the Proposer non-responsible and constitute grounds for offer rejection.

4.9 Protest of Award

OEBB will publicly announce the Board's selection of this RFP's ASPs and intent to issue a Notice of Intent to Award immediately following the public meetings at which ASPs are chosen. Concurrently, each Proposer to this RFP will be sent a written notice indicating the Proposer's respective selection status.

A Proposer that claims to have been adversely affected or aggrieved by the selection of a competing Proposer will be allowed to submit a written protest to OEBB, consistent with OAR 111-005-0040(11). To be adversely affected or aggrieved, the Proposer must demonstrate in its written protest of award all the factors described in OAR 111-005-0040(11).

To be considered, protests must be submitted in writing and addressed to the RFP's Single Point of Contact shown on the front page of this RFP. Furthermore, protests must be received by the due dates listed in **Section 1.2**. In addition, protests must meet the following requirements to be considered:

1. Protests must be signed by a Proposer's authorized representative;
2. Protests must identify the proposing entity (Proposer's name as it is listed in the Proposal);
3. Protests must reference this specific RFP by number; or,
4. Proposers must explicitly state the reasons for the protest.

To ensure the integrity of the RFP process, no protests will be accepted by any OEBB staff, Board Member, or Towers Watson staff. Rather, protests will only be accepted by RFP's Single Point of Contact. Furthermore, protests shall be considered void and not responded to, in the following events or situations:

1. Protests submitted by phone;

2. Protests received later than seven (7) calendar days after the date on which OEBC issued its Intent to Award;
3. Protests that do not identify the person or party requesting the information; and,
4. Protests that are not relevant to the awarding of the Contracts.

OEBC will consider protests in accordance with applicable state law. OEBC intends to respond in writing to properly-filed protests submitted by adversely affected or aggrieved Proposers. Any response provided by OEBC, however, is not intended to, and may not in and of itself constitute, confirmation that the Proposer is in fact adversely affected or aggrieved and therefore entitled to protest the intent to award.

Section 5: Execution of Contract

5.1 Inability to Reach Agreement

If an agreement on the terms of the Contract cannot be reached, or if an ASP fails to execute the Contract in a timely manner, OEGB may immediately terminate negotiations with that ASP and may subsequently begin negotiations with the next best qualified Proposer or designated alternates, as determined by the Board. This process may continue until acceptable Contracts are reached.

In negotiating the terms of the Contract, Proposers agree, by submitting a proposal to this RFP, that in developing rates for the 2016-17 Plan Year (and potentially subsequent Plan Years), OEGB requires that proposals be based on OEGB's overall population. The claims data for OEGB's current plans are provided in the Claims Data Set in **Exhibit 9**.

5.2 Allowance for Amendment to Contract

OEGB reserves the right to amend any resulting Contract, including amending the Statement of Work that results from this RFP, if the amendment is within the Scope of Work described in this RFP. In addition, Proposers must recognize that the State Legislature may pass benefit mandates affecting OEGB, or revise OEGB statutes or other statutes that may impact this Contract.

5.3 Permission Required for News and other Media Releases

Participants in this RFP process, including the ASPs that eventually enter into a Contract with OEGB for the services contained in this RFP, may issue news releases pertaining to this procurement process and any resulting Contract only with the prior written consent from and in coordination with OEGB's Administrator.

THE END: The 27 pages include the title page which does not have a page number.

SECTION A- ADMINISTRATIVE SERVICES QUESTIONNAIRE

1.1 Company Background

1.1.1 Indicate the primary person responsible for completing this questionnaire.

| | Answer |
|----------------|-------------------|
| Name | <i>Unlimited.</i> |
| Title | <i>Unlimited.</i> |
| Address | <i>Unlimited.</i> |
| Phone Number | <i>Unlimited.</i> |
| E-Mail address | <i>Unlimited.</i> |

1.1.2 Do you have a parent organization? If yes, indicate if you are a subsidiary of another corporation and describe the corporate structure as well as the financial relationship between your company and the parent company. Please provide an organizational chart in Part D, Attachment 10, depicting the corporate structure and where your company is located in that structure.

1: Yes: [500 words],
2: No

1.1.3 Describe your company's organizational mission, vision and value.
[500 words]

1.1.4 Indicate your top three strategic priorities and how they will achieve OEBC's mission.
[500 words]

1.1.5 Provide a description of any company initiatives or innovations, either current or planned, over the next 18 to 24 months, which will impact the delivery of services to OEBC during the Contract period. Examples include system changes or migrations, call center opening/closing, mail service, or network re-contracting, etc.
[500 words]

1.1.6 Identify all contracted 3rd party contractors that may implement or provide services that are included as part of this proposal to OEBC. Describe:

- The services they each will provide OEBC.
 - The duration you have been working together.
 - How your organization monitors performance and ensures accountability from each contractor.
 - How your contracts ensure that 3rd party contractors maintain high levels of customer service to plan members receiving services through a contracted vendor.
 - Any services that are intended to be subcontracted for future business delivery.
- [1000 words]

1.1.7 For any subcontracted service, do you hold the subcontractor to the same standards for Member Services, Access to care and Claims Payment?

[100 words]

1.1.8 Provide references for three current clients (similar size or similar services as requested by OEBC); and three clients that have recently terminated.

| Current Clients | Client 1 | Client 2 | Client 3 |
|-------------------------|----------|----------|----------|
| Client Name | | | |
| Primary Contact | | | |
| Title | | | |
| Telephone Number | | | |
| E-mail Address | | | |
| # of Members & Retirees | | | |

| Terminated Clients | Client 1 | Client 2 | Client 3 |
|---------------------------|----------|----------|----------|
| Client Name | | | |
| Primary Contact | | | |
| Title | | | |
| Telephone Number | | | |
| E-mail Address | | | |
| # of Members & Retirees | | | |

1.1.9 How many clients and participants do you currently provide the following types of coverage to? (NA if doesn't apply)

| | Year your company began providing these services | Number of clients | Number of clients with over 10,000 employees | Number of participants |
|--|--|-------------------|--|------------------------|
| Medical (including behavior health, addiction services and alternative care) | <i>Decimal.</i> | <i>Decimal.</i> | <i>Decimal.</i> | <i>Decimal.</i> |
| Pharmacy | <i>Decimal.</i> | <i>Decimal.</i> | <i>Decimal.</i> | <i>Decimal.</i> |
| Vision | <i>Decimal.</i> | <i>Decimal.</i> | <i>Decimal.</i> | <i>Decimal.</i> |

1.1.10 Provide your most recent audited financial statement in Part D, attachment 10.

1.1.11 Briefly describe any additional or optional services that your organization offers that have not specifically been requested (value added services).
[1000 words]

1.2 Account Services

1.2.1 Team Assignments (Account Management, Medical Director, Pharmacist, Implementation Manager, Member Services, Claims) for all services you are applying for:

| | Account Management | Medical Director | Pharmacist | Implementation Manager | Member Services | Claims |
|--|--------------------|------------------|------------|------------------------|-----------------|--------|
| Name | | | | | | |
| Title | | | | | | |
| Location | | | | | | |
| Years with company | | | | | | |
| Dedicated or designated? | | | | | | |
| Current # of clients | | | | | | |
| Primary responsibilities | | | | | | |
| Relevant experience with public sector clients | | | | | | |
| What does this team member specifically bring to OEBC? [50 words] | | | | | | |
| The percentage of time the assigned person will be dedicated to working with OEBC. | | | | | | |

1.2.2 Confirm members of the account management team are expected to respond to all account inquiries from the OEBC staff within one business day.

- Confirmed,
 Not confirmed, explain: [100 words]

1.2.3 Describe the working relationship between your member service, account management and implementation teams.
[500 words]

1.2.4 Please provide a comprehensive implementation plan including the following information. Please attach the Implementation Plan and Timeline in Part D, Attachment 10.

- i. Detailed Implementation Schedule
- ii. Implementation Communication Plan
- iii. Implementation Work Plan
- iv. Disruption Minimization Plan
- v. Organization charts for implementation and account management teams

1.2.5 Will an implementation manager and support team be assigned to lead and coordinate the implementation activities with OEBC?

Yes

No

1.2.6 Are the key people involved with ongoing account management also involved in the implementation?

- Yes
- No, If not please explain [100 words]

1.2.7 Confirm your procedures for handling the following during the transition period (*check all that apply*):

- Services that have been prior-authorized but not completed as of the effective date must also be pre-certified by new plan
- Services that have been prior-authorized but not completed as of the effective date will be honored and payable by new administrator
- Will provide pre-enrollment materials to members
- Will make customer service line available to members prior to the effective date.
- Provide an attachment describing your network transition of care provisions for patients that are currently receiving care for services at providers that are not in your network

1.2.8 Provide information on the staffing and training in your various departments to handle the onboarding of up to 150,000 members all at once?

[500 words]

1.3 Member Services

1.3.1 Describe your member service philosophy and the ways the organization carries out this philosophy.

[500 words]

1.3.1 Confirm that your member services will handle each service you are proposing. If not, please indicate who will be.

| | Yes, calls for this service are answered by internal staff. List the unit that handles these calls. | No, we will not handle calls for this service. | Name company that will handle member service calls for this service. |
|---|---|--|--|
| Medical (includes mental health, addiction services and alternative care) | | | |
| Pharmacy | | | |
| Vision Services | | | |

1.3.2 Describe the member service center(s) that will serve OEBC (for each of the services you are proposing):

| | | | |
|--|---------|----------|--------|
| | Medical | Pharmacy | Vision |
|--|---------|----------|--------|

| | | | |
|--|--|--|--|
| Member Services Location(s) | | | |
| Dedicated unit (Only calls for OEBC will be serviced) | | | |
| Designated unit (Only calls for OEBC and specified other Accounts will be serviced) | | | |
| Not a Dedicated or Designated unit | | | |
| Number of member service representatives at each location during office hours | | | |
| Average Years of experience of member service representatives at each location | | | |
| How many member service representatives, and what percent of the total, are located off-shore, outside the US, if any? | | | |

1.3.3 When calls are answered by IVR, how many prompts will the member need to enter at the most before getting a live person to talk with during **regular business days from 7:30 a.m. – 5:30 p.m. PST?**

| | Medical | Pharmacy | Vision |
|---|-----------------------|-----------------------|-----------------------|
| No IVR used. All calls answered by a Live person during normal business hours | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 1 prompt | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2 prompts | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 3 or more prompts | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

1.3.4 Call Documentation and Tracking System:

| | Response |
|--|----------|
| Are all calls recorded? | |
| How long are recorded calls archived? | |
| What types of calls do you document in your call tracking system? | |
| What percent of all member services inquiries are documented in your call tracking system? | |
| What percentage of member service calls is audited? | |

1.3.5 Do claims and member services staff have access to the same systems or have access to each other's systems?

- Yes
- No

1.3.6 Can your member services unit support non-English speaking Members? Check all that apply.

- Yes, Plan representative remains on line to ensure Member needs are being addressed. Please list languages.
- Yes, Members are transferred to a language service. Please list languages.

- Yes, Plan employs CSRs who speak other languages. Please list languages.
- We do not support non-English speaking Members

1.3.7 How does your organization work with participants who are hearing or visually impaired?

- Resources are available. Please describe (100 words)
- No resources available. Please explain (100 words)

1.3.8 Confirm you will assign a toll-free telephone line dedicated to handle OEBC member inquiries, if enrollment exceeds 10,000 members or you have 80% of the service area's enrollment.

- Yes
- No, please explain:

1.3.9 Respond to the following regarding the member services center for 2014 for each service you are proposing:

| 1 | What was the Average Phone Response Time in seconds | Medical | Pharmacy | Vision |
|---|---|---------|----------|--------|
| 2 | What was your average turnaround time for ID cards? (Defined as the average number of business days between enrolling a new group and plan mailing ID cards to Members) | | | |
| 3 | What was the turnover rate (do not include internal promotions) for your customer service staff? | | | |
| 4 | What is your initial call resolution rate? (calls not requiring a call back by either party) | | | |
| 5 | What percentage of calls were answered by a live person within 30 seconds? | | | |
| 6 | What was the Call Abandonment Rate? | | | |

1.3.10 Provide the hours of operation in Pacific Standard Time for the services you are proposing.

| | Medical | | Pharmacy | | Vision | |
|--|---------|---------|----------|---------|---------|---------|
| | Weekday | Weekend | Weekday | Weekend | Weekday | Weekend |
| Claims Department | | | | | | |
| Eligibility Enrollment | | | | | | |
| Member Service (live) | | | | | | |
| Member Service (voice messaging) | | | | | | |
| Customer/Member Service - On-line chat | | | | | | |

1.3.11 Indicate after-hours accessibility to member services:

- Members reach a live representative in the member services 24 hours per day, 7 days per week.
- Member services telephones are answered by an automatic telephone system that directs the Member to self-service options (e.g., ordering ID cards, provider directories, etc.).
- Members can leave a message and be contacted by your personnel the next business day.
- Members receive a recorded message providing your hours of operation and instructions to Members to access emergency care
- Members receive a recorded message providing your hours of operation and instructions to call the Member's provider to access services.

- Members receive a recorded message prompting them to access your web site
- Members receive a recorded message explaining you are closed and Member should call back during normal business hours.

1.3.12 Identify the specific services and information a Member can access via each of the mediums below.

| | | Toll-free Number | Email | APP |
|---|----------------------------------|------------------|-------|-----|
| 1 | Address/contact change info | | | |
| 2 | Enrollment/family status changes | | | |
| 3 | Request ID Card | | | |
| 4 | Eligibility Clarification | | | |
| 5 | Prior-Authorization | | | |
| 6 | Provider Network questions | | | |
| 7 | Benefit Clarification | | | |
| 8 | Claims Status | | | |

1.3.13 Is emailing available to membership services? If yes. What is the average response time.

- Yes: Average Response Time: _____
- No

[500 words]

1.4 Eligibility and Enrollment

1.4.1 Confirm you can accept full weekly and monthly eligibility files that include all new and ongoing actively enrolled members and coverage terminations for the week/month via a HIPAA 834, 5010 version file transfer process.

- Confirmed,
- Not confirmed, explain: [100 words]

1.4.2 Outside of OEBC's regular weekly file transfer process, how frequently can you update Member eligibility on your system for ad hoc situations?

- Real time
- Daily (information is batched and made available next business day)
- Weekly
- Less frequently than weekly
- Online eligibility is not supported

1.4.3 How long after notification does it take to process a new member so they are eligible in the system?

- Within 24 hours
- Within 48 hours
- Within 5 business days
- Longer than 5 business days

1.4.4 What functionality is available to OEBC for enrollment processing? Check all that apply.

| | Web-based | Telephonic | Paper-based | E-mail |
|------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Add enrollees | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Change enrollees | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| Ad hoc change | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Terminate enrollees | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| View enrollment status by individual Member | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

1.4.5 How often can member eligibility be updated?

- Daily
- Weekly
- Semi-monthly
- Monthly
- Other, please provide

1.4.6 Can OEBC update members on an ad hoc basis - outside of the normal eligibility update schedule?

- Yes
- No

1.4.7 How long after notification does it take to process a new member so they are eligible in the system?

- Within 24 hours
- Within 48 hours
- Within 5 days
- Longer than 7 days

1.4.8 What forms do you have for ID cards? Check all that apply

- Our system is paperless
- Hard copy
- Electronic
- Smart Phone
- Other _____

1.5 Billing & Claims Processing

1.5.1 Will the claims service location(s) handle all proposed coverages)?

| | Medical | Pharmacy | Vision |
|--|-----------------------|-----------------------|-----------------------|
| Yes, | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| No, | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| If No, explain where and how they are handled for each service you are proposing [50 words each] | | | |

1.5.2 Respond to the following table regarding claims processing? team structure:

| | Response |
|--|----------|
| Designated or dedicated to OEBC? | |
| # of claims processing team members | |
| If not designated, the # of accounts or clients serviced and total members | |
| Are any claim processors located "off shore" ? | |

| | |
|---|----------------------------------|
| Average ratio of claim examiners to covered lives (employee + dependents) | One examiner per _##.##_ members |
| Other | |

1.5.3 Provide year-end **average** claim statistics for the office that will service OEBB’s plan(s) for the most recent two years for each service you are proposing:

| | Medical | | Pharmacy | | Vision | |
|--|---------|------|----------|------|--------|------|
| | 2013 | 2014 | 2013 | 2014 | 2013 | 2014 |
| Claim turnaround time | | | | | | |
| % of claims processed in 7 days | | | | | | |
| % of claims processed in 15 days | | | | | | |
| % of claims processed in 30 days | | | | | | |
| Financial (dollar) accuracy | | | | | | |
| Regarding overpayment recovery: | | | | | | |
| What is your Book of Business (BOB) overpayment recovery rate for the past year-percentage of overpaid dollars recovered within: | | | | | | |
| 90 calendar days | | | | | | |
| 180 calendar days | | | | | | |
| Specific to third party liability recoveries | | | | | | |
| Describe your success in auditing do not pay (never) events | | | | | | |

1.5.4 What percent of recoveries was retained for administration in 2014?
[Percentage-2014 __%]

1.5.5 Confirm that your proposal includes claim fiduciary services.

- Confirmed,
 Not confirmed, explain: [100 words]

1.5.6 Outline your claims payment system for each service you are proposing (include any subcontractors who pay claims):

| | Medical | Pharmacy | Vision |
|--|---------|----------|--------|
| Are any claim payments outsourced? If so, state the vendor and reason | | | |
| Describe any system upgrades or conversions anticipated in the next three years | | | |
| Identify the editing system used to comply with NCCI and identify inappropriate claims and coding issues | | | |

| | | | |
|---|--|--|--|
| Describe the functionality of the claims editing system | | | |
|---|--|--|--|

- 1.5.7 What kind of support is available to Members requiring care out of state but within the US? How are those claims administered?
[500 words]
- 1.5.8 What resources are available to Members that are located internationally for extended periods of time (i.e., 1 year or more)? How is care obtained internationally when traveling? How are those claims administered?
[500 words]
- 1.5.9 Do you have a disaster recovery plan and a business continuity plan for claim operations? Have either of them been tested or implemented?
 Yes, Explain
 No, Explain
- 1.5.10 What percentage of claims were automatically adjudicated (no manual intervention of any kind) by your system?
Percent – 2014 ___%
- 1.5.11 Overall, what percentage of all claims processed are subject to a random internal audit review?
Percentage-2014___%
- 1.5.12 Indicate which of the following programs are housed on the same platform as your claims system (check all that apply):
 Eligibility
 Network provider pricing
 Customer service Member call notes
 Referrals/Prior Authorizations
 None
- 1.5.13 If any of the above programs are not housed on the same platform as the claims system, confirm there is an electronic link between your claims system and any programs housed outside of the claims system that allows integrated reporting.
[100 words]
- 1.5.14 How often do you update your Usual and Customary Rates (UCR) tables for each of the services you are proposing?

| | | Monthly | Quarterly | Twice per year | Less frequently than twice per year |
|---|---|--------------------------|--------------------------|--------------------------|-------------------------------------|
| 1 | Medical (include any subcontractors who pay claims) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2 | Pharmacy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3 | Vision | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

- 1.5.15 Describe all your methods used to determine allowable fees for each of the services you are proposing and the % of time each of them is used.

| | | Inside US | Outside US | Not Applicable |
|---|---|-----------|------------|----------------|
| 1 | Medical (include any subcontractors who pay claims) | | | |
| 2 | Pharmacy | | | |
| 3 | Vision | | | |

- 1.5.16 Discuss your internal audits and controls applied to ensure that a customized, client-specific plan design that may deviate from your standard system logic is being properly administered.
[500 words]
- 1.5.17 Does your system have the ability to accommodate a benefit revision or retroactive benefit change?
 Yes, system automatically identifies prior claims to be adjusted.
 No, claim processors must manually identify claims to be adjusted.
- 1.5.18 What are the average elapsed times for the following:
 Plan Standard Actual elapsed time (from most recent audit): [number of days #.#]
 Between clean claim submission and re-pricing: [number of days #.#]
 Between re-pricing and adjudication: [number of days #.#]
 Between adjudication and transmission of EOB: [number of days #.#]
- 1.5.19 Are you willing to submit to external audits that verify the accuracy of your re-pricing and/or adjudication functions when requested by your clients?
 Yes
 No If no, Explain. [100 words]
- 1.5.20 Provide an overview of your internal audit procedures to safeguard against fraud or billing irregularities.
[500 words].
- 1.5.21 Are providers in your network required to hold patients harmless from charges that exceed the agreed upon fees (balance billing)?
 Yes, verification is available
 Yes; however, verification is not available. Please explain. [500 words]
 No, please explain [500 words].
- 1.5.22 Describe your claims appeals process. How many levels of appeals do you have? Include your process for Independent Review Organization (IRO) appeals. Attach a copy of your appeal and grievance report for 2014 in Part D, Attachment 10.
[500 words].

1.6 Communications

OEBB believes that clear, meaningful, engaging and responsive communication with Members is integral to the success of OEBB's overall goals of better health, better care and lower costs. OEBB expects its partners will provide customized and thoughtful communications (in various formats) that will assist Members in understanding their benefits and engage them in proactively managing their health.

1.6.1 Open Enrollment Support: During the annual Open Enrollment period (historically August 15-September 15), participating entities of varying sizes throughout Oregon hold information meetings and benefit fairs. If you service the entire state, this could be over 100 meetings, many on the same day in

different parts of Oregon. Confirm you will have knowledgeable representatives attend these meetings and benefit fairs in person as requested by OEGB.

- Confirmed,
- Not confirmed, explain: [500 words]

1.6.2 Describe communications support that you currently provide to your customers (e.g. Member Handbook, ID card, EOB, etc). Include examples of these communications in Part D, Attachment 10. [500 words].

1.6.3 Describe member direct mailers, emails, and other targeted communications your organization provides to outreach to members. Indicate how frequently these targeted communications are provided. Include examples of these communications in Part D, Attachment 10. [500 words].

1.6.5 Describe how the plan proactively supports two-way communication with members, actively seeking and incorporating feedback from members on:

| | Response | Frequency |
|----------------------------|----------|-----------|
| Online tools and resources | | |
| Network | | |
| Plan programs | | |
| Provider service | | |
| Patient satisfaction | | |
| Other | | |

1.6.6 How will the plan work with OEGB to ensure that OEGB feels confident that you will put the members and their families at the center of your approach? [500 words]

1.6.7 Describe how feedback is obtained and incorporated around members' individual experience with care in the office:

| | Response |
|---------------------------------|----------|
| Wait times | |
| Treatment while there | |
| Access | |
| Information and communications. | |

1.6.8 How frequently is your provider directory updated both online and in hard copy? What is your process for ensuring information in the directory is accurate, current, and complete? [100 words]

1.6.9 Describe your plans' resources for providing technical support to members using your member web portal (e.g., account set-up assistance, password reset, etc.). [500 words]

1.6.10 Describe your plan’s communication strategies using technology including social media to enhance communication with members, engage them in participating in their own health and educating them on your plan’s wellness programs.
[1000 words]

1.6.11 What are your methods for communicating practitioner contracting changes (adds, deletes, address or phone number changes, etc.)? Respond specifically with respect to the methods of communication (listed in far-left column) used in direct-to-Member communication and direct-to-employer communication.

Members and Employers Members only Employers only Neither
Directory
Letter
Website
Publications
Electronic file updates

1.6.12 Which of the following services are currently available through your website for each of the services you are proposing?

| | Medical | Pharmacy | Vision |
|--|-----------------------|-----------------------|-----------------------|
| Member Services - Confirm members can: | | | |
| View Member Handbook | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Access benefit plan summaries | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Check eligibility and enrollment | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Order replacement ID cards | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| View and print ID cards from the website | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Submit inquiries to member service via email | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Engage in member service representative chats | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Participate in community forums | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Look up health care cost information | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Compare health care costs by Provider | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Talk to Providers via IM/chat/email or phone | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| File a claim | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Download printable versions of claim forms | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Check claim status | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Submit complaints or appeals | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| View Explanation of Benefits (EOBs) online | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Opt out of paper EOB’s | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| PHARMACY ONLY: | | | |
| Perform an OEBC-specific formulary search? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Perform an OEBC-specific formulary comparison (e.g., brand vs. generic)? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Track mail order status? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Track specialty pharmacy fills and status? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

| | | | |
|--|-----------------------|-----------------------|-----------------------|
| Search for a pharmacy, including mapping software? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Obtain drug pricing information? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Review and print personal drug profiles? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

1.6.12 Indicate the types of information available through your web-based provider directory. Check all that apply.

| | | Displayed only | Searchable and displayed | Not Available |
|----|--|--------------------------|--------------------------|--------------------------|
| 1 | Provider name search | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2 | Facility name search | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3 | County Search | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4 | Zip Code Search | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5 | Driving Instructions | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6 | Provider office hours | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7 | Providers accepting new patients | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8 | Provider specialty search | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9 | Handicap accessible and hearing impaired notification | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10 | Provider languages spoken | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11 | Identify Patient Centered Primary Care Homes (PCPCH) certified by the Oregon Health Authority (OHA)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12 | Provider search tailored to Member's specific plan design and/or network limitations | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13 | Access and search Provider quality indicators and performance measure information | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14 | Information on How to Select a Provider | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15 | Degrees | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 16 | Certifications | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

1.6.13 What information is mailed or emailed to new members within the first 21 days of their coverage effective date? Check all that apply below.

| | | Mailed | Mailed Only Upon Request | Emailed |
|---|--|--------------------------|--------------------------|--------------------------|
| 1 | Welcome Letter with web page URL's to locate information and resources including items listed below: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2 | Member Services Phone Number | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3 | ID Card | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4 | Benefit/Coverage information | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5 | Member Handbook | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6 | Hard Copy Provider Directory | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7 | Online access to Provider directory and search engine | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8 | Customized Provider List by Geographic Location of Member | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| | | | | |
|---|---|--------------------------|--------------------------|--------------------------|
| 9 | Information on How to Select a Provider | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|---|---|--------------------------|--------------------------|--------------------------|

1.6.14 Confirm that you will agree to provide OEBC the opportunity to review and approve all direct member communications and marketing materials prior to printing/distribution or posting on your website

- Confirmed,
- Not confirmed, explain: [100 words]

1.6.15 Confirm that you are willing to customize communication materials at no charge

- Confirmed,
- Not confirmed, explain: [100 words]

1.6.16 What languages other than English can you make informational materials available?
[50 words]

1.6.17 What outreach methods do you employ to educate providers on the OEBC plans?
[100 words]

1.6.18 Indicate if member satisfaction surveys are conducted about your health plan and its providers (e.g., CAHPS, Press Ganey). State percentage that were satisfied or very satisfied, or scored 8 out of 10 or better on a ten point scale in latest survey for each. If measured differently, please describe. Include who results are shared with and the frequency member satisfaction surveys are performed. Submit the survey and results as an Attachment in Part D, Attachment 10.

- Surveys conducted and results uploaded
- No surveys have been conducted

1.6.19 Confirm your ability to co-brand the following. Check all that apply:

| | |
|--------------------------|------------------------------|
| <input type="checkbox"/> | Member communications |
| <input type="checkbox"/> | Member materials |
| <input type="checkbox"/> | ID cards |
| <input type="checkbox"/> | Website – OEBC member portal |
| <input type="checkbox"/> | Open Enrollment materials |

1.6.20 How do you support delivery of culturally competent health care and health equity within your organization and what additional steps will you take to promote this for OEBC Members?

1.7 Technology Capabilities

1.7.1 Can you accommodate the use of OEBC's unique member identifier for your ID cards and for members to use for signing-on to your website? Provide sample online access to website and reporting system.
[100 words]

1.7.2 Describe your other “technology” platforms to connect with members, such as smart phone or tablet apps, email, or other? Describe how these enhance or support OEBC achieving its vision.
[500 words]

1.7.3 Which of the following services are currently available through your website? If not available, please indicate when it can be available.

| Provider Support: Confirm providers can: | <i>Yes/No</i> | <i>If no, when can it be available?</i> |
|--|---------------|---|
| Verify in “real-time” the eligibility status of members? | <i>Yes/No</i> | |
| Input virtual medical records for their patients? | <i>Yes/No</i> | |
| Access drug and medical history for their patients from other providers or entities within their primary health system? | <i>Yes/No</i> | |
| Access drug and medical history for their patients from other providers or entities outside their primary health system? | <i>Yes/No</i> | |
| Access lab values? | <i>Yes/No</i> | |
| Submit electronic claims? | <i>Yes/No</i> | |
| Check claims status online and/or electronically | <i>Yes/No</i> | |
| Submit electronic prior-authorization and referral requests? | <i>Yes/No</i> | |
| Respond to member questions? | <i>Yes/No</i> | |
| Access to other tests results (e.g. reports on x-ray. MRI, Cats Scans) and other prescribed items? | <i>Yes/No</i> | |
| Do you have other “technology” platforms to connect with providers through mobile technology such as Smart phone apps? iPad apps? Email? | <i>Yes/No</i> | |
| Member Services: Confirm Members can: | | |
| Complete Health Assessment online? | <i>Yes/No</i> | |
| Check claim status online? | <i>Yes/No</i> | |
| View EOB online? | <i>Yes/No</i> | |
| Verify eligibility online? | <i>Yes/No</i> | |
| Request ID card? | <i>Yes/No</i> | |
| View Member Handbook and Summaries of Benefits online? | <i>Yes/No</i> | |
| Access Wellness Tools online? | <i>Yes/No</i> | |

1.7.5 Describe how your systems will be prepared to handle the onboarding of up to 150,000 new members at once.

[500 words]

1.7.6 Provide a copy of your three-year IT Strategic Plan in Part D, Attachment 10.

1.8 Compliance, Health Reform, HIPAA, and Privacy

1.8.1 Confirm your organization is fully compliant with the current terms of the Patient Protection and Affordable Care Act (ACA).

Confirmed,

Not confirmed, explain: [100 words]

1.8.2 Confirm your organization is in compliance with all current Health Insurance Portability and Accountability Act (HIPAA) regulations for privacy and security.

- Confirmed,
 Not confirmed, explain: [100 words]

1.8.3 Confirm all personal health information obtained while providing the services outlined in this RFP and any information provided by or to Members online or through any other method will be encrypted and password protected.

- Confirmed,
 Not confirmed, explain: [100 words]

1.8.4 Describe the services and tools available from your organization to assist OEBC in complying (e.g., providing enrollment counts) with regulations in the Patient Protection and Affordable Health Care Act (ACA).

[500 words]

1.8.5 Describe your prior authorization appeals process and address the following:

- Standard response time guidelines
- Notification of denial and appeal rights
- Qualifications for determining the need for provider review

[1000 words]

1.8.6 For informational purposes, confirm your organization's ability to use the International Classification of Diseases (ICD)-10 by providing the following:

- Your organization's current status for using the ICD-10
- A brief summary of your project plan for ICD-10 implementation, including applicable dates for each major phase of the project plan

- Confirmed,[100 words]
 Not Confirmed [100 words]

1.8.7 Are you compliant with the HIPAA Security Rule that was established April 21, 2005?

- Yes
 No, please explain

1.8.8 Are you in compliance with the 834 HIPAA standards?

- Yes
 No, please explain:

1.9 Financial & Analytics Reporting

1.9.1 OEBC has developed robust reporting requirements. **Part D-Attachment 2** is a slightly revised copy of our current requirements. All Proposers must respond to Sections 1a-h; 2 a & b; 3h-n; 4 e-g and Section 7 and indicate if they are able to comply with each requirement.

MEDICAL ONLY: Please review Section 3 a-g and Section 4 a-d and indicate if you are able to comply with each requirement

PHARMACY ONLY: Please review Section 1 i-k, Section 3 o & p and Section 6 and indicate if you are able to comply with each requirement.

1.9.2 Confirm you will provide reports specific to the OEGB's population and you have the ability to create group-level reports by employer and employee group within an organization. Include your ability to track individual members if they change from one plan, employer or employee group to another. Can you provide comparative data from your book of business?

- Confirmed, explain: [100 words]
 Not confirmed, explain: [100 words]

1.9.3. Provide your Underwriting Analysis in Part D, Attachment 10.

- Confirmed,
 Not confirmed.

1.9.4 Provide your standard monthly, quarterly, semi-annual and annual Financial Reports in Part D, Attachment 10.

- Confirmed,
 Not confirmed.

1.10 Performance Guarantees

OEGB has standard administrative performance guarantees. **Part D-Attachment 2** is a copy of our current performance guarantee with two (2) new ones for implementation. Please review Section 5 and indicate if you are able to comply with each requirement

1.10.1 As noted in **Part D-Attachment 2** Section 5, OEGB expects your commitment to providing Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results for OEGB members; unless there are less than 100 OEGB member plan enrollments - then the overall book of business can be used. If you do not participate in CAHPS due to the size of your business, confirm your commitment to conduct a quarterly Member satisfaction survey for OEGB Members using a mutually-agreeable instrument.

- Confirmed, explain: [100 words]
 Not confirmed, explain: [100 words]

1.10.2 Confirm that you agree to allow OEGB to audit your reported performance guarantee results, including an independent or mutually agreed upon third-party audit if requested by OEGB. You agree to use the results of any such audit as the basis for measurement of the performance guarantees for the period in question.

- Confirmed,
 Not confirmed, explain: [100 words]

1.10.3 Please provide your standard and actual results for the last two (2) years for each of the following

| 2014 Standard | 2014 Actual | 2013 Standard | 2013 Actual |
|---|-------------|---------------|-------------|
| Claims processing rate: % of claims processed within 10 business days (all claims) | | | |
| Claims processing rate: % of claims processed within 15 business days (all claims) | | | |
| Claims dollar accuracy: \$ paid correctly/ total \$ paid (percentage, please respond in decimal form) | | | |
| Claims incidence accuracy: claims paid correctly/ total claims paid (non-financial). | | | |

1.11 Quality (Please provide specific information for each of the services you are proposing)

- 1.11.1 Explain how you measure provider and facility quality and support improvement. *[1000 words]*
- 1.11.2 Do you have a procedure for monitoring and responding to provider sanctions and complaints?
Yes, describe [500 words]
No
- 1.11.3 How does the plan make cost and quality information available to members? Please answer the following questions and provide the requested following information:
- a. Is the information available via your member website and/or mobile app?
 - b. Are members able to review the costs of various providers and facilities by procedures and services performed and compare these costs to a benchmark in advance of receiving services? Describe the tool and its capabilities including if it identifies in-and-out-of network providers and member's potential out-of-pocket costs.
 - c. What quality data is integrated into the member self-service transparency tool? Please list sources and types of information.
[1000 words]
- 1.11.4 Describe the source of your pricing and quality data and how frequently each data source updated?
[500 words]
- 1.11.5 Do you combine projected price information with your members' benefit plan design to provide information about the price of services, benefit design, deductibles, coinsurance, etc. on your website?
Yes, describe [500 words]
No, describe [500 words]

SECTION B - MEDICAL SERVICES QUESTIONNAIRE

The Board's major goals are consistent with the health care Triple Aim – better health, better care, and lower costs. In providing benefits to educational and local government employees, the Board believes in creating strong partnerships with Contractors to transform the healthcare delivery system, promote evidence-based care, support Member engagement in health care decision making and advance prevention and wellness.

The following questions are intended to help identify the current structure of your Plan's approach, as well as your capacity to be flexible and innovative.

2.1 Care Transformation

OEBB supports collaborative efforts within Oregon to transform healthcare delivery, promote evidence-based care, enhance patient safety, improve outcomes and lower costs. This includes support of initiatives led by the Oregon Health Authority (OHA) Transformation Center, Oregon Healthcare Quality Corporation (OHQC), Oregon Patient Safety Commission and other public partners and stakeholders. OEBB expects Contractors to actively engage in collaborative initiatives aimed at improving quality, access, safety and outcomes, as well as lowering the cost of care provided to OEBB Members. OEBB also expects Contractors to continuously enhance the quality and safety expectations included in their provider and facility contracts and actively manage their contracts to ensure these expectations are being met.

2.1.1. Propose innovative benefits or alternative network approaches not yet included in OEBB's benefits program that your Plan would suggest OEBB consider in support of furthering the Triple Aim.

[1000 words]

2.1.2 Recognizing that behavioral health and addiction diagnosis and treatment is often underutilized, OEBB would like to improve the diagnosis and treatment of these conditions in its population. Describe innovations in screening, identification, care coordination and care delivery your Plan has implemented, or are pursuing, to improve diagnosis and treatment of individuals with behavioral health and addiction challenges and how that links to OEBB's vision. Innovations could be implemented at the plan level or systems the plan has in place to support innovation at the provider level. Describe specific steps your Plan will take to promote additional service delivery integration in OEBB's Plan Designs for OEBB Members.

2.1.3 Describe innovations your Plan has implemented to better integrate care across other areas of the healthcare system including, but not limited to, vision, pharmacy and dental care.

[1000 words]

2.1.4 Describe your Plan's experience coordinating care with Employee Assistance Programs (EAP) to ensure continuity in care from an EAP's provider to a provider on your panel.

[1000 words]

2.2 Primary Care Providers (PCPs) and Patient Centered Primary Care Home (PCPCH)

OEBB has actively supported the medical home model of care delivery for a number of years. OEBB’s current and future medical home strategies align with broader health system transformation efforts occurring in the state of Oregon and support use of Patient Centered Primary Care Homes (PCPCH) as recognized by the Oregon Health Authority. OEBB will partner with Contractors that support its strategies and offer Members access to care through OHA-recognized PCPCHs. OEBB seeks partners committed to incentivizing Members’ use of this care delivery model and enhancing provider adoption of patient centered primary care.

2.2.1 Complete the table outlining the number of Primary Care Providers (PCPs) in your Plan’s network in each County within Oregon. Provide the number of PCPs that were within a Patient Centered Primary Care Home (PCPCH) as of April 2015.

| County | Number of PCPCH’s* in 2014 | Number of PCP’s** in 2014 | Number of PCP’s ** in PCPCH as of 4/2015 |
|-------------------|----------------------------|---------------------------|--|
| Baker County | | | |
| Benton County | | | |
| Clackamas County | | | |
| Clatsop County | | | |
| Columbia County | | | |
| Coos County | | | |
| Crook County | | | |
| Curry County | | | |
| Deschutes County | | | |
| Douglas County | | | |
| Gilliam County | | | |
| Grant County | | | |
| Harney County | | | |
| Hood River County | | | |
| Jackson County | | | |
| Jefferson County | | | |
| Josephine County | | | |
| Klamath County | | | |
| Lake County | | | |
| Lane County | | | |
| Lincoln County | | | |
| Linn County | | | |
| Malheur County | | | |
| Marion County | | | |
| Morrow County | | | |
| Multnomah County | | | |

| | | | |
|-------------------|--|--|--|
| Polk County | | | |
| Sherman County | | | |
| Tillamook County | | | |
| Umatilla County | | | |
| Union County | | | |
| Wallowa County | | | |
| Wasco County | | | |
| Washington County | | | |
| Wheeler County | | | |
| Yamhill County | | | |
| TOTALS | | | |

2.2.2 Complete the table outlining the number of Primary Care Providers (PCPs) in your Plan’s network in each of the bordering counties to Oregon. Provide the number of PCPs that were within a Patient Centered Primary Care Home (PCPCH) as of April 1, 2015.

| County | State | Number of PCPCH's* in 2014 | Number of PCP's** 2014 | Number of PCP's ** in PCPCH as of 4/2015 |
|-------------|-------|----------------------------|------------------------|--|
| Pacific | WA | | | |
| Wahkiakum | WA | | | |
| Cowlitz | WA | | | |
| Clark | WA | | | |
| Skamania | WA | | | |
| Klickitat | WA | | | |
| Benton | WA | | | |
| Walla Walla | WA | | | |
| Columbia | WA | | | |
| Garfield | WA | | | |
| Asotin | WA | | | |
| Owyhee | ID | | | |

| | | | | |
|------------|----|--|--|--|
| Canyon | ID | | | |
| Payette | ID | | | |
| Washington | ID | | | |
| Adams | ID | | | |
| Idaho | ID | | | |
| Nez Perce | ID | | | |
| Del Norte | CA | | | |
| Siskiyou | CA | | | |
| Modoc | CA | | | |
| Washoe | NV | | | |
| Humboldt | NV | | | |
| TOTALS | | | | |

* **Patient Centered Primary Care Home (PCPCH)** means a health care team or clinic as defined in ORS 414.655, which meets the standards pursuant to OAR 409-055-0040 and has been recognized through the process pursuant to OAR 409-055-0040.

** **Primary Care Provider** means a clinician who provides integrated, accessible health care services and who is accountable for addressing a large majority of personal health care needs, including providing preventive and health promotion services for men, women, and children of all ages, developing a sustained partnership with patients, and practicing in the context of family and community, as recognized by a State licensing or regulatory authority. (This definition includes Physician Assistants and Nurse Practitioners). From: **Section 5405 of the ACA Primary Care Extension Program**

2.2.3 What percentage of your Plan's total primary care network are certified as a Patient Centered Primary Care Home through the Oregon Health Authority (OHA)?

Tier I- Percentage: __%
 Tier II- Percentage: __%
 Tier III- Percentage: __%
 Total Percentage: _____%

2.2.4 What percentage of your Plan's Members were currently enrolled in a PCPCH as of April 1, 2015?

Tier I- Percentage: __%
 Tier II- Percentage: __%

Tier III- Percentage: __%
Total Percentage: ___%

2.2.5 Are you willing to meet a requirement for increasing the percentage of your network providers to be PCPCHs? An annual report will be required showing progress.

- Yes,
 No

2.2.6 Are you willing to meet a requirement for increasing the percentage of members covered under an alternate payment methodology? An annual report will be required showing progress.

- Yes,
 No.

2.2.7 Are you willing to meet a requirement that you offer contract to essential community providers such as Indian health centers, federally qualified health centers, family planning providers?

- Yes,
 No.

2.2.8 Are you willing to meet a requirement for your primary care providers to be certified as a medical home by a national accrediting body? The first year of the contract would be used as a baseline with an increasing percentage being coverage on an annual basis?

- Yes,
 No.

2.2.9 What change management or care transformation assistance does your Plan currently provide to PCPs and Providers? Your plan does not necessarily need to directly provide this assistance. This work could be contracted to other entities with expertise in practice transformation. Please be sure to describe whether this assistance includes supporting practices in achieving PCPCH certification and supporting practices that have achieved certification in moving to more advanced PCPCH tiers. If you do not currently provide assistance, please describe your plans and the timeline for providing this assistance in the future. If you have one, please include a P.C.P/Medical Home Enrollment Report in Part D, Attachment 10.

[1000 words]

2.2.10 Describe how your Plan supports delivery of culturally competent health care and health equity and what additional steps will the Plan will take to promote this for OEGBB Members in the medical offices or other care locations?

[500 words]

2.2.13 Describe how your Plan will provide translators in the medical offices or other care locations for non-English speaking OEGBB Members.

[500 words]

2.2.14 Describe how your Plan ensures hospital admissions, hospital discharges, emergency department (ED) visits and transitions to and from other care settings are coordinated within the Patient Centered Primary Care Homes (PCPCH) or other Primary Care Providers (PCP). Please include samples of patient communication in Section D. Attachment 10.

[500 words]

2.2.15 Describe how your Plan integrates non-traditional Providers into the network to improve care and lower costs (i.e., patient navigators, health coaches, community health workers, etc.). This could either be through direct integration at the plan level or at the PCPCH/provider level.
[500 words]

2.3 Improving Health Outcomes

OEBB seeks to improve outcomes for Members with chronic conditions. Toward this goal, OEBB has reduced or eliminated Member cost-sharing for office visits, medications, lab services, radiology and other services associated with treating and managing certain chronic diseases (such as asthma, COPD, CHF, CAD and diabetes).

2.3.1 Discuss your Plan’s ability to manage and provide a customized administration process that waives or reduces Member cost-sharing for certain services to treat and manage chronic conditions.
[1000 words]

2.3.2 OEBB’s current Plan Designs promote care for many conditions with no barriers. Review the current design and conditions with no barriers to care, and based on your review confirm you will provide barrier free access for these conditions and describe any additional chronic conditions or services your Plan would recommend being included as barrier-free that are included in your premiums costs included in this proposal.
[1000 words]

2.3.3 OEBB is dedicated to seeing measureable achievements in the following areas: reducing tobacco use rates and obesity, increasing screening for substance abuse and other addictions, depression; physical activity. OEBB expects Plans to make their best efforts to increase patient engagement, and provide for Members suffering from depression to receive both talk and drug therapies, as appropriate. Specific outcomes, targets and guarantees will be established for successful proposers during the contracting process. Respond to the following table in regards to each area:

| | Reducing tobacco use rates | Reducing obesity | Increasing screening for substance abuse and other addictions | Increasing screening for depression | Increasing screening for physical activity | Increasing patient engagement and assuring that Members suffering from depression receive both talk and drug therapies as appropriate |
|---|----------------------------|------------------|---|-------------------------------------|--|---|
| Describe any initiatives your Plan has implemented or is pursuing to improve outcomes and reduce costs. | | | | | | |

| | | | | | | |
|---|--|--|--|--|--|--|
| <p>Confirm your agreement to adhere to specific targets for improved outcomes in these areas. OEGB expects Contractor partners to commit to guarantees related to achieving certain levels of improvement in key health outcomes.</p> | | | | | | |
|---|--|--|--|--|--|--|

2.3.4 Confirm your Plan’s willingness to support statewide efforts to identify consistent evidence-based clinical guidelines for major conditions and promote these to Providers.

- Confirmed, Describe
- Not confirmed, explain: [100 words]

2.3.5 Describe the clinical guidelines used in your provider engagement efforts. Be sure to include an explanation of how your Plan assures that the guidelines that are used are non-biased and based on strong clinical evidence and how your Plan utilizes the Health Evidence Review Commission’s (HERC) clinical guidelines.

[1000 words]

2.3.6 Describe how your Plan tracks and evaluates a provider’s adherence to clinical guidelines. Describe efforts and successes to increase the use of evidence-based clinical guidelines including how you give Providers feedback on their adherence to these clinical guidelines.

[1000 words]

2.3.7 Describe your Plan’s ability to tie adherence to clinical guidelines to payment methodologies for Providers

[500 words]

2.3.8 Describe your Plan’s specific efforts to improve quality and manage costs in areas of high cost care, such as cardiac, renal, orthopedics and perinatal/maternity care.

[1000 words]

2.3.9 Describe your Plan’s experience with reducing preventable hospital admissions and readmissions. Include reduction strategies, how performance is tracked and monitored and modes of care that have contributed to reduced hospitalizations.

[1000 words]

2.3.10 Describe the approaches your Plan uses to identify high-utilizers and provide support and care alternatives to these Members. Describe what specific steps you will take to further these approaches for OEGB Members.

[500 words]

2.3.11 Describe the information and programs your Plan has available to assist Members in identifying self-care conditions that do not require a medical intervention (e.g., colds, minor sprains, upset stomach) and what the Member should do to address the concern.

[500 words]

2.3.12 Describe how your Plan coordinates care management activities with short-term and long-term disability, employee assistance programs (EAPs), health care decision support activities, and health and wellness related vendors

[500 words]

2.3.13 Describe your Plan's efforts to improve quality reporting that: supports improved administration efficiencies, educates and engages members in general and individually with specific health and wellness tools and programs, and empowers Providers to provide the right care to the right people at the right time.

[1000 words]

2.4 Innovative Alternatives

The Board is seeking innovative health plan partners dedicated to increasing use of alternative payment methodologies, patient education opportunities and transparency on price and quality.

2.4.1 Provide examples of your Plan's support of community public health care and population health initiatives in Oregon and how OEGB Members would directly benefit.

[500 words]

2.4.2 Indicate whether your Plan would be able to administer a reference-based pricing benefit as a way to manage cost variation for surgical procedures. If so, what specific procedures do you believe lend themselves to this sort of a benefit (e.g., bariatric surgery, joint replacement, etc.)?

Yes: Explain [100 words]

No: Explain [100 words]

2.4.3 Would your Plan be able to administer a travel benefit in conjunction with a reference-based pricing benefit to offset costs Members may incur traveling to and from a preferred hospital or Centers of Excellence for surgery?

Yes:

No: Explain [100 words]

2.4.4 Can your Plan administer a benefit that would require Members to complete a decision support lesson or program before they receive services for certain preference-sensitive conditions? If "Yes," describe how your decision support tool was developed (for example, was the tool's development evidence-based and, if so, what evidence or information was used).

Yes: Explain [500 words]

No: Explain [500 words]

2.4.5 Describe patient engagement and patient activation methods used by your Plan as well as how your Plan will educate Members on both the total cost and the Member's share of cost of certain treatments, procedures and provider visits. Be sure to describe how this information is provided to Members.

[500 words]

2.4.6 Describe how your Plan engages Providers in issues related to member satisfaction, member engagement and access to care, and how Providers are educating Members about their options for treatments and procedures? Be sure to describe how training and technical support for these tools is shared with Providers.

[500 words]

2.4.7 How does your Plan evaluate the introduction of new technology or services in a contracted hospital to determine if these new services should be included in your contract with the hospital? For example, if a hospital adds a cardiac surgery service, how would your Plan determine if Members could be referred to that hospital for that service?

[500 words]

2.5 Health Engagement Model/Wellness

Implemented in 2014, OEGB's current medical Plan Design includes a health engagement program focused on encouraging Members to become aware of their health risks and begin to take steps to address identified risks. The program provides a reduced deductible or an equivalent reduction in copayments to employees when they, along with their covered spouse or domestic partner, complete an online personal health assessment (PHA) on their health Plan's website by an established deadline. Participating employees also agree to complete two healthy actions during the course of the Plan year. Through this program OEGB seeks to engage Members in understanding their risks and managing their health. Over time OEGB expects that increased Member engagement will lead to improvements in the OEGB population's health status and in turn lower costs. OEGB expects Contractors to provide ongoing support for this health engagement program and to remain flexible and innovative as OEGB's wellness strategy evolves in future years. A critical aspect of program support includes the availability of a health assessment tool and ongoing communication to Members to support their understanding of health risks and engagement in the program.

2.5.1 Describe your Plan's standard wellness services available to Members. Please include examples of Member/Patient Incentives that you have utilized. Confirm that all of your Plan's standard wellness services can be included or excluded at OEGB's discretion.

Confirmed, Describe [100 words]

Not confirmed, explain: [100 words]

2.5.2 Describe how your Plan's successes with the wellness services are measured and how they align with OEGB's vision. Please address any potential changes that may be planned for the programs in the future.

[500 words]

2.5.3 Describe your Plan's strategies to encourage Members to have age-appropriate preventive screenings, given the USPSTF recommendations. Be sure to include how you measure the success of these strategies?

[500 words]

2.5.4 OEGB is interested in increasing its Members' levels of regular physical activity. Describe innovations your Plan would propose to increase OEGB Members' physical activity.

[500 words]

2.5.5 Confirm your Plan's ability to administer a different benefit Plan design based on Member completion of a personal health assessment (PHA) (for example, Members completing the PHA would receive an enhanced benefit compared to those who did not complete the PHA). If "Confirmed," indicate whether your Plan's online PHA is customizable and identify any limitations to benefit Plan design

modifications. Please provide a copy of your Personal Health Assessment Questionnaire & the 2014 Summary Report in Part D, Attachment 10.

- Confirmed, Describe [500 words]
- Not confirmed, explain: [100 words]

2.5.6 Currently, OEGB's medical benefits include an evidence-based weight management program for Members age 10 and older at no cost. This benefit is administered by OEGB's contracted medical Plans and requires that program participants maintain a specified program attendance level to continue to be eligible for the program at no cost. OEGB expects you to be capable of offering a similar weight management benefit. OEGB weight management program expectations are outlined below. Provide feedback regarding your capabilities: [100 words each]

| | Response |
|---|----------|
| Access to program services by at least 90% of covered employees | |
| Services available at the worksite during scheduled work hours | |
| Online alternative to services during non-work hours | |
| Services provided in the community | |
| No requirement that participants purchase products, such as special meals | |
| Communications approved by Plan | |
| Providing reports on claims costs for participants, over specified time | |
| Program Plan with participation goals | |
| Providing reports on participation levels over specified time including unique Members counts | |

2.5.7 OEGB has implemented several innovative benefits and programs aimed at supporting Member wellness and health improvement. Confirm your ability to provide services and program administration for each of the following:

| | Response |
|--|----------|
| Weight Watchers program | Yes/No |
| Living Well-a chronic disease self-management program | Yes/No |
| A team-based worksite wellness and health improvement program, which allows employees at the worksite to form teams and work collaboratively toward health improvement goals, earning team points and individual points for their efforts. | Yes/No |
| Diabetes Prevention Program | Yes/No |
| MoodHelper | Yes/No |

2.5.8 Given that OEGB provides benefits to approximately 60,000 employees at hundreds of employer worksites across Oregon, describe the resources your Plan would make available, your experiences and successes in supporting wellness at employer sites.
[500 words]

2.5.9 Describe how available wellness programs and services target employees as well as covered spouses/partners and children. Does your Plan estimate or capture these programs' Returns on Investment

(ROI)? Provide most recent Wellness Summary Report in Part D, Attachment 10 including demonstrated Return on Investments (ROIs) related to your wellness programs and initiatives.

[500 words]

2.5.10 Describe how your Plan works with Providers, specifically including Patient Centered Primary Care Homes, to facilitate member use of available wellness services.

[500 words]

2.5.11 Would your Plan be willing to provide a dedicated wellness coordinator to lead OEGB's wellness initiatives?

Yes: Describe the proposed services and availability [200 words]

No: Explain [100 words]

2.5.12 Describe how your Plan will administer a wellness visit (covered in full, with no cost to Members) that would be a broad-based appointment to assess the overall health of an OEGB Member. In your response, address screenings for depression, substance abuse, tobacco, addiction problems, weight management, physical activity and patient engagement.

[1000 words]

2.6 Health Information Technology and Data Exchange

The Board believes that expanding use of Health Information Technology (HIT) and promoting greater health information sharing across Providers is an important component of improving care delivery and lowering healthcare system costs. OEGB expects Contractors to proactively facilitate expansion of HIT and data sharing, including provider adoption of electronic medical records, electronic capture of lab results and electronic sharing of patient health information across care settings. OEGB expects that over time, increased use of HIT and broader data sharing among Providers will reduce duplication of health care services, allow for more comprehensive tracking of health outcomes and support the delivery of higher quality care.

2.6.1 As of April 1, 2015, what percentage of your network uses federally certified Electronic Health Records (EHRs)?

2014 Percentage ___%

2.6.2 Explain how your network exchanges medical information, and conducts care coordination activities, with those Providers that do not have EHRs.

[100 words]

2.6.3 What percentage of your physician and hospital network has met Stage 1 Meaningful Use requirements for using their Electronic Health Records (EHRs)?

2014 Percentage ___%

2.6.4 Describe your Plan's strategy, incentives and timeline for expanding adoption of Electronic Health Records (EHRs), including holding network Providers accountable for adoption of EHRs in contracts? Be sure to identify the strategies specific to ensuring that every network provider is either registered with a statewide or local Direct-enabled Health Information Services Provider, or a member of an existing Health Information Organization (entity that provides health information exchange services enabling electronic sharing of patient information across disparate organizations)?

[500 words]

2.6.5 Describe efforts your Plan has taken to support electronic health data sharing across Providers, such as physicians, hospitals, etc.

[500 words]

2.6.6 Describe your Plan's current capacity and strategies to improve in the areas of data analytics and quality improvement through Health Information Technology (HIT).

[500 words]

2.6.7 Describe your Plan's strategy and timeline for expanding meaningful use (including current Stage 1 requirements and upcoming Stage 2 Meaningful Use requirements), including holding network Providers accountable for meeting meaningful use requirements in your contracts?

[500 words]

2.6.8 Describe your Plan's strategies to support patient engagement through (HIT) and electronic health data sharing with patients.

[500 words]

2.6.9 Describe any initiatives your Plan has started or implemented to provide telehealth services. Discuss the extent to which telehealth services would be available to the OEGB population. Be sure to address the questions below:

- a. Is your claims system able to receive electronic claim submissions from a telehealth provider, adjudicate the claim against OEGB's benefit Plan and remit payment to the telehealth provider?
- b. Are you able to verify eligibility with the telehealth vendor?
- c. What are your capabilities to pass and receive clinical data (e.g., electronic health record (EHR), personal health record (PHR), personal health assessment, etc.) with a telehealth vendor?
- d. How are telemedicine services integrated with your Plan's delivery models including PCPCHs?

[1000 words]

2.6.10 Does your Plan reimburse providers for on-line and phone appointments?

Yes: Describe the services and availability [200 words]

No: Explain [100 words]

2.7 Networks

The Board is interested in understanding how your Plan's networks will drive transformation, move away from fee-for-service payments to alternative payment approaches and support the Triple Aim overall.

2.7.1 Provide an overview of your Plan's network contracting approach and strategy and how it aligns with the Triple Aim. Be sure to identify your Plan's top three priorities and expected outcomes with regards to network development over the next three years?

[500 words]

2.7.2 If OEGB requests, is your Plan willing to recruit additional physicians into your network prior to the effective date of the Contract?

Yes: Explain [100 words]

No: Explain [100 words]

2.7.3 What was the provider turnover rate in your networks during the following years (voluntary is provider initiated; involuntary is Plan initiated)?

| | Voluntary Turnover | Involuntary Turnover |
|------|--------------------|----------------------|
| 2013 | % | % |
| 2014 | % | % |

2.7.4 Describe your network within the US, but outside of the Oregon area (including Washington, Idaho and California) and identify major hospital system and physician group contracts in Oregon, Washington, Idaho and Northern California that are up for renegotiation before January 1, 2017.
[500 words]

2.7.5 Are any of the networks proposed for OEBC rented or leased? Describe the arrangement(s).
[100 words]

2.7.6 Does your Plan have agreements with practitioners or hospitals (or Providers of any kind) where discounts, allowances, incentives, adjustments and settlements are retained for the sole benefit of your organization?

- Yes, If yes, discuss what percentage of your contracts have such agreement a how your organization believes it can comply with OEBC 's requirement which necessitates a full pass through of all negotiated savings
- No, our contracts do not have such agreements. Any withhold, incentives, adjustments, or settlements are shared with OEBCs and are not retained by the Proposer.

2.7.7 Describe how alternative care Providers (chiropractors, naturopaths, acupuncturists) are integrated into the network or otherwise made accessible to Members.
[100 words]

2.7.8 How do you ensure that your Provider network is robust and diverse enough to meet the cultural needs in your Members' locations?
[100 words]

2.7.9 Does your Plan have or is your Plan developing Centers of Excellence (COEs) or Reference-based Pricing Agreements for the following conditions:

| | Centers of Excellence | Location (s) | Reference-based Pricing | Location(s) |
|-----------------------------|---|--------------|---|-------------|
| Cancer treatment | <i>Single, Pull-down list.</i> 1: In place, 2: Being developed, 3: No Plans to develop | | <i>Single, Pull-down list.</i> 1: In place, 2: Being developed, 3: No Plans to develop | |
| Cardiac surgical procedures | <i>Single, Pull-down list.</i> 1: In place, 2: Being developed, 3: No Plans to develop | | <i>Single, Pull-down list.</i> 1: In place, 2: Being developed, 3: No Plans to develop | |
| Spinal surgery | <i>Single, Pull-down list.</i> 1: In place, 2: Being developed, 3: No Plans to develop | | <i>Single, Pull-down list.</i> 1: In place, 2: Being developed, 3: No Plans to develop | |

| | | | | |
|----------------------|---|--|---|--|
| Transplants | <i>Single, Pull-down list.</i> 1: In place, 2: Being developed, 3: No Plans to develop | | <i>Single, Pull-down list.</i> 1: In place, 2: Being developed, 3: No Plans to develop | |
| Bariatric surgery | <i>Single, Pull-down list.</i> 1: In place, 2: Being developed, 3: No Plans to develop | | <i>Single, Pull-down list.</i> 1: In place, 2: Being developed, 3: No Plans to develop | |
| Renal Dialysis | <i>Single, Pull-down list.</i> 1: In place, 2: Being developed, 3: No Plans to develop | | <i>Single, Pull-down list.</i> 1: In place, 2: Being developed, 3: No Plans to develop | |
| Joint replacement | <i>Single, Pull-down list.</i> 1: In place, 2: Being developed, 3: No Plans to develop | | <i>Single, Pull-down list.</i> 1: In place, 2: Being developed, 3: No Plans to develop | |
| Hemophilia | <i>Single, Pull-down list.</i> 1: In place, 2: Being developed, 3: No Plans to develop | | <i>Single, Pull-down list.</i> 1: In place, 2: Being developed, 3: No Plans to develop | |
| Rheumatoid Arthritis | <i>Single, Pull-down list.</i> 1: In place, 2: Being developed, 3: No Plans to develop | | <i>Single, Pull-down list.</i> 1: In place, 2: Being developed, 3: No Plans to develop | |
| HIV | <i>Single, Pull-down list.</i> 1: In place, 2: Being developed, 3: No Plans to develop | | <i>Single, Pull-down list.</i> 1: In place, 2: Being developed, 3: No Plans to develop | |
| Multiple Sclerosis | <i>Single, Pull-down list.</i> 1: In place, 2: Being developed, 3: No Plans to develop | | <i>Single, Pull-down list.</i> 1: In place, 2: Being developed, 3: No Plans to develop | |

2.7.10 Are there other specific procedures where your Plan relies on Centers of Excellence (COE), reference-based pricing, or some other narrower network, to provide services other than those listed in 2.7.9? If “Yes,” describe and be sure to describe any travel benefits associated with the use of a COE, reference price facility or narrowed network. If “No,” explain why not.

[100 words]

2.7.11 Describe your Plan’s physician and hospital credentialing process. Be sure to include the frequency for re-credentialing and how information is verified at the federal and state levels.

[500 words]

2.7.12 Indicate which of the following are included in the credentialing and re-credentialing applications:

| | Included in credentialing and re-credentialing application | Included in credentialing only | Included in re-credentialing only | Not included in either |
|--|--|--------------------------------|-----------------------------------|------------------------|
| Current attestation by the practitioner regarding ability to perform the essential function of the position | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Current attestation by the practitioner and external confirmation regarding Valid Drug Enforcement Agency license | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Board certification | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Current attestation by the practitioner regarding illegal drug use | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Current attestation by the practitioner and external confirmation regarding history of loss of license or felony convictions | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Current attestation by the practitioner and external confirmation regarding loss or limitation of Hospital privileges | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Current attestation by the practitioner and external confirmation regarding malpractice | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Current attestation by the practitioner regarding and correctness and completeness | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

2.7.13 Are network physicians contractually obligated to refer patients to other in-network physicians, labs, or radiology services?

- Yes, network physicians are contractually required to refer patients to other in-network physicians.
- Yes, network physicians are contractually required to refer patients to in-network lab Providers.
- Yes, network physicians are contractually required to refer patients to in-network radiology Providers.
- No, describe procedures and contract provisions to discourage referrals to out-of-network Providers and to ensure that neither the Member nor OEBC is penalized for physicians' referral practices:

2.7.14 Describe how your Plan manages the DME benefit. Be sure to address costs, professional services and accessibility for Members.

[500 words]

2.7.15 Describe how your Plan uses data to address physicians, hospitals and other Providers who are outliers on cost or quality and how your Plan actively works with Providers to address areas of concern.

[500 words]

2.7.16 How does your Plan share updates on network terminations, including PCPs, PCPH and other Providers with affected Members? Check all that apply.

| | PCP | PCPCH | Other (hospital, lab etc.) |
|--|-----|-------|----------------------------|
| Auto-generation of email notification to Members | | | |
| Auto-generation of manual letter notification to Members | | | |
| No information is shared with Members outside of open enrollment communication | | | |
| Manual list of terminations/updated communicated to Plan sponsor | | | |
| Other: | | | |

2.7.17 The following are OHA’s access standards for Providers:

- a. Emergency Care: immediately or referred to an emergency department depending on Members condition;
- b. Urgent Care: within 72 hours or as indicated in initial screening;
- c. Routine wellcare: within 4 weeks or within the community standard.

What are your current access standards in your provider contracts for the following types of providers?

| | # of days from call for an appointment to the appointment. | Hours of Operation during the week? | Hours of Operation after hours and on weekends |
|--|--|-------------------------------------|--|
| Routine Adult Primary Care (Internal Medicine) | | | |
| Routine Family Practice | | | |
| Routine Pediatrics | | | |
| Urgent Adult PCP Appointments | | | |
| Urgent Family Care Appointments | | | |
| Urgent Pediatric Appointments | | | |
| Urgent Care (after hours and weekends) | | | |
| Mental and Behavioral Health | | | |
| Substance Abuse and other addictions | | | |

2.8. Performance

The Board seeks health plan partners who will advance Oregon’s healthcare system transformation efforts to achieve better health, better care, and lower costs. The Board Plans to establish specific accountable metrics for health, quality and costs. OEBC seeks partners willing to accept accountability and share upside and downside risk for attaining these benchmarks.

2.8.1 The table below lists the performance measures developed by the Oregon Health Authority (OHA) that OEBC intends to use for establishing additional fees at risk for the 2018 Plan Year and beyond.

OEBB would like to know if you currently track any of these items. Please provide your Plans' most recent rates for each measure you are tracking. See Part D Attachment 10. Indicate your commitment to negotiating performance guarantees (PGs) specific to achieving targeted levels of improvement on a focused subset of measures after baseline data has been established during the first year of the contract.

NQF= National Quality Forum Information about measures 1, 9, 16 and 33 can be found at <http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx>

| No. | Measure | Measure Data Source: Claims, Medical Records / Charts, Surveys, | Currently Measure Yes/No | Willing to Negotiate PGs in the future? Yes/No |
|-------|--|---|--------------------------|--|
| pm-1 | Alcohol or other substance misuse (SBIRT) | Claims | Yes/No | Yes/No |
| pm-2 | Follow-up after hospitalization for mental illness (NQF 0576 & (HEDIS) | Claims | Yes/No | Yes/No |
| pm-3 | Screening for clinical depression and follow-up plan (NQF 0418) | Medical records / charts | Yes/No | Yes/No |
| pm-4 | Follow-up care for children prescribed ADHD meds (NQF 0108 & HEDIS) | Claims | Yes/No | Yes/No |
| pm-5 | Prenatal and postpartum care: Timeliness of Prenatal Care (NQF 1517 & HEDIS) | Claims; medical records / charts | Yes/No | Yes/No |
| pm-6 | PC-01: Elective delivery before 39 weeks (NQF 0469) | Other | Yes/No | Yes/No |
| pm-7 | Ambulatory Care: Outpatient and Emergency Department utilization (HEDIS) | Claims | Yes/No | Yes/No |
| pm-8 | Colorectal cancer screening (HEDIS) | Claims; medical records / charts | Yes/No | Yes/No |
| pm-9 | Patient-Centered Primary Care Home Enrollment | Other | Yes/No | Yes/No |
| pm-10 | Developmental screening in the first 36 months of life (NQF 1448) | Claims | Yes/No | Yes/No |
| pm-11 | Adolescent well-care visits (NCQA & HEDIS) | Claims | Yes/No | Yes/No |
| pm-12 | Controlling high blood pressure (NQF 0018 & HEDIS) | Medical records / charts | Yes/No | Yes/No |
| pm-13 | Diabetes: HbA1c Poor Control (NQF 0059 & HEDIS) | Medical records / charts | Yes/No | Yes/No |
| pm-14 | CAHPS adult and child composites: Access to care | Surveys | Yes/No | Yes/No |
| pm-15 | CAHPS adult and child composites: Satisfaction with care | Surveys | Yes/No | Yes/No |
| pm-16 | EHR adoption | Other | Yes/No | Yes/No |

| No. | Measure | Measure Data Source: Claims, Medical Records / Charts, Surveys, | Currently Measure Yes/No | Willing to Negotiate PGs in the future? Yes/No |
|-------|--|---|--------------------------|--|
| pm-17 | Prenatal and postpartum care: Postpartum Care Rate (NQF 1517) | Claims; medical records / charts | Yes/No | Yes/No |
| pm-18 | Plan all-cause readmission (NQF 1768 & HEDIS) | Claims | Yes/No | Yes/No |
| pm-19 | Well-child visits in the first 15 months of life (NQF 1392) | Claims | Yes/No | Yes/No |
| pm-20 | Childhood immunization status (NQF 0038 & HEDIS) | Claims; other | Yes/No | Yes/No |
| pm-21 | Immunization for adolescents (NQF 1407 & HEDIS) | Claims; other | Yes/No | Yes/No |
| pm-22 | Appropriate testing for children with pharyngitis (NQF 0002 & HEDIS) | Claims | Yes/No | Yes/No |
| pm-23 | Medical assistance with smoking and tobacco use cessation (CAHPS & HEDIS) (NQF 0027) | Surveys | Yes/No | Yes/No |
| pm-24 | Comprehensive diabetes care: LDL-C Screening (NQF 0063 & HEDIS) | Claims | Yes/No | Yes/No |
| pm-25 | Comprehensive diabetes care: Hemoglobin A1c testing (NQF 0057 & HEDIS) | Claims | Yes/No | Yes/No |
| pm-26 | PQI 01: Diabetes, short term complication admission rate (NQF 0272) | Claims; other | Yes/No | Yes/No |
| pm-27 | PQI 05: Chronic obstructive pulmonary disease admission (NQF 0275) | Claims, other | Yes/No | Yes/No |
| pm-28 | PQI 08: Congestive heart failure admission rate (NQF 0277) | Claims; other | Yes/No | Yes/No |
| pm-29 | PQI 15: Adult asthma admission rate (NQF 0283) | Claims; other | Yes/No | Yes/No |
| pm-30 | Chlamydia screening in women ages 16-24 (NQF 0033 & HEDIS) | Claims | Yes/No | Yes/No |
| pm-31 | Cervical cancer screening (NQF 0032 & HEDIS) | Claims | Yes/No | Yes/No |
| pm-32 | Child and adolescent access to primary care practitioners (NCQA) | Claims | Yes/No | Yes/No |
| pm-33 | Effective Contraception use among women at risk of unintended pregnancy | Claims | Yes/No | Yes/No |

2.8.2 Confirm your Plan's ability to track and report the HEDIS measures listed below. The measures that have been included in the CCM measures above have been eliminated in the HEDIS measures below. If

you have submitted HEDIS measures, please attach a copy of your most recent report in Part D, Attachment 10.

| (1) Use of appropriate medications for people with Asthma (ASM) | <i>Yes/No.</i> |
|---|----------------|
| % of members age 5-50 with persistent asthma who were appropriately prescribed medication during the measurement year | |
| | 5-11 yrs |
| | 12-50 yrs |
| | total |

| (4) Antidepressant Medication Management (AMM): Effective Continuation Phase Treatment | <i>Yes/No.</i> |
|--|----------------|
| | |
| % of members 18 and older who were diagnosed with a new episode of depression, treated with antidepressant medication, and remained on an antidepressant for at least 180 days | |

| (7) Use of imaging studies for low back pain (LBP) | <i>Yes/No.</i> |
|---|----------------|
| Proportion of patients age 18-50 who had an outpatient or ED primary diagnosis of low back pain and did not have an imaging study performed | |

| (10) Adult BMI Assessment (BMI) | <i>Yes/No.</i> |
|--|----------------|
| | |
| % of members age 18-74 who had an outpatient office visit and had their BMI documented during the measurement year or the prior year | |

| (11) Weight Assessment and Counseling for Nutrition and Physical Activity in Children/Adolescents | <i>Yes/No.</i> |
|--|----------------|
| % of children 2 to 17 years old who had an outpatient visit with a primary care physician or OB/GYN and who had documentation of the BMI percentile, counseling for nutrition and counseling for physical activity during the measurement year | |
| (a) Weight assessment - documentation of BMI percentile | |
| (b) Counseling for nutrition | |
| (c) Counseling for physical activity | |

| (12) Breast Cancer Screening (BCS) | <i>Yes/No.</i> |
|---|----------------|
| % of women 40-69 years of age who had a mammogram to screen for breast cancer | |

2.8.3 **Confirm your Plan's ability to track and report performance metrics established for CAHPs.**
If you have submitted CAHPS measures, please attach a copy of your most recent report in Part D, Attachment 10.

| | |
|---------------------------|----------------|
| Overall Ratings | Comply |
| Rating of All Health Care | <i>Yes/No.</i> |
| Rating of Health Plan | <i>Yes/No.</i> |
| Rating of Personal Doctor | <i>Yes/No.</i> |

| | |
|---|----------------|
| Rating of Specialist Seen Most Often | <i>Yes/No.</i> |
| Claims Processing | Comply |
| How often did your health plan handle your claims quickly? | <i>Yes/No.</i> |
| How often did your health plan handle your claims correctly? | <i>Yes/No.</i> |
| Customer Service | Comply |
| How often did the printed material or Internet provide the information you needed about how your health plan works? | <i>Yes/No.</i> |
| How often did your health plan's customer service give you the information or help you needed? | <i>Yes/No.</i> |
| How often did your health plan's customer service treat you with courtesy and respect? | <i>Yes/No.</i> |
| How often were the forms from your health plan easy to fill out? | <i>Yes/No.</i> |
| Getting Care Quickly | Comply |
| When you needed care right away, how often did you get care as soon as you thought you needed it? | <i>Yes/No.</i> |
| Not counting the times you needed care right away, how often did you get an appointment at the doctor's office as soon as you thought you needed it? | <i>Yes/No.</i> |
| Getting Needed Care | Comply |
| How often was it easy to get appointments with specialists? | <i>Yes/No.</i> |
| How often was it way to get the care, tests or treatment you thought you needed through your health plan? | <i>Yes/No.</i> |
| How well Doctors Communicate | Comply |
| How often did your personal doctor explain things in a way that was easy to understand? | <i>Yes/No.</i> |
| How often did your personal doctor listen carefully to you? | <i>Yes/No.</i> |
| How often did your personal doctor show respect for what you had to say? | <i>Yes/No.</i> |
| How often did your personal doctor spend enough time with you? | <i>Yes/No.</i> |
| Plan Information on Cost | Comply |
| How often were you able to find out from your health plan how much you were going to have to pay for a health care service/equipment? | <i>Yes/No.</i> |
| Shared Decision Making | Comply |
| Did a doctor or other health provider talk to you about the pros and cons of each choice for your treatment or health care? | <i>Yes/No.</i> |
| When there was more than once choice for your treatment or health care did a doctor or other health care provider ask you what choice you thought was best for you? | <i>Yes/No.</i> |
| Smoking Cessation | Comply |
| How often have you been advised to quit using tobacco by a provider in your health plan? | <i>Yes/No.</i> |
| How often have you been advised to quit using tobacco by a provider in your health plan? Medications recommended. | <i>Yes/No.</i> |
| How often have you been advised to quit using tobacco by a provider in your health plan? Strategies recommended. | <i>Yes/No.</i> |
| Aspirin Use | Comply |
| Do you take an aspirin daily? (qualified population) | <i>Yes/No.</i> |
| Has your provider discussed the benefits/risks of taking aspirin daily to avoid strokes? | <i>Yes/No.</i> |
| Flu Shots | Comply |
| Have you had a flu shot since September 1, 2013? | <i>Yes/No.</i> |
| Health Promotion and Education | Comply |
| How often did you see a doctor or other health care provider about specific things you could do to prevent illness? | <i>Yes/No.</i> |
| Coordination of Care | Comply |
| How often did your personal doctor seem informed and up to date about the care you got from other providers? | <i>Yes/No.</i> |

2.8.4. What is your Plan doing to improve preventive care, chronic illness care and patient experience relative to the HEDIS and OHA measures? Please provide an example in each category.

[1000 words]

2.8.5 Identify the health status metrics your Plan currently reviews to manage member health risks, and describe how your Plan manages these metrics to improve the health of your Plan’s Membership?

[500 words]

2.8.6 Describe how your Plan will report out on these metrics to Providers and to OEBC?

[500 words]

2.8.7 Describe how your Plan requires Providers to measure performance at the clinician, or practice team/and or practice site level, and at the Plan level.

[500 words]

2.8.8 Describe what your Plan is doing to ensure care is provided in the most appropriate setting. Be sure to include how contracted Providers are currently rewarded based on their performance in delivering appropriate care at the right time (For example, timely preventive care, appropriate prescribing of antibiotics, and avoidance of emergency utilization), if applicable?

[500 words]

2.8.9 Below are examples of performance metrics that may be negotiated with a Contractor partner. Confirm your Plan will work with OEBC to establish performance criteria that will establish expectations for performance standards to be met by your Plan. These will initially be reported on a semi-annual basis.

2.8.10 Indicate whether performance is measured, benchmarked, or reported for any of the following:

| | Measured | Reporting results with benchmarking | Reporting results to Providers | Public reporting |
|-----------------------------|--|--|--|--|
| a. Specialty Referral Rate | Single, Pull-down list. 1: Yes, 2: No, 3: Not tracked |
| b. Inpatient Admission Rate | Single, Pull-down list. 1: Yes, 2: No, 3: Not tracked |
| c. Average Length of Stay | Single, Pull-down list. 1: Yes, 2: No, 3: Not tracked |
| d. Emergency Room Visits | Single, Pull-down list. | Single, Pull-down list. 1: Yes, | Single, Pull-down list. | Single, Pull-down list. |

| | | | | |
|---|---|---|---|---|
| | 1: Yes, 2: No, 3: Not tracked | 2: No, 3: Not tracked | 1: Yes, 2: No, 3: Not tracked | 1: Yes, 2: No, 3: Not tracked |
| e. Readmissions | <i>Single, Pull-down list.</i> 1: Yes, 2: No, 3: Not tracked |
| f. Medical Claims Costs | <i>Single, Pull-down list.</i> 1: Yes, 2: No, 3: Not tracked |
| g. Financial Results | <i>Single, Pull-down list.</i> 1: Yes, 2: No, 3: Not tracked |
| h. Longitudinal Efficiency (episode of care) | <i>Single, Pull-down list.</i> 1: Yes, 2: No, 3: Not tracked |
| i. IT Capacity (use of e-health visits, etc.) | <i>Single, Pull-down list.</i> 1: Yes, 2: No, 3: Not tracked |
| Other | <i>Single, Pull-down list.</i> 1: Yes, 2: No, 3: Not tracked |
| Comments | 50 words. Nothing required | 50 words. Nothing required | 50 words. Nothing required | 50 words. Nothing required |

2.9 Clinical Management

The Board seeks health plan partners that are transforming traditional models of Case and Care Management Programs by seamlessly connecting health Plan management with care being delivered to Members in their provider’s offices. OEBC is specifically interested in examples of how health Plans’ Case and Care Management tools and resources are used to support Patient Centered Primary Care Homes (PCPHs) and specialists by enhancing care coordination and engaging Members with both acute complex conditions and those with chronic conditions.

2.9.1 Describe the specific highlights or elements of your Plan’s philosophy and/or clinical programs that separates your organization's program from other competitors in managing chronic conditions. Be sure to include any aspects of your plan’s philosophy that address social determinants of health.

[500 words]

2.9.2 Describe any key initiatives related to cost management and/or Case and Care Management your Plan is implementing or will be launching over the next two years.

[500 words]

2.9.3 Indicate whether your Plan offers a Care Management Program for each of the conditions listed below. If so, note the number of total Members and percent of the Plan’s total population identified as having each condition and number of Members and percent of the Plan’s identified population actively participating in each program.

| | Care Management Program | Number of Members | Percent of Active Participation |
|--|-------------------------|-------------------|---------------------------------|
| Arthritis | Yes/No. | ### | % |
| Asthma | Yes/No. | ### | % |
| Chronic pain management | Yes/No. | ### | % |
| Congestive heart failure | Yes/No. | ### | % |
| Chronic obstructive pulmonary disease (COPD) | Yes/No. | ### | % |
| Coronary artery disease (CAD) | Yes/No. | ### | % |
| Depression | Yes/No. | ### | % |
| Diabetes | Yes/No. | ### | % |
| Renal disease | Yes/No. | ### | % |
| Hyperlipidemia | Yes/No. | ### | % |
| Hypertension | Yes/No. | ### | % |
| Musculoskeletal (including back pain) | Yes/No. | ### | % |
| Obesity | Yes/No. | ### | % |
| HIV | Yes/No. | ### | % |
| Multiple Sclerosis | Yes/No. | ### | % |
| Others | Yes/No. | ### | % |

2.9.4 Describe the ways in which Members are identified for your Care Management and Care Management Programs. Be sure to include the percent of Members who were identified as potentially appropriate for both Case and Care Management in 2014 and of those identified, the percent of Members who were actively involved in Case and Care Management Programs in 2014.

[500 words]

2.9.5 Describe the staff that conducts both the Case and Care Management Program’s outreach. Be sure to identify if the outreach is performed through a contractor or using staff internal to the Plan and include their location, hours of operation, and professional credentials.

[500 words]

2.9.6 How are results and efforts of your Plan's Case and Care Management Program(s) integrated in Members' health records, or otherwise shared with the Primary Care Provider (PCP)?

[100 words]

2.9.7 Describe any Returns on Investment (ROI) and/or other outcomes associated with your Case and Care Management Programs. Be sure to include the most recent data that demonstrates your program's performance and how that would align with OEBC's vision.

[500 words]

2.9.8 Describe how Care Management staff coordinate with and support the work of Providers directly caring for Members with chronic conditions. Be sure to include specific examples of how Care Management tools and resources are used to enhance care coordination, support primary and specialty care Providers in delivering care to Members with acute complex conditions and engage Members with chronic conditions in self-management. Describe patient risk-stratification criteria, and any care plan approaches.

[500 words]

2.9.9 Describe how your Plan integrates medical, disease management and wellness data with the clinical programs your organization offers?

[100 words]

2.9.10 Describe your Plan's capabilities to integrate pharmacy data from a PBM or a carve-out pharmacy Plan administrator.

[100 words]

2.9.11 Describe how your Plan integrates specialty pharmacy and Case and Care Management programs (through first fill reporting, sharing of outreach interventions, etc.) to proactively engage members with chronic conditions and their treating Providers. Be sure to address the following conditions: rheumatoid arthritis, multiple sclerosis, hemophilia, HIV and renal failure in your response.

[500 words]

2.9.12 Describe your Plan's infusion services capabilities including home care capabilities and availability of infusion suites. In addition, please describe your process to promote cost-effective infusion sites of care and your Plan's ability to integrate/partner with vendors to accomplish this goal.

[100 words]

2.9.13 Does your Plan have a program to monitor and improve patient compliance with prescribed drug therapy? If "Yes," describe how your Plan improves the compliance of participants receiving specialty pharmacy products, please include the methods your Plan uses to measure compliance, the frequency of measurement, and your ability to document and report these programs.

1: Yes (explain): [500 words],

2: No

2.9.14 Describe how your Plan measures medication possession ratio (MPR) and explain how your organization helps to improve MPR for Members. Provide your most recently measured book of business MPR for the following classes and note the applicable time period:

[100 words]

| Condition | Employer book of business MPR | Time period for MPR |
|----------------------------------|-------------------------------|---------------------|
| a. Hypertension | <i>Unlimited.</i> | <i>Unlimited.</i> |
| b. Dyslipidemia | <i>Unlimited.</i> | <i>Unlimited.</i> |
| c. Congestive Heart Failure | <i>Unlimited.</i> | <i>Unlimited.</i> |
| d. Asthma/COPD | <i>Unlimited.</i> | <i>Unlimited.</i> |
| e. Diabetes | <i>Unlimited.</i> | <i>Unlimited.</i> |
| f. Antiplatelets/ Anticoagulants | <i>Unlimited.</i> | <i>Unlimited.</i> |
| g. Rheumatoid Arthritis | <i>Unlimited.</i> | <i>Unlimited.</i> |
| h. Multiple Sclerosis | <i>Unlimited.</i> | <i>Unlimited.</i> |
| i. Hepatitis | <i>Unlimited.</i> | <i>Unlimited.</i> |
| j. Depression | <i>Unlimited.</i> | <i>Unlimited.</i> |

2.9.15. Select which clinical offerings from the table below that are available to OEBC. Provide your Book of Business statistics on how many clients have these programs in place today and provide any potential ROI Guarantees.

| Condition | Available Programs | Percent Employer Book of Business Participation | ROI Guarantee |
|----------------------|--|---|-------------------|
| Rheumatoid Arthritis | <i>Multi, Checkboxes.</i> 1: Step Therapy, 2: Prior Authorization, 3: Quantity per Duration, 4: Dose Optimization, 5: Polypharmacy, 6: Concurrent Drug Utilization Review, 7: Retrospective Drug utilization Review, 8: Medication therapy | <i>Percent.</i> | <i>Unlimited.</i> |
| Multiple Sclerosis | <i>Multi, Checkboxes.</i> 1: Step Therapy, | <i>Percent.</i> | <i>Unlimited.</i> |

| | | | |
|---------------------|--|-----------------|-------------------|
| | 2: Prior Authorization, 3: Quantity per Duration, 4: Dose Optimization, 5: Polypharmacy, 6: Concurrent Drug Utilization Review, 7: Retrospective Drug utilization Review, 8: Medication therapy | | |
| High Cholesterol | <i>Multi, Checkboxes.</i> 1: Step Therapy, 2: Prior Authorization, 3: Quantity per Duration, 4: Dose Optimization, 5: Polypharmacy, 6: Concurrent Drug Utilization Review, 7: Retrospective Drug utilization Review, 8: Medication therapy | <i>Percent.</i> | <i>Unlimited.</i> |
| High Blood Pressure | <i>Multi, Checkboxes.</i> 1: Step Therapy, 2: Prior Authorization, 3: Quantity per Duration, 4: Dose Optimization, 5: Polypharmacy, 6: Concurrent Drug Utilization Review, 7: Retrospective Drug utilization Review, 8: Medication therapy | <i>Percent.</i> | <i>Unlimited.</i> |
| Depression | <i>Multi, Checkboxes.</i> 1: Step Therapy, | <i>Percent.</i> | <i>Unlimited.</i> |

| | | | |
|-------------|--|-----------------|-------------------|
| | 2: Prior Authorization, 3: Quantity per Duration, 4: Dose Optimization, 5: Polypharmacy, 6: Concurrent Drug Utilization Review, 7: Retrospective Drug utilization Review, 8: Medication therapy | | |
| Asthma/COPD | <i>Multi, Checkboxes.</i> 1: Step Therapy, 2: Prior Authorization, 3: Quantity per Duration, 4: Dose Optimization, 5: Polypharmacy, 6: Concurrent Drug Utilization Review, 7: Retrospective Drug utilization Review, 8: Medication therapy | <i>Percent.</i> | <i>Unlimited.</i> |
| Diabetes | <i>Multi, Checkboxes.</i> 1: Step Therapy, 2: Prior Authorization, 3: Quantity per Duration, 4: Dose Optimization, 5: Polypharmacy, 6: Concurrent Drug Utilization Review, 7: Retrospective Drug utilization Review, 8: Medication therapy | <i>Percent.</i> | <i>Unlimited.</i> |
| HIV | <i>Multi, Checkboxes.</i> 1: Step Therapy, | <i>Percent.</i> | <i>Unlimited.</i> |

| | | | |
|------------------|---|-----------------|-------------------|
| | <p>2: Prior Authorization, 3: Quantity per Duration, 4: Dose Optimization, 5: Polypharmacy, 6: Concurrent Drug Utilization Review, 7: Retrospective Drug utilization Review, 8: Medication therapy</p> | | |
| Pain (narcotics) | <p><i>Multi, Checkboxes.</i> 1: Step Therapy, 2: Prior Authorization, 3: Quantity per Duration, 4: Dose Optimization, 5: Polypharmacy, 6: Concurrent Drug Utilization Review, 7: Retrospective Drug utilization Review, 8: Medication therapy</p> | <i>Percent.</i> | <i>Unlimited.</i> |
| Other: | <p><i>Multi, Checkboxes.</i> 1: Step Therapy, 2: Prior Authorization, 3: Quantity per Duration, 4: Dose Optimization, 5: Polypharmacy, 6: Concurrent Drug Utilization Review, 7: Retrospective Drug utilization Review, 8: Medication therapy</p> | <i>Percent.</i> | <i>Unlimited.</i> |

2.10 Case and Care Management Programs

The Board is seeking health plan partners who have developed unique programs and approaches outside of standard Utilization and Case Management programs.

2.10.1 Share your Plan’s definition of lowest net cost. Describe your Plan’s approach to managing to lowest net cost for OEBB. Specifically describe unique programs and approaches outside of standard Utilization Management programs, including items such as gaps in care, inflation caps therapeutic category management, etc. Include any lowest net cost guarantees that your organization is proposing for OEBB including measurement, reporting and any conditions that may apply.

[500 words]

2.10.2 Describe your Plan’s Utilization Management (UM) Program. Be sure to include which services require prior authorization by the Plan?

[500 words]

2.10.3 Complete the table providing a brief description of each program, describe when these are applicable, the process and staff performing these functions and the average timeframe from the date the item was received to the date the results were sent to the requestor.

| | Response [500 words each] |
|--|---------------------------|
| Prior authorization of facility stays | |
| Prior authorization of outpatient services | |
| Inpatient concurrent review | |
| Discharge Planning | |
| Follow-up care | |
| Other | |

2.10.4 List the key indicators your Plan tracks and evaluates to monitor your Utilization Management program, including any measures related to access to, and timelines of, care.

[100 words]

2.10.5 Describe how your Plan provides utilization data to your provider network to assist and inform them?

[500 words]

2.10.6 Describe how your Plan manages Members that are high utilizers of Schedule 2 prescription medications?

[500 words]

2.10.7 Describe how your Plan coordinates and supports transitions of care. Be sure to include how care will be transitioned for OEBB members that are currently receiving care for services at practitioners or facilities that are not in your network.

[500 words]

2.10.8 Based on the utilization data provided, propose a custom suite of clinical programs designed to achieve lowest net cost utilization and improved member health outcomes that OEBB should consider

implementing, including an implementation timeline, member impact, expected fees, return on investment and clinical performance guarantees.

[500 words]

2.10.9 Does your Plan profile individual practitioners, group practitioners, or hospitals on the parameters listed below? Check below if yes, check all that apply.

| | Individual practitioners | Group practitioners | Hospitals | Do not profile |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| Outcome or clinical performance indicators | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Utilization | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cost | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Comparison with peers | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Comparison with benchmarks | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Satisfaction surveys | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

2.10.10 Describe your Plan’s Case Management program and approach. Please include the health conditions and care situations that are included in your Case Management program and how Members are identified for inclusion in your Case Management program. Include a description of patient risk-stratification criteria, and any care plan approaches.

[500 words]

2.10.11 a. Provide the percentage of members identified as potentially appropriate for Case Management in 2014. b. Of those identified, provide the percentage of members who were actively case-managed in 2014.

a. Percentage (%)

b. Percentage (%)

2.10.12 Does your Plan have any Care Management or Case Management accreditations? If “yes,” list the accreditations.

[50 words]

2.11 Quality Performance

The Board is seeking health plan partners that are dedicated to improvement in the health status of its members and are dedicated to providing quality health care.

2.11.1 Are you NCQA accredited? If not, when do you anticipate obtaining your accreditation by?

Yes

No, Anticipated Accreditation date:

2.11.2 Describe your Plan's commitment to support efforts led by the Oregon Healthcare Quality Corporation (OHQC) to measure quality of care in Oregon and promote use of evidence-based guidelines. Include your organization's requirements for provider participation OHQC's collaborative quality initiatives.

[1000 words]

2.11.3 Describe your Plan's commitment to ensure patient safety through your provider and facility contracts and policies including participating in the Patient Safety Commission's work.

[500 words]

2.11.4 Describe any other collaborative efforts your Plan is currently engaged in with Providers, employer groups, or other carriers to facilitate system-wide improvement in quality, safety, or costs.

[1000 words]

2.12 Benefit Design

OEBB is seeking health plan partners that are flexible and capable of facilitating changes, innovative design administration and capable of responding quickly to the requested changes, throughout the Plan year.

2.12.1 Provide examples on your Plan's flexibility and administrative responsiveness to changes. Identify limitations as well.

[100 words]

2.12.2 OEBB expects your Plan's processing system to be able to apply different copayments or coinsurance levels to specific services as identified by OEBB (i.e., additional cost tier, wellness visits, preventive care and chronic condition visits). Confirm your Plan's ability to administer this type of benefit and describe your Plan's experience with administering this type of benefit.

Confirmed, [100 words]

Not confirmed,

2.12.3 Confirm your willingness to work with OEBB on mid-year benefit changes as needed.

Confirmed,

Not confirmed,

2.12.4 Describe your Plan's experience in adjusting benefit coverage based on whether Members complete required member engagement or decision support activities before receiving authorization for certain services, or prior to certain care being received?

[100 words]

2.12.5 Propose additional possibilities to further value-based benefit designs and how your Plan has used guidance from the Health Evidence Review Commission (HERC) to make these recommendations.

[100 words]

2.12.16 Are patients involved in committees or oversight? What avenues do they have to advocate for member quality indicators (e.g. transparency of measures)?

[100 words]

2.13 Reimbursement Models

The Board believes that adopting alternatives, over time, to the fee for service payment system is critical to lowering health care cost trends and improving health care quality. OEGB will partner with Contractors that demonstrate experience using alternative payment models and display a clear commitment to expanding the use of alternatives to fee-for-service in the future. In particular, OEGB supports payment alternatives that incentivize evidence-based care, promote quality, and encourage delivery of the right care in the most appropriate setting. OEGB’s annual medical and prescription drug spend is expected to be around \$636 million for the 2014-15 Plan Year and The Governor’s Budget limits OEGB cost growth starting in the 2015-16 plan year, holding per member cost increases to 4.4 percent and 3.4 percent going forward.

2.13.1 Describe how your Plan’s payment methodologies currently promote the Triple Aim and, in particular, how your Plan will:

| | Response [100 words each] |
|--|------------------------------|
| Provide motivation for comprehensive coordination or create shared responsibility across provider types and levels of care that promote the use of the PCPCH system of care. | |
| Provide financial support, differentially based on the PCPCH tier level achieved, to PCPCHs for meeting the PCPCH standards and operating as effective PCPCHs | |
| Align financial incentives for evidence-based and best emerging clinical practices | |
| Align financial incentives that support outcomes based treatments. | |
| Provides motivation for cost containment | |
| Make use of population-based payment (with shared savings or shared risk) | |
| Make use of episode-based payment (with shared savings or shared risk) | |
| Make use of service-specific capitation (e.g., primary care) | |
| Make use of other alternative payment methods not cited in the preceding three lines | |
| Pay providers differentially based on performance on pre-identified quality measures, including measures of population health and patient experience | |

2.13.2 If your Plan’s current payment methodologies do not promote the Triple Aim, but are expected to in the future, please include answers to the above questions, including a proposed timeline for implementation. [1000 words]

2.13.3 Describe how the baseline spend would be established, how the trend/rate increase would be measured and how a trend/rate guarantee would be tied to the health of the OEGB population. [500 words]

2.13.4 Describe proposed risk-sharing arrangements with your Provider network to manage the “per OEGB Member” cost increases. Indicate whether these are currently in place, can be prior to October 1, 2016, or provide an implementation plan and timeline for each of the proposed risk-sharing arrangements. Address how this risk sharing arrangements can help achieve the trend rate. [500 words]

2.13.5 Identify which internal models are used to assess financial impact and outcomes, for both estimated prospective savings and for retrospective program evaluation. Be sure to include emerging delivery care, contracting and reimbursement models. Also, be sure to indicate the following in your response:

- a. If your Plan has conducted internal or external reviews for program evaluation to estimate savings or ROI
- b. What is measured to assess financial impact
- c. What is measured to assess clinical and quality outcomes
- d. What are your Plan’s efficiency and quality metrics of success for these emerging models

2.13.6 What new payment methodologies have you developed to support the integration of behavioral and physical health?

[500 words]

2.13 Questions for CCMs ONLY: (Answers wil not be scored)

2.13.1 Confirm each member will be assigned to a PCPCH they have selected, or auto-assigned a PCPCH and notified if they have not made a selection in a reasonably required timeframe.

- Confirmed,
- Not confirmed, explain: [100 words]

2.13.2 How do you ensure that the member can adequately access the PCP/PC team within their assigned PCPCH?”

[100 words]

2.13.3 Describe your ability to implement a single care management plan shared between physical and behavioral health providers for members with issues in both areas.

[500 words]

2.14 Geo Access Report

The Board expects that OEGB carriers ensure contracted physicians, Providers and facilities render quality care at sustainable payment levels and understands facilities and Providers may not be included in health plan networks if they do not meet OEGB's expectations.

2.14.1 Provide a GeoAccess report with the following report sections for each provider type.

A. Report Sections

- i. Title page
- ii. Accessibility Summary: Urban employees **with** access
- iii. Accessibility Summary: Urban employees **without** access
- iv. Accessibility Summary: Suburban employees **with** access
- v. Accessibility Summary: Suburban employees **without** access
- vi. Accessibility Summary: Rural employees **with** access
- vii. Accessibility Summary: Rural employees **without** access

B. Criteria

| | Urban Employees | Suburban Employees | Rural Employees |
|-------------------------|------------------------|---------------------------|------------------------|
| Persons per Square Mile | Greater than 3,000 | 1,000 to 3,000 | Less than 1,000 |
| Provider Type | Urban Employees | Suburban Employees | Rural Employees |

| | | | |
|---|----------------------------------|-----------------------------------|-----------------------------------|
| • Primary Care Providers | Two PCPs within 5 miles | Two PCPs within 10 miles | Two PCPs within 15 miles |
| • Specialists | Two specialists within 5 miles | Two specialists within 10 miles | Two specialists within 30 miles |
| • Pediatric | Two Pediatricians within 5 miles | Two Pediatricians within 10 miles | Two Pediatricians within 15 miles |
| • OB/GYN | Two OB/GYNs within 5 miles | Two OB/GYNs within 10 miles | Two OB/GYNs within 15 miles |
| • PCPCH | Two PCPCHs within 5 miles | Two PCPCHs within 10 miles | Two PCPCHs within 15 miles |
| • Hospitals | Two hospitals within 10 miles | One hospital within 10 miles | One hospital within 20 miles |
| • Non-Allopathic | Two Providers within 5 miles | Two Providers within 10 miles | Two Providers, within 30 miles |
| • Non-MD Behavioral Health Provider | Two Providers within 10 miles | Two Providers within 15 miles | Two Providers within 20 miles |
| • MD Behavioral Health Provider | Two Providers within 10 miles | Two Providers within 15 miles | Two Providers within 20 miles |
| • Behavioral Health Acute Care Facility | Two facilities within 30 miles | Two facilities within 30 miles | One facility within 30 miles |

PART B - ATTACHMENT 4 Vision Questionnaire

4.1 Benefits

4.1.1 Are discounts available for items such as designer frames, special coatings, tints, etc.? Please check all that apply.

Designer frames
Special coatings
Tints
UV
Anti-reflective
Other

4.1.2 Do you offer a discounted arrangement for laser surgery performed to correct vision deficiencies?

Yes
No

4.1.3 Confirm that the full provider discounts are passed onto OEGB and its members for all eligible in network claims.

Confirmed
Not confirmed, explain

4.1.4 Confirm you can administer a benefit with standard glasses, conventional or disposable contact lenses, available once every 12 months until age 19?

Confirmed
Not confirmed, explain

4.2. NETWORK ARRANGEMENTS

4.2.1 Identify the total number of vision plan group members enrolled as of the following dates:

Total number of members in Oregon as of 1/1/2006 (##.##)
Total number of members in the US as of 1/1/2006 (##.##)
Total number of members in Oregon as of 6/1/2007 (##.##)
Total number of members in the US as of 6/1/2007 (##.##)

4.2.2 Does your vision network allow the ability for 24-hour turnaround on glasses through your network? If no, please explain.

Yes

No

4.2.3 What percentage of Ophthalmologists and Optometrists make up your network in Oregon?

Ophthalmologists %

Optometrists %

4.2.4 List the top 5 major optical chain stores in Oregon that participate in your organization's network (if you do not contract with chain stores, enter N/A).

#1

#2

#3

#4

#5

4.2.5 Proposer agrees to provide an annual **access report documenting member access**. Based on findings, the plan will prepare a project plan for additional development where plan and OEBC both believe that growth is practicable. There are annual rates at risk if GEO access reports and project plans are not submitted to OEBC by January 1 of each contract year. Reporting frequency is annually, payment back to OEBC is annually.

Yes, agree

No, proposed alternative

4.2.6 What specific qualifications and credentials does your organization require of optometrists within your network? Check all that apply.

| | |
|--------------------------|---|
| <input type="checkbox"/> | Must be a licensed, private practice ophthalmologist |
| <input type="checkbox"/> | Must be in good standing with their state licensing board |
| <input type="checkbox"/> | Ophthalmologists must become certified by the American Board of Ophthalmology |
| <input type="checkbox"/> | Current malpractice liability insurance at required levels as governed by state law |
| <input type="checkbox"/> | Must disclose loss or limitations of privileges or disciplinary activity |
| <input type="checkbox"/> | Must provide any history of loss of license and/or felony conviction |

4.2.7 What specific qualifications and credentials does your organization require of ophthalmologists within your network? Check all that apply

| | |
|--|---|
| | Must be a licensed, private practice ophthalmologist |
| | Must be in good standing with their state licensing board |
| | Ophthalmologists must become certified by the American Board of Ophthalmology |
| | Current malpractice liability insurance at required levels as governed by state law |
| | Must disclose loss or limitations of privileges or disciplinary activity |
| | Must provide any history of loss of license and/or felony conviction |

4.2.8 What was the provider turnover rate in your networks during the following years (voluntary is provider initiated; involuntary is network initiated)?

Voluntary Turnover Involuntary Turnover
2007 % %
2006 % %

4.2.9 Please conduct a GEO access network match for ALL ELIGIBLE employees using the access standards indicated in the instructions for Network Access located in the Reference Documents section, along with the census data.

- i. Title page
- ii. Accessibility Summary: Urban employees **with** access
- iii. Accessibility Summary: Urban employees **without** access
- iv. Accessibility Summary: Suburban employees **with** access
- v. Accessibility Summary: Suburban employees **without** access
- vi. Accessibility Summary: Rural employees **with** access
- vii. Accessibility Summary: Rural employees **without** access

B. Criteria

| | Urban Employees | Suburban Employees | Rural Employees |
|-------------------------|-------------------------------------|--------------------------------------|--------------------------------------|
| Persons per Square Mile | Greater than 3,000 | 1,000 to 3,000 | Less than 1,000 |
| Provider Type | Urban Employees | Suburban Employees | Rural Employees |
| • Optometrists | Two Optometrists within 5 miles | Two Optometrists within 10 miles | Two Optometrists within 30 miles |
| • Ophthalmologists | Two Ophthalmologists within 5 miles | Two Ophthalmologists within 10 miles | Two Ophthalmologists within 30 miles |
| • Opticians | Two Opticians within 5 miles | Two Opticians within 10 miles | Two Opticians within 30 miles |

| | | | |
|---------|-----------------------------|------------------------------|------------------------------|
| • Other | Two _____ within 5 miles | Two _____ within 10 miles | Two _____ within 15 miles |
|---------|-----------------------------|------------------------------|------------------------------|

DRAFT

EXHIBIT 1 Overview of OEBB

I. Introduction

Oregon has a long history of innovative healthcare reform efforts. However, Oregon continues to face a number of common challenges: healthcare costs that are increasingly unaffordable for individuals, the state and federal government, and businesses; cost growth that far outpaces the growth in state general fund revenue and personal income; and a healthcare system that rewards volume, not value.

Without resolution, healthcare will continue to be increasingly unaffordable for everyone. Furthermore, the rising costs of healthcare are not supported by improvements in the quality of care, or a decrease in inequities among certain groups. Nationally it is estimated that about 30 percent of care provided is either unnecessary or does not lead to better patient health. Within this environment, OEBB has seen an increase in healthcare costs without a corresponding increase in improved health outcomes of our Members.

The Oregon Health Authority (OHA), which is the largest public purchaser of healthcare services in the state, includes most of the state's healthcare programs, such as Public Health, the Oregon Health Plan, the Public Employees Benefit Board (PEBB) and the Oregon Educators Benefit Board (OEBB). OHA is seeking to transform the healthcare system in Oregon by improving the delivery of care and patient outcomes, reducing waste and redefining how and what services are paid for.

OEBB's Vision and Guiding Principles were developed in 2009 and are listed in Section II below. The Vision focuses on the fundamental belief that collaboration is key to providing affordable, value-added benefits. The Guiding Principles are used by the Board and staff to guide decision-making and support the powers, duties, and vision of OEBB as described in ORS 243.862, 243.866 (1)(a-h) and OAR 111-002-005 (3).

OEBB expects greater value from its healthcare partners through a healthcare delivery system that is accountable for costs and outcomes. By eliminating waste and controlling costs, OEBB will ensure that its Members receive the healthcare they need today and in the future. In addition, OEBB strives to ensure that its Members' healthcare is coordinated across the continuum and that quality and financial incentives are more aligned throughout the delivery system. When making decisions about its healthcare partners, OEBB will look for better health outcomes and patient-centered programs with demonstrated success.

OEBB believes the Coordinated Care Model (CCM) is essential to achieving the Board's goals and that a successful coordinated care model health plan includes the following characteristics:

1. Best practices to manage and coordinate care
 - Patient and family-centered primary care
 - Team-based care across appropriate disciplines

- Plans to manage care for 20 percent of the population driving 80 percent of costs, including those with chronic conditions
 - Plans for prevention and wellness, including addressing disparities among the population served
 - Broad adoption and use of electronic health records
2. Sharing responsibility and engaging Members in better health
 - Shared healthcare decision-making that involves Members and Providers
 - Member education and accountability strategies
 - Member responsibility for personal health behaviors
 - Plan and Provider responsibility to provide resources and support to aid Members in understanding their risks and engaging them in taking steps to improve their health
 3. Measuring performance
 - Quality, cost and access metrics
 - Strategies for achieving targets and improvement
 4. Paying for outcomes and health
 - Payments aligned to health outcomes not volume
 - Incentives for prevention and improved care of chronic conditions
 5. Providing information
 - Readily available, accurate, reliable and understandable data, including, but not limited to, cost and quality
 - Price and value for payers, providers and patients
 6. Financially sustainable per Member rate of growth
 - Focusing on preventing cost shift to Members and their families
 - Utilization and cost trend guarantees

OEBB expects to contract with health plan partners committed to transforming Oregon's healthcare system to achieve better health, better care and lower costs for OEBB Members and all Oregonians and who offer OEBB Members a range of affordable benefit plan designs.

Proposals should clearly demonstrate that better health, better care and lower costs to our Members, the state and Oregon taxpayers will be achieved through innovative efforts, increased accountability and transparency. Within this context and consistent with the characteristics described directly above, OEBB may select at least one statewide Apparent Successful Proposer and multiple CCM Apparent Successful Proposers to offer Members choice in counties across

Oregon to the extent possible and practical. The statewide and CCM Plans selected under this RFP will possess characteristics consistent with Sections 2 of this RFP.

II. *OEBB's Vision and Guiding Principles*

A. *OEBB'S VISION*

OEBB will work collaboratively with participating educational entities and local governments, members, carriers and providers to offer value-added benefit plans that support improvement in members' health status, hold carriers and providers accountable for outcomes, and provide affordable benefits and services.

Key components of the OEBB program are:

- Support Oregon's healthcare system transformation efforts promoting better health, better care and lower costs.
- Support improvement in members' health status through a variety of measurable programs and services.
- Value-added plans that provide high-quality care and services at an affordable cost to members.
- Measurable goals and programs that hold carriers and providers accountable for health outcomes.
- Encourage members to take responsibility for their own health outcomes.
- Collaboration with participating entities, members, carriers and providers that ensures a synergistic approach to the design and delivery of benefit plans and services.
- Benefits are in compliance with all state and federal laws and support participating entities' ability to comply with healthcare-related laws and regulations.

B. *OEBB's GUIDING PRINCIPLES*

ORS 243.866 outlines specific criteria that OEBB is to emphasize in considering whether to enter into a contract for a benefit plan. The Board further defined those criteria to serve as a guide in carrying out its charge.

- Employee choice among high-quality plans

Board Definition—OEBB will offer employees a range of affordable Benefit Plan designs that provide high-quality care and services.

- Encouragement of a competitive marketplace

Board Definition—OEBB will encourage competition in the marketplace in the areas of quality, outcomes, service and cost.

- Plan performance and information

Board Definition—OEBC will consider plan performance in the areas of quality, administrative processes, costs and outcomes in making its decisions. It will promote system-wide transparency that provides members with comprehensive information on these issues including decision-making resources and price transparency.

- Flexibility in plan design and contracting

Board Definition—OEBC will offer a range of affordable Benefit Plan designs that provide participating Entities and employee groups with the flexibility to choose options through collective bargaining agreements and documented entity policies that meet their and their employees' financial and health needs.

- Quality customer service

Board Definition—OEBC will collaborate with participating Entities and Benefit Plans to ensure that Members receive efficient, effective and timely service in the areas of enrollment, benefit and service coverage, and claims administration and are highly satisfied with the benefits and services received.

- Creativity and innovation

Board Definition—OEBC will seek out Plans and Providers that use creative and innovative methods and practices that are Evidence-Based, have measurable outcomes and promote better health, better care and lower costs.

- Plan benefits as part of total compensation

Board Definition—OEBC will consider the impact of benefit costs on Members' compensation when designing, selecting and renewing Benefit Plans and programs.

- Improvement of employee health

Board Definition— OEBC will promote employee health and wellness through a variety of means with a focus on those activities supported by evidence of improvement in health outcomes.

- Cost Affordable to the participating entities, employees and taxpayers

Board Definition—OEBC will take into account the present and future costs of benefit plans (premiums, deductibles, copayments, etc.) in offering a range of affordable, high-quality benefit plan designs and will advance Oregon's health system transformation

efforts through the availability and promotion of coordinated care model health plans and increased transparency for members.

III. OEBB Demographics

As one of the largest public Benefit Plan purchasers in the state, OEBB currently has nearly 250 Educational Entities (school districts, educational service districts, community colleges and public charter schools) and four Local Governments (two counties and two Special Districts) throughout Oregon participating in the benefits program. As of March 2015, OEBB provided Benefit Plans for more than 142,200 eligible Subscribers and Dependents.

In addition to the current participating Educational Entities and Local Governments, there are nine school districts with **11,630** potential Subscribers, one community college with **700** potential Subscribers, and **1,218 Local Governments and Special Districts** with approximately **42,700 potential Subscribers** that are eligible to join OEBB.

As of March 2015, 71 percent of OEBB subscribers are female and the average subscriber age is 48.

- average female age is 48.3
- average male age is 48.1.

The average family size is 4.1.

OEBB subscribers are located in every county within Oregon. OEBB also has approximately 1,315 covered lives that reside out-of-state and a small number of Subscribers that reside internationally (less than 20).

OEBB's annual medical and prescription drug spend is expected to be approximately \$636 million for the 2014-15 Plan Year and The 2015-2017 Governor's Budget limits cost growth on premiums for the OEBB medical and pharmacy coverages in the 2015-16 plan year to 4.4 percent and 3.4 percent thereafter.

IV. OEBB's Current Medical, Pharmacy and Vision Programs

OEBB's current programs include the following medical plans:

- Moda Health Plan offers eight medical/Rx plan options with varying deductibles and annual maximum out-of-pocket amounts, including a qualified high deductible health Plan (HDHP). The options are available through a statewide PPO Network and two CCM Networks that cover large portions of the state.
 - The PPO plan has approximately 39,176 Subscribers and 57,530 Dependents enrolled for a total of 96,706 covered lives.

- Moda Health Plan offers four (4) vision Plans. These Plans currently have 40,259 Subscribers and 63,299 Dependents for a total of 103,558 covered lives.
 - The Summit Network serves 12 counties in eastern Oregon and has approximately 460 Subscribers and 914 Dependents enrolled for a total of 1,374 covered lives.
 - The Synergy Network serves 12 counties in western Oregon and has approximately 2,557 Subscribers and 4,058 Dependents enrolled for a total of 6,615 covered lives.
- Kaiser Permanente of the Northwest offers three medical/Rx plan options, including a traditional HMO option, a low deductible option and a qualified high deductible health Plan (HDHP). These Plans are available to Members who live or work in the Kaiser service area.
 - Kaiser has approximately 10,355 Subscribers and 14,345 Dependents enrolled for a total of 24,700 covered lives.
- Kaiser Permanente of the Northwest offers one vision Plan. This Plan is available to OEGB Members who enroll in Kaiser Permanent's medical Plan. The Plan currently has 7,301 Subscribers and 9,962 Dependents for a total of 17,263 covered lives.

V. OEGB Program Administration

Pursuant to ORS 243.061, OEGB operates within the Oregon Health Authority (OHA). OEGB was formed by the signing of Senate Bill 426 on March 21, 2007. OEGB purchases benefits for active and certain retired employees of most Educational Entities which includes the following: public school districts (K-12), education service districts, community colleges and public charter schools in Oregon. Effective January 1, 2014, HB 2279 allows Local Governments which include cities, counties and Special Districts to join OEGB. OEGB is specifically authorized by Oregon Revised Statute (ORS) 243.874 to provide and administer flexible benefits plans to these Entities.

The Board has engaged Towers Watson as its Consultant. Except where this RFP specifically refers to the Board, any action of OEGB may be taken either by the Board or by its designees including OEGB staff and Towers Watson. Furthermore, Towers Watson has retained Proposal Technologies Network, Inc. (Proposal Tech) to provide the Proposal Submission Website. Proposal Tech is not affiliated with OEGB or the state of Oregon.

The RFP, and its evaluation process described herein, is the intellectual property of OEGB but includes certain tools and materials, which originated as the copyrighted product or other intellectual property of Towers Watson and Proposal Tech. Such tools and materials are used by OEGB with the permission of Towers Watson under the terms and conditions of Towers Watson's contract with OEGB. No Proposer or other third party shall have any right to use the tools and materials of Towers Watson or Proposal Tech by reason of OEGB's use of them in this RFP, or in the evaluation process hereunder, except to the extent that Proposers are required to use them to provide required responses to this RFP.

VI. *OEBB's Board and Its Workgroups*

OEBB is governed by a 12-member Board whose members are appointed by the Governor and confirmed by the Senate. The Board currently meets on the first Tuesday of the month. Members of the Board also serve on the following workgroups and committee:

Strategies on Evidence and Outcomes Workgroup (SEOW)

The OEBB Strategies on Evidence Workgroup (SEOW) is a standing workgroup comprised of OEBB Board members, consultants, carrier representatives and medical directors, and OEBB staff. The SEOW is charged with addressing a broad range of issues related to improving Members' health status through a variety of measurable goals, programs and services and advancing evidence-based and value-based benefits in the OEBB benefits program. This Workgroup meets monthly, generally on the same day as the full Board, and most Contractors attend both the SEOW and Board meetings.

Administrative Review Committee (ARC)

The purpose of the ARC is to evaluate third-level administrative review requests. The administrative reviews consist of eligibility appeals that have been reviewed and denied by OEBB staff as Appeals (first level appeals) and as Requests for Reconsideration (second level appeals), or claim or benefit denials that have gone through the multi-level appeal process with the insurance carrier. The Board has delegated decision-making authority to this Committee.

Business and Operations Workgroup (BOW)

The BOW makes recommendations regarding OEBB operations including budget, administrative rules, procedures and policies.

Engagement Workgroup (formerly Communications Workgroup)

The Engagement Workgroup provides recommendation to the Board regarding OEBB communication strategy, establishing communication priority and how best to educate, communicate and promote OEBB programs with OEBB Members.

Healthy Futures Workgroup (HFW)

The HFW provides recommendations to the Board on the Healthy Futures Program OEBB offers to all its Members which includes identifying requirements for qualifying for incentives, creating and maintaining wellness program and activity offerings and increasing Member awareness and engagement.

VII. OEBB's Health and Wellness Programs

The Healthy Futures Program is designed to encourage OEBB Members to learn their individual health risks and to take action to reduce or eliminate risks whenever possible. Members who elect to participate, complete an online health assessment and complete two healthy actions receive an enhanced Benefit Plan that may include a reduction in a Member's out-of-pocket expenses or other incentives as approved by the Board. Participation in any of the wellness tools and programs described below counts as a health action and are available to OEBB Members on the Contractors' website:

- a. **Online personal health assessment.** Contractors provide access to a confidential and secure online resource or tool that allows OEBB Members to complete a health assessment that provides suggestions for mitigating or eliminating health risks.
- b. **Health conversation modules.** Contractors provide online and telephone access to health resources and healthcare professionals relative to various topics and medical conditions.
- c. **Weight Management Program.** Contractors provide a weight management program for Members. WeightWatchers[®] (WW) is the current subcontractor through Moda Health Plan and Kaiser Permanente. The Program incorporates healthy eating, physical activity, behavior modification and a supportive atmosphere at worksite or community meetings and online. Anyone enrolled in an OEBB medical plan can enroll in their first 13-week session at no cost (age restrictions may apply to children. Those who maintain participation requirements qualify for up to four 13-week sessions per plan year.
- d. **Tobacco Cessation.** The Quit For Life[®] Program is the current subcontractor through Moda Health Plan. Kaiser Permanente does not use a subcontractor and provides tobacco cessation resources through their own program. Quit For Life[®] is available at no cost to anyone enrolled in an OEBB medical plan. There are also other tobacco cessation resources available through the Contractors, such as telephone consults, web coaching, nicotine replacement therapy that includes gum, patches and prescription medications when certain criteria are met by the Member.
- e. **Team-Based Worksite Wellness Program.** Contractors currently provide a team-based worksite wellness program through Healthy Team Healthy U (HTHU) that encourages Members to meet regularly and complete group and individual learning activities to promote better health. The participants learn to lead a healthier life by forming fun teams with coworkers or family members. The program has tools to improve diet, increase physical activity, increase energy and enjoy better overall health. OEBB Subscribers and Dependents age 18 or older enrolled in an OEBB medical plan can participate at no cost.

- f. **Diabetes Prevention.** On behalf of OEGB, Moda Health Plan partnered with Community Connection of Northeast Oregon (CCNO) representing 12 counties and both Moda and Kaiser Permanente partnered with Family YMCA of Marion and Polk Counties (YMCA) to pilot the Diabetes Prevention Program (DPP) as a covered benefit. The Diabetes Prevention Programs offered by CCNO and YMCA are community-based, lifestyle improvement programs for adults with pre-diabetes. Participants in the programs attend 16 weekly and six monthly maintenance sessions. OEGB's contracted carriers subcontract for services related to the DPP benefits and assist with other functions, such as outreach and reporting. OEGB Subscribers and Dependents age 18 or older enrolled in an OEGB medical plan can participate at no cost.
- g. **Managing Chronic Care.** Contractors currently provide access to Better Choices, Better Health which is an online self-management course developed by Stanford University to assist people in dealing with problems associated with chronic medical conditions. Workshops are led by trained facilitators and include approximately 25 participants. Participants can participate in the six-week interactive workshop at their own pace from any computer with internet access. OEGB Subscribers and Dependents age 18 or older enrolled on an OEGB medical plan can participate at no cost.
- h. **Behavioral and Mental Health.** Kaiser Permanente currently provides the MoodHelper program which is an online program for adults to help manage depression. MoodHelper offers interactive tools and the option of connecting with trained coaches, by telephone, who will work with participants on applying the lessons available on the website to day-to-day life. Participants gain skills to overcome depression which have been effective for millions of people. OEGB Subscribers and Dependents age 18 or older enrolled on an OEGB medical plan can participate at no cost.

EXHIBIT 5 Definitions

The definitions below apply to this Request for Proposals (RFP). Please refer to the definitions in OAR Chapter 111, Division 10 for all capitalized terms that are not defined in the RFP.

Addiction means a state characterized by compulsive engagement in rewarding stimuli, despite adverse consequences. For purposes of this RFP, the definition of addiction includes, but is not limited to, illegal drugs, prescription drugs, alcohol, gambling, gaming, etc.

Addenda means any amendments, clarifications, or changes to the terms of the RFP as found on ORPIN.

Administrative Overpayments means payments that exceed the benefit amount payable under the Plan resulting from a Provider billing error, retroactive or inaccurate eligibility information, coordination of benefits, third-party liability, Medicare disputes, missing information or similar circumstances.

Affiliate of a proposer means all affiliates, assignees, subsidiaries, parent companies, successors and transferees, and persons under common control with the person; any officers, directors, partners, agents and employees of such person; and all others acting or appearing to act on their behalf or in concert with them. Has the meaning provided in ORS 732.548

Affiliated Company means an “affiliate” as defined in ORS 732.548 (insurance holding company registration statute).

Agreement means this RFP’s resulting Contract between an Apparent Successful Proposer (ASP) and OEGB.

Apparent Successful Proposer or ASP means a proposer that has met all minimum requirements in this RFP, has been deemed responsive, has been selected by the Board to be interviewed, and, based on scoring and all other considerations described in this RFP, has been selected by the Board to proceed to contract negotiations.

Behavioral Health means services related to either mental health and/or addiction services.

Benefits Claim means a claim of a Participant for benefits under this Agreement.

“**Benefit Plan**” includes, but is not limited to, insurance or other benefits including:

- (a) Medical (including non-integrated health reimbursement arrangements (HRAs));
- (b) Dental;
- (c) Vision;
- (d) Life, disability and accidental death;

- (e) Long term care;
- (f) Employee Assistance Program Plans;
- (g) Supplemental medical, dental and vision coverages (including Integrated General Purpose and Integrated Post-Deductible health reimbursement arrangements (HRAs); and Limited Purpose, Post-Separation/Retiree, and Premium Only health reimbursement arrangements (HRAs);
- (h) Any other remedial care recognized by state law, and related services and supplies;
- (i) Comparable benefits for employees who rely on spiritual means of healing; and
- (j) Self-insurance programs managed by the Board.

Best Efforts means the use of reasonable diligence as well as good faith in the performance of the Contract. Improvement shall be achieved from one Plan Year to the next. This level of Best Effort is expected until a clear set of criteria is developed for a specific performance measure either in accordance with state statute, administrative rule, or mutually agreed to by both parties.

Board means the governing board of OEBC and may be used interchangeably with OEBC for purposes of this RFP.

Broker means a person who is under, or is expected to or has responded to a Procurement to be under, a contract as a consultant, broker, agent, representative, or other person responsible for evaluating insurance services.

Care Management means services for Members with one or more chronic medical conditions (including but not limited to diabetes, chronic obstructive pulmonary disease, congestive heart failure and hypertension) and are at high risk of future inpatient and Emergency Department (ED) use, includes coordination of care which will ultimately improve the Member's health status and impact future service utilization.

Carrier means an insurance company or health care service contractor holding a valid certificate of authority from the Oregon Insurance Division. This contract assumes Contractor is a Carrier.

Case Management means a program that supports Members with complex acute health care needs who require a case management process that fully integrates medical, behavioral, acute care, medication management and patient education into a seamless experience, ensuring Members receive the right care at the right time, are engaged, understand the care plan and receive ongoing support from their care team in order to prevent avoidable future inpatient and ED utilization.

Claims Data Set means the de-identified claims data Proposers will need to provide a responsive proposal.

Clinical Overpayments means payments that exceed the appropriate amount payable due to errors in clinical coding, incorrect application of Provider contracts and other clinical audit items.

Competitive Range means those regions or service category portions of proposals that the Board selects to proceed to the interview portion of the RFP.

Confidential Information includes:

- (a) information marked or designated in writing by either party as “confidential” prior to initial disclosure, and
- (b) enrollment information, medical records, claims, payment information and any Protected Health Information (“PHI”) within the meaning of the Federal Privacy Rule.

Confidential Member Information means information that contains personally identifiable health information about a Member.

Consultant means the entity OEBB contracts with to provide a variety of consulting services related to OEBB’s benefit plans and this RFP. For purposes of this RFP, OEBB has retained Towers Watson Delaware, Inc. as its Consultant.

Contingent Commission means any payment or other incentive by an Insurance Services Contractor to, or agreement of an Insurance Services Contractor with, a Broker that is contingent in any way upon

- (a) the volume or growth of Insurance Services Contractor business placed by the Broker;
- (b) the profitability or quality of Insurance Services Contractor business placed by the Broker, (e.g. total amount of Benefits Claims paid a loss ratio);
- (c) persistency, i.e. how many of the Broker's clients renew policies with the Insurance Services Contractor or with the incumbent Contractor when a policy comes up for renewal; or,
- (d) rendering by the Broker of asserted services for the Insurance Services Contractor that are fictitious or bear no relation to the amount of the fee.

Contingent Commissions may be styled as a ‘contingent commission,’ ‘overrides,’ ‘advisory fees,’ ‘placement service fees,’ ‘market services fees,’ ‘special compensation,’ ‘direct vendor marketing fees,’ ‘enrollment fees,’ ‘communications fees,’ ‘finders fees,’ ‘administration fees,’ or ‘preferred broker compensation.’

Contract or Group Benefits Contract are synonymous with “Contract” and mean the contracts that result from this RFP process. The terms Contract, Groups Benefits Contract, and Agreement may be used interchangeably.

Contractor means a party providing health benefits and related services to Participants under this RFP’s resulting Contracts.

Contractor Intellectual Property means any intellectual property owned by Contractor and developed independently from the Work.

Coordinated Care Model means carriers and organizations which apply Evidence-based best practices of health care delivery to produce better quality of care, improved patient health outcomes, lower cost of care and create a positive patient experience.

Dependent means and includes the Eligible Employee’s Spouse or Eligible Domestic Partner, or Child as defined in OAR 111-010-0015 (7), unless otherwise defined in another OEBC Rule.

Educational Entities means public school districts (K-12), education service districts (ESDs), community colleges and public charter schools participating in OEBC.

Effective Date means the date that Contracts awarded under this RFP will begin, which is when they are fully executed by the parties and after they receive all necessary approvals from the State of Oregon, including legal sufficiency approval from the Oregon Department of Justice

Electronic Health Record is an official digitalized health record for an individual that is shared among multiple facilities and agencies

Entity means an Educational Entity or Local Government or Special District.

“**E-Number**” means the identification number used in the Premium files from payroll centers and applicable third party administrators.

Evidence-Based means the practice of medicine in which the physician finds, assesses and implements methods of diagnosis and treatment on the basis of best available current medical research, clinical expertise and the needs and preferences of the patient.

Health Benefits may include medical, hospital, dental, vision, wellness, pharmacy, and disease management benefits.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as amended from time to time, and the rules thereunder including the Federal Privacy Rule.

HMO means a Health Maintenance Organization medical plan.

Insurance Division means the Insurance Division of the Oregon Department of Consumer and Business Services.

Insurance Services includes but is not limited to the services of an insurance company, reinsurer, dental care service contractor, dental services manager, third-party administrator, insurance broker, insurance agent, risk manager, utilization review organization, consultant, Benefits Claims payment processor, or any other employee benefits management company or contractor.

Insurance Services Contractor means a company or person which is currently, or is responding to a Procurement to become, under contract with or otherwise furnishing Insurance Services to the State of Oregon.

Legal Claim means any claim, suit, action, or proceeding between OEBC (or any other agency or department of the State of Oregon) and Contractor that arises from or relates to this Agreement.

Local Government means cities, counties and Special Districts in Oregon.

Medical Home means a Patient Centered Primary Care Home.

Member(s) means and includes the following:

- (a) "Eligible Employee" as defined by OAR 111-010-0015(17).
- (b) "Child" as defined by OAR 111-010-0015(7).
- (c) "Eligible Domestic Partner" as defined by OAR 111-010-0015(15).
- (d) "Spouse" as defined by OAR 111-010-0015(31).

Member is used interchangeably with Participant for purposes of this RFP.

Member Handbook means the document delivered by Contractor in accordance with Exhibit 4 (Scope of Work) of this RFP, and provided to Members to describe the terms and conditions of coverage offered under the Plan in accordance with federal and state requirements, if applicable. This document may also be referred to as Evidence of Coverage (EOC) or Certificate of Coverage (COC).

Network means a Provider or group of Providers who have entered into or are governed by contractual arrangements with a Contractor, a Contractor's affiliate or subcontractor under which they agree to provide health care services to Members and to accept negotiated fees for such services under at least one Plan.

Network Pharmacy means a pharmacy which has entered into an agreement with Contractor or a Contractor affiliate or subcontractor to provide prescription drug services to Members under at least one of the Plans.

Network Provider means a Provider who participates in one of Contractor's Networks for at least one of the Plans.

Noncompetitive Response means bidding, proposing, or otherwise responding to a Procurement, which response (as a result of actions of or circumstances that are created in whole or part by a Proposer or its Affiliates):

- (i) is not bona fide;
- (ii) favors the incumbent Insurance Services Contractor;
- (iii) restricts or allocates opportunities to sell Insurance Services to the State of Oregon;
- (iv) is rigged, steered to a particular Insurance Services Contractor to avoid fee disclosures or for other reasons not specified in the Procurement, based on target premiums or fixed prices or chosen by the State of Oregon under false pretenses;
- (v) has a backup quote or protective quote, a so-called 'B Quote' not based on underwriting analysis, false or inflated quotes, or quotes that were deliberately inferior in order to manipulate market pricing or to present the quotes of Insurance Services Contractor or the Broker's negotiating powers in a more favorable light;
- (vi) is collusive, fictitious or otherwise noncompetitive; or,
- (vii) induces or causes the State of Oregon to purchase Insurance Services at prices higher than it would have paid, or on terms less favorable than would have been available, in a competitive market.

OAR means Oregon Administrative Rule(s).

OEGB means the State of Oregon, acting by and through its Oregon Educators Benefit Board.

OHA means the Oregon Health Authority. Pursuant to ORS 243.061, OEGB is a part of OHA.

OID means the Oregon Insurance Division.

OPDP means the Oregon Prescription Drug Plan.

ORPIN means the Oregon Procurement Information Network, which is the source for all

official RFP documents including, without limitation, exhibits, attachments, clarifications, and addenda.

ORS means the Oregon Revised Statutes.

Participant means an OEBB Member who is an Eligible Employee of an Entity and who is covered by the Benefit Plan. The term Participant also includes family member, or other individual insured or otherwise covered by or participating in, or eligible for, OEBB insurance plan benefits. The term Participant may be used interchangeably with the term Member for purposes of this RFP.

Patient-Centered Primary Care Home (PCPCH) means a health care team or clinic as defined in ORS 414.655, meets the standards pursuant to OAR 409-055-0040, and has been recognized through the process pursuant to OAR 409-055-0040.

Performance Requirements means specific measures selected by OEBB to evaluate Contractor performance in certain functions, services and areas of interest to OEBB. Specific targets may be set by OEBB based on OHA metrics, HEDIS, CAHPS or other measures determined appropriate by OEBB that Contractor must achieve and report their level of performance. If a Performance Requirement is not met, improvement targets may be set by OEBB that Contractor must demonstrate continuous improvement from one Plan Year to the next until the Performance target is met.

PHI means Protected Health Information, as defined under HIPAA.

Plans means the ASP's plans selected by OEBB resulting from this Medical RFP. **Plan** means at least one of the Plans, as the context requires.

Plan Year means the twelve month period starting on October 1 of a year and ending on September 30 of the following year.

Population-based Contracting: under this type of arrangement a Plan contracts with a provider who agrees to accept responsibility for a set of health services for a group of patients in exchange for a set amount of money. If the provider effectively manages cost and performs well on quality of care targets, then the provider may keep a portion of the savings generated, but if the provider does not perform well then they may be held responsible for some of the additional costs incurred.

PPO means a Preferred Provider Organization medical plan.

Primary Care Provider means a clinician who provides integrated, accessible health care services and who is accountable for addressing a large majority of personal health care needs, including providing preventive and health promotion services for men, women, and children of all ages, developing a sustained partnership with patients, and practicing in the context of family and community, as recognized by a State licensing or regulatory authority. (this

definition includes PAs and NPs). From: **Section 5405 of the ACA Primary Care Extension Program**

Provider means a health care practitioner or a facility that is validly licensed by the appropriate state agency to diagnose or treat health conditions, and is providing services within the scope of that license.

Procurement means a solicitation or procurement for an Insurance Services Contractor or other decision by the State of Oregon among Insurance Services Contractors. “Procurement” includes negotiation, renewal or renegotiation of an Insurance Services Contractor’s contract or policy with the State of Oregon without regard to whether a formal solicitation or procurement process is used.

Proposer means a person who is responding to this RFP on behalf of an agency, organization or Carrier.

RFP means the OEBC Request for Proposal that preceded the resulting contract.

Selection Committee means a quorum of the OEBC Board and an OEBC administrative staff member.

Single Point of Contact means the person Proposers must submit all questions, requests for clarifications, and protests to, except for technical assistance questions for the proposal submission website.

Special District means any district listed in ORS Chapter 198 “Special Districts Generally,” or as determined by the Board.

Subscriber means “Eligible Employee” as defined by OAR 111-010-0015(17).

Team based care: The provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers – to the extent preferred by each patient – to accomplish shared goals within and across settings to achieve coordinated high-quality care.

Telehealth means the use of medical information exchanged from one site to another via electronic communications to improve a patient’s clinical health status. Telehealth includes a growing variety of applications and services using two-way video, email, smart phones, wireless tools and other forms of telecommunications technology.

Third Party Intellectual Property means any intellectual property owned by parties other than OEBC or Contractor.

Triple Aim means the three overarching goals OEBC has adopted for this RFP: to provide better health, better care, and at a cost we all can afford.

Value-based Network Design means the explicit use of employee health care plan benefits to create consumer incentives for the use of high performance providers who adhere to Evidence-based treatment guidelines.

Value-based Plan Design means the explicit use of plan incentives to encourage enrollee adoption of one or more of the following, including but not limited to:

- appropriate use of high value services, including certain prescription drugs and preventative services;
- adoption of healthy lifestyles, such as smoking cessation or increased physical activity; and
- use of providers who adhere to evidence-based treatment guidelines.

Vendor means a person who is under a contract with the State of Oregon for Insurance Services.

Work means the deliverables to be completed under this Agreement by Contractor.

Work Product means every invention, discovery, work of authorship, trade secret or other tangible or intangible item and all intellectual property rights therein that Contractor is required to deliver to OEBC pursuant to the Work.

SECTION D- ATTACHMENT 2- Reporting and Performance Requirements

A. Introduction

The following Reporting and Performance Requirements contain the Work under which the Contract will operate. This Attachment provides the opportunity (**in the far right column**) for Proposers to indicate if they agree or disagree to provide a specific report or put fees at risk on a performance requirement. **If Proposer disagrees with providing a report as stated (or with the appropriate template) or to put fees at risk for a performance requirement, these may be negotiated if the Proposer is selected as one of the ASPs.**

Contractor shall provide the reports described below in Section D. Reporting Requirements. Contractor shall adhere to the information requirements, due dates and delivery requirements associated with each individual report listed below.

1. **Delivery of Reports.** Contractor shall submit financial reports in Microsoft Excel. All narrative reports must be in Word, PDF or other format as agreed upon by Contractor and OEGB. Contractor shall submit all reports by electronic methods to MyOEGB Document Management. Contractor shall notify OEGB's Contracts Coordinator and Program/Policy Analyst when information has been posted to MyOEGB. Contractor shall not provide any report that contains Protected Health Information (PHI). The exception to the above requirements is the enrollment reporting that goes directly to OEGB's Financial Department and the annual rate renewal information which goes directly to the Consultant.
2. **Reporting Standards.** Contractor shall meet the Performance Requirements as stated below during the Plan Year with audit periods beginning each October 1 and ending the following September 30. Contractor shall report its performance on each of the Performance Requirements to OEGB within 90 days of the end of a Plan Year. Contractor shall use a sample size of Claims or other data set large enough to ensure a 95 percent confidence level in the reported performance measurement. Contractor shall select Claims from those received and adjudicated during the Plan Year being assessed.
3. **Assessment of Penalties:** OEGB may assess the Contractor for the financial penalty associated with a Performance Requirement listed in the tables below if:
 - a. Contractor failed to meet all of the requirements associated with the particular Performance Requirement and the reasons for Contractor's failure to meet the Performance Requirement were within Contractor's control;
 - b. Contractor failed to provide a report to OEGB that meets all of the requirements associated with the particular report within five (5) business days of OEGB's written notification to Contractor; or,
 - c. Data Warehouse:
 - i. Contractor has failed to meet all of the requirements associated with the report;
 - ii. The reasons for Contractor's failure to meet the reporting requirements are within Contractor's control;
 - iii. Contractor has failed to provide a report to the data warehouse vendor that meets all the requirements associated with the particular report within three (3) business days of notification from the data warehouse vendor, and,
 - iv. OEGB or has notified the Contractor in writing of the failure to meet the reporting requirements
4. **Payment of Penalties:** OEGB shall evaluate Contractor's compliance with Performance Requirements and timeliness of reporting based on annualized results, except where otherwise noted. Contractor's failure to submit all reports on a timely basis that have a penalty associated with them will result in a maximum penalty equal to 0.025 percent

PEPM annually for each late report. The “fees at risk” are based on the administrative fees, excluding legislatively mandated assessments, and are calculated on an annualized amount. The penalties for failure to meet the requirements below are contingent on Contractor receiving written notification within 10 business days of the due date from OEGB or OEGB’s representatives regarding the failure to perform. Contractor shall be allowed 10 business days to produce a report that meets the contract specifications before penalty assessments begin. Contractor shall send OEGB a check in the amount of the penalty due within 60 days after submission of their final annual report. OEGB shall not withhold any premium due under the Contract based on its knowledge, expectation, opinion, or belief that a penalty is payable pursuant to this Contract.

5. **Dispute Resolution.** If OEGB and Contractor, in good faith, fail or are unable to resolve the dispute relating to Performance Requirements informally, then each shall appoint a duly authorized representative with no prior direct involvement in the dispute to negotiate a resolution of such dispute. The representatives shall promptly confer, in person or by other means, to negotiate a resolution of the dispute.
6. **Enforceability.** Notwithstanding use of the word “penalty,” OEGB and Contractor intend that the penalties in this Exhibit are enforceable performance incentives and not penalties that are unenforceable under Oregon law.

B. Definitions:

For purposes of this Exhibit only, the terms below have the following meanings:

“Business Day” means a weekday, excluding holidays observed by OEGB and state mandated furlough days.

“CAD” means coronary artery disease.

“CHF” means congestive heart failure.

“Consultant” means OEGB’s current benefits consultant, currently Towers Watson Delaware, Inc.

“EMRs” mean electronic medical records.

“EOM” means the end of the month.

“EOQ” means the end of the Plan quarter.

“EOY” mean the end of the Plan Year.

“HEDIS” means the Healthcare Effectiveness Data and Information Set (HEDIS). HEDIS is a tool used by health plans to measure performance on important dimensions of care and service.

“Meaningful Use” or “MU” means meaningful use objectives and measures as defined by the Centers for Medicare and Medicaid Services (CMS).

“MyOEGB” means the operating system utilized by OEGB for enrollment and eligibility purposes.

“OEGB” means the Oregon Educators Benefit Board.

“PEPM” means Per Employee Per Month.

“Performance Requirement” means specific measures selected by OEBB to evaluate Contractor performance in certain functions, services and areas of interest to OEBB. Specific targets may be set by OEBB based on OHA metrics, HEDIS, CAHPS or other measures determined appropriate by OEBB that Contractor must achieve and report their level of performance. If a Performance Requirement is not met, improvement targets may be set by OEBB that Contractor must demonstrate continuous improvement from one Plan Year to the next until the Performance target is met.

“Plan Quarter” means each of the four (4) three (3)-month periods beginning October 1, January 1, April 1, and July 1.

“SEOW” means the OEBB workgroup charged with addressing a broad range of issues related to improving Members’ health status through a variety of measurable goals, programs and services, and evidence-based and value-based benefits and plan designs.

“YTD” means year to date.

C. Reporting Requirements: Contractor shall adhere to the following Reporting Requirements:

1. Claim Experience and Financial Reports

| Report # | Category | OEBB Medical Contract Provisions | Measurement & Methodology | Reporting Criteria and Frequency | Agree to Report / Put Fees at Risk |
|----------|--------------------------|--|--|---|---|
| 1-a | Data Warehouse Reporting | <p>a) Monthly file of all OEBB Member claims. The format will include, but not be limited to, claims paid by date of service, paid amounts and claims counts for ED, non-ED outpatient, non-psychiatric inpatient, psychiatric inpatient, and pharmacy as well as all other covered services;</p> <p>i) Other data as specified by OEBB; and</p> <p>ii) Other data as required by OEBB for other program vendors and for data warehouse vendor.</p> <p>b) Files must pass the quality review process. If errors are found, the claims data warehouse vendor will notify the Contractor of the errors within two business days of finding the error and replacement files must be provided no later than three business days from the date notification is received from the claims data warehouse vendor. The penalty described in c) below will be assessed if accurate files are not submitted within three business days from the claims data warehouse vendor notification. This</p> | Data will be submitted as defined in the “Claims Functional Specifications for File Layout” document developed by the claims data warehouse vendor. Each attribute will contain the required number of defined data elements and be in the format specified. | Monthly by the 20 th of the following month to the claims data warehouse vendor. | Agree Contractor will pay a penalty if data not submitted accurately by due date Confirm Not Confirm |

| Report # | Category | OEBB Medical Contract Provisions | Measurement & Methodology | Reporting Criteria and Frequency | Agree to Report / Put Fees at Risk |
|----------|--|--|---|--|---|
| | | <p>applies to the monthly data only. If data needs to be re-run for a longer timeframe, additional time will be allotted.</p> <p>c) Penalty for failure to submit by due date: Costs to the data warehouse vendor to import and rerun their data not to exceed \$5,000.</p> | | | |
| 1-b | All-Payer-All-Claims (APAC) Submissions | Contractor shall submit claims data to the All-Payer-All Claims (APAC) database in accordance with OAR 409-025-0100 through 409-025-0170 and any waivers agreed to by OHA and all applicable state and federal laws. | In accordance with OAR 409-025-0100-0170. | In accordance with OAR 409-025-0100-0170. | N/A |
| 1-c | Distribution of Paid Medical/Vision Claims Report | See Exhibit 9-b & c for reporting template. | Excel format utilizing OEBB's template in Exhibit 9-b & c. Reported Quarterly, but broken out by month. | Quarterly within 45 days of EOQ with annual rollup due December 31. | Fees at risk if not submitted timely Confirm Not Confirm |
| 1-d | Medical/Vision Experience Report | See Exhibit 9-b & c for reporting template. | Excel format utilizing OEBB's template. Reported Quarterly, but broken out by month and by Plan. | Quarterly within 45 days of EOQ with annual rollup due December 31. | Fees at risk if not submitted timely Confirm Not Confirm |
| 1-e | Monthly Medical Claims Report | <p>Monthly Claims Reports shall include the following:</p> <ol style="list-style-type: none"> 1. Claims Lag Report; 2. Large Claims Report by case with diagnosis with aggregate claims over a \$100,000 threshold broken out by month for the Plan Year. Cases should be de-identified prior to reporting and organized by month in which the claims accrued. | Excel format. | Monthly within 45 days of EOM. | Agree to put fees at risk if not submitted timely Confirm Not Confirm |
| 1-f | Weekly Medical Claims Report for Minimum Premium Plans | <p>Weekly claims reimbursement invoice submitted by Contractor to OEBB. Includes the Total Premiums collected, minimum Premium calculation, and the Maximum Claims Liability and Cumulative Claims Liability Balance.</p> <p>NOTE: This Report only applies to Proposers who are submitting Minimum Premium Proposals.</p> | Report should reflect the same Total Premiums amount that is provided in the Carrier report, retroactive adjustment report, and COBRA Premium payment report submitted by | Weekly to Finance within 7 business days of the weekly invoice period close. | Agree to put fees at risk if not submitted timely Confirm Not Confirm |

| Report # | Category | OEBB Medical Contract Provisions | Measurement & Methodology | Reporting Criteria and Frequency | Agree to Report / Put Fees at Risk |
|----------|---|--|---|--|---|
| | | | OEBB to Contractor upon reconciliation. | | |
| 1- g | Claims Audit Report | Summary of the number of claims processed, the total dollars reviewed, total amount of under- and over-payments; claim processing accuracy percentage (total claims reviewed and the number with financial and non-financial errors), the claim processing category of errors, and the disposition of those with errors broken out by month with a quarterly total. | Narrative and Excel format. | Quarterly within 45 days of EOQ. | Agree to Report Confirm Not Confirm |
| 1-h | Avoidance and Recovery Report | Report will include the following: <ul style="list-style-type: none"> Recoveries broken out by type of overpayment including TPL, COB and retroactively terminated Members; Carry forward of debts incurred, quarter debts incurred, total debt incurred, quarter recovered and sum of recoveries received; and, Who payments were recovered from: Member, Provider, Collections, or if the debt was written off. | All reports will have a monthly breakdown in an Excel spreadsheet. Annual reports will have a table/graph that compares the current Plan Year to the previous Plan Year, if applicable. | Quarterly within 45 days after EOQ with annual rollup due December 31. | Agree to put fees at risk if not submitted timely Confirm Not Confirm |
| 1-i | Pharmacy Utilization Report | See Attachments I-2 and I-3. This report is based on paid claims. | Excel format utilizing OEBB's template. Reported Quarterly, but broken out by month and by Plan. | Quarterly within 60 days after EOQ with annual rollup due December 31. | Agree to put fees at risk if not submitted timely Confirm Not Confirm |
| 1-j | Summary RX Rebate Report | Summary report by month by PBM by Therapeutic Class. | Excel format. | Quarterly within 60 days after EOQ with annual rollup due December 31. | Agree to Report Confirm Not Confirm |
| 1-k | Prior Authorizations Approval Rate for Medical and Pharmacy | Report includes the number of prior authorizations by diagnostic category submitted for medical procedures and for pharmacy | Total number of prior authorization requests, include the number approved, denied, and pending | Quarterly with annual summary by January 31. | Agree to Report Confirm Not Confirm |

2. Enrollment Reports

| Report # | Deliverable Title | Deliverable Description | Measurement & Methodology | Reporting Frequency and Due Date | Agree to Report/ Put Fees at Risk |
|----------|--------------------------------------|--|---|--|---|
| 2-a | Unresolved Discrepancy Report | This Report lists any unresolved discrepancies determined by Contractor’s reconciliation of their monthly eligibility as compared to the OEGB provided “Carrier Report,” “Retroactive Adjustment Report,” and the “COBRA Premium Payment Report. | Report will be in Excel format with one record per row containing: Member Name; OEGB E-Number; Entity Name (Group ID); Entity Number (Class Description); Member Type (Subgroup); Plan Name; Premium Amount by Plan; Period of Coverage; and, description of the discrepancy. | Monthly by the 15 th day of the month after coverage. | Agree to Report Confirm Not Confirm |
| 2-b | Team-Based Worksite Wellness Program | Submit itemized invoice identifying the services, or item(s) selected, and the cost of each service or item. | Contractor will invoice OEGB in Excel format for the amount billed from the Team-Based Worksite Wellness Program. The invoice will include the following information on one row per record: Name of Subscriber, OEGB E-number, DOB, date of registration in the Program, type of service received and the costs of the | Invoice to OEGB will be sent within five (5) business days of receiving invoice from Team-Based Worksite Wellness Program. | Agree to Report Confirm Not Confirm |

| | | | | | |
|--|--|--|------------------------|--|--|
| | | | services and/or items. | | |
|--|--|--|------------------------|--|--|

3. OEBC Annual Reports

| Report # | Deliverable Title | Deliverable Description | Performance Measurement & Methodology | Reporting Frequency and Due Date | Agree to Report/ Put Fees at Risk |
|----------|---------------------------|---|---|------------------------------------|---|
| 3-a | HEDIS Measures | Report OEBC-specific and commercial book of business scores for selected HEDIS measures to be determined by OEBC or other work groups or committees that OEBC participates in, given a denominator size of 30 or more. Upon notification to OEBC, Contractor may substitute a commercial book of business score for an OEBC-specific score, if: OEBC-specific scores are statistically invalid; or, OEBC-specific scores cannot be produced due to insufficient available data. | Excel and narrative format. See Exhibit 9-a | Annually on August 31. | Agree to Report Confirm Not Confirm |
| 3-b | Quality Activities Report | Annual report should include a narrative update report about Contractor's Quality Improvement program including but not limited to: <ul style="list-style-type: none"> • Detail support for Leapfrog. Include efforts made to include Leapfrog in hospital contracts, any incentives used and the number of new hospital contracts negotiated that added Leapfrog reporting. • Detail progress on inclusion of treatment guidelines in Provider contracts as the guidelines are adopted by OHQC or recommended by the Oregon Health Authority, or guidelines that closely align with them. Include the number and percentage of contracted hospitals that are reporting quality and safety measurements. • The quality activities Contractor has initiated during the year and any results from previous year's QA activities. • Progress in palliative care, hospital safety, bariatric surgery program, costs and outcomes, readmissions, C-section rates, etc. • Problems encountered and recommendations for improvement in the above areas when applicable. | Narrative Report | OEBC Annual Report due January 31. | Agree to Report Confirm Not Confirm |

| Report # | Deliverable Title | Deliverable Description | Performance Measurement & Methodology | Reporting Frequency and Due Date | Agree to Report/ Put Fees at Risk |
|----------|---------------------------------|---|---|--|---|
| 3-c | Wellness Activities Report | <p>Annual report should include a narrative update report about Contractor’s wellness program including, but not limited to:</p> <ul style="list-style-type: none"> • Wellness activities offered and participation rates(including names of activities, types of activities, Member and employer satisfaction rates, and change from previous year); • An update on Wellness Health Coaching Programs (Lifestyle Coaching, etc.); • What Contractor is doing to promote individual wellness activities, including online activities; and, • What wellness activities Contractor has initiated during the year and results from previous year’s activities. | Narrative Report to include all commercial activities with OEBC-specific data when possible. | OEBC Annual Report due January 31. | Agree to Report Confirm Not Confirm |
| 3-d | Case and Care Management Report | <p>Annual report should include a narrative update report about Contractor’s disease/case management programs, including but not limited to, a description of:</p> <ul style="list-style-type: none"> • outreach efforts to both Members and Providers to improve referrals and participation for Plan Year; • type of disease management programs and any associated health • patient engagement and activation in condition self-management and health behaviors, • Member-reported health status and well-being outcomes measures. • tobacco cessation and weight management activities during the past year; and, • disease management activities Contractor has initiated during the year and any results from previous year’s activities. | Narrative format. | OEBC Annual Report due January 31. | Agree to Report Confirm Not Confirm |
| 3-e | Chronic Care Management Report | <ol style="list-style-type: none"> 1. Report including the number of OEBC Members Contractor has identified in each of the top chronic disease areas including, but not limited to, asthma, diabetes, CAD, CHF and COPD. 2. Number of Members identified and invited to participate in disease and/or care management programs. 3. Number of Members engaged in disease and/or care management programs. | <p>See Exhibit 9-h for reporting template.</p> <p>Technical specifications for measures are located at: http://qualityindicators.ahrq.gov/Modules/PQI_TechSpec.aspx</p> | OEBC Annual Report due January 31. The report will be based on the most recent data available at the time the report is generated. | Agree to Report Yes /No |

| Report # | Deliverable Title | Deliverable Description | Performance Measurement & Methodology | Reporting Frequency and Due Date | Agree to Report/ Put Fees at Risk |
|----------|---|---|--|--|---|
| 3-f | Substance Abuse Treatment and Mental Health /Behavioral Health Report | <p>Report describing cost and utilization for outpatient, inpatient and residential treatment of substance abuse and mental health and behavioral health services for the Plan Year.</p> <p>At minimum, this report will include the following information:</p> <ul style="list-style-type: none"> • Efforts to better coordinate mental and behavioral health care services with physical health care services and with the OEGB-contracted Employee Assistance Program (EAP) Provider whenever applicable. • A narrative describing Plan’s efforts to educate contracted Providers on the SBIRT screening. This will include the number of Providers that have received SBIRT training. | Narrative & Excel format. Report to include all commercial activities with OEGB specific data when possible. Additional requirements to be included on this report shall be mutually agreed upon by OEGB and Contractor. | OEGB Annual Report due January 31. The report will be based on the most recent data available at the time the report is generated. | Agree to Report Confirm Not Confirm |
| 3-g | Contraception Services | Contractor shall report on the number of women (ages 15-50) enrolled in the OEGB medical plans they administer who used one of the following contraception methods during the measurement period: sterilization, IUD, implant, contraception injection, contraceptive pills, patch, ring, or diaphragm. Report on the effective contraceptive use among women not desiring to become pregnant. | 50 percent of enrolled women (ages 15-50) who used one of the measure’s effective contraception methods | OEGB Annual Report due January 31. The report will be based on the most recent data available at the time the report is generated. | Agree to Report Confirm Not Confirm |
| 3-h | Health Care Transformation Report | <p>A narrative report describing progress and efforts of the work listed below:</p> <ul style="list-style-type: none"> • Oregon Healthcare Quality Corp (OHQC) • Administrative Simplification • Payment Reform • Health Information Exchange • E-Prescribing | Narrative Report to include all commercial activities with OEGB-specific data when possible. | Annual Report due January 31. | Agree to Report Confirm Not Confirm |

| Report # | Deliverable Title | Deliverable Description | Performance Measurement & Methodology | Reporting Frequency and Due Date | Agree to Report/ Put Fees at Risk |
|----------|--------------------------------------|---|---|-------------------------------------|---|
| 3-i | Provider Satisfaction Survey | Results from the Contractor-conducted annual Provider satisfaction surveys with medical office managers and Providers. OEBB to review and approve the content and how it is distributed. | Surveys are conducted each Plan Year. Annual Report should compare the current Plan Year Report to the previous two Plan Years Reports. | OEBB Annual Report due January 31. | Agree to Report Confirm Not Confirm |
| 3-j | Annual Network Report | Complete the Geo Access Report using OEBB template. See Exhibit 9-j for template. DCBS access standards will be substituted for Geo Access Report once completed. | Excel format using OEBB's template in Exhibit 9-j | OEBB Annual Report due December 31. | Agree to put fees at risk if not submitted timely Confirm Not Confirm |
| 3-k | Top 25 Drugs by Cost and Utilization | Report includes number of prescriptions dispensed and total cost YTD for each drug in the top 25 by cost and each drug in the top 25 based on number dispensed. | Excel format. Annual Report will have a table/graph that compares the current Plan Year to the previous two Annual Reports. | Annually by January 31. | Agree to Report Confirm Not Confirm |
| 3-l | Web Portal Report | Utilization report including total number of Members registered online, number of new Members registered each quarter, aggregate data on number of Member visits to top 10 content areas in both administrative and wellness areas. Submit OEBB-specific data if available. | Excel format. Annual Report will have a table/graph that compares the current Plan Year to the previous two Annual Reports. | Annually by January 31. | Agree to Report Confirm Not Confirm |
| 3-m | Maternity/ Newborn Report | Contractor shall provide a report that provides the following information by hospital for hospitals with 30 admissions or more for commercial population and a total for all other hospitals for the Plan Year: <ul style="list-style-type: none"> • Total Number of births for commercial population; • Total Number of vaginal deliveries for commercial population; • Total Number of C-sections for commercial population; • Percentage of C-sections for commercial population; and, • The above information for OEBB Population (not by hospital). | Excel Report using OEBB's Template. (See Exhibit 9-e) Annual Report will have a table/graph that compares the current Plan Year to the previous two Annual Reports. | Annually by January 31. | Agree to Report Confirm Not Confirm |

| Report # | Deliverable Title | Deliverable Description | Performance Measurement & Methodology | Reporting Frequency and Due Date | Agree to Report/ Put Fees at Risk |
|----------|--------------------------------------|---|---|----------------------------------|---|
| | | Report shall also include a summary of the efforts to reduce elective C-sections and elective inductions <41 weeks. | | | |
| 3-n | Hospital Readmission Report | <p>Report shall use the agreed upon format and shall include the following for current Plan Year for OEBC population:</p> <ol style="list-style-type: none"> 1. Total number of admissions by diagnostic category; 2. Total number of readmissions by diagnostic category; 3. Rate per 1000 admissions; and 4. A graph of the top 10 hospitals with the highest readmission rates. <p>NOTE: Criteria based upon readmission to any facility within 30 days with same or different diagnosis for commercial population. There must be at least 30 admissions in a diagnostic category to be counted.</p> <p>Report shall also include a summary of the efforts to reduce hospital re-admissions.</p> | Excel format using OEBC's Template (See Exhibit 9-f). Annual Report will have a table/graph that compares the current Plan Year to the previous two Annual Reports by hospital. | Annually by January 31. | Agree to Report Confirm Not Confirm |
| 3-o | Additional Cost Tier Report | <p>Report will include the following:</p> <ol style="list-style-type: none"> i) Total number of claims paid broken out by the categories for the previous Plan Year and this reporting period; ii) Utilization /1,000; iii) Average Facility Costs; iv) Average Professional Costs; and, v) Average Total Costs. | See Exhibit J- Attachment 2 for list of Additional Cost tiers to be reported in Excel format. Annual Report will have a table/graph that compares the current Plan Year to the previous two Annual Reports. | Annually by January 31. | Reports not submitted on a timely basis or do not meet all the requirements will be included in a report to OEBC Admin. |
| 3-p | Bariatric Surgery Utilization Report | <p>Report must include the following:</p> <ol style="list-style-type: none"> 1. Number of Members Requests for bariatric surgery; 2. Number of bariatric surgery prior-authorizations; 3. Number of surgeries (includes pre-authorization and participants) by facility for BMI 35 – 39.9 with 1 or 2 life threatening comorbidities, BMI 40 – 49.9 with 1 or 2 comorbidities, BMI ≥50 with or without comorbidities and BMI ≥60; 4. Number of Readmissions and unique number of Members readmitted for BMI 35 – 39.9 with 1 or 2 life threatening comorbidities BMI 40 – 49.9 with 1 or 2 comorbidities, BMI ≥50 with or without comorbidities and BMI ≥60; | Excel format. Annual Report will have a table/graph that compares the current Plan Year to the previous two Annual Reports. | Annually by January 31. | Reports not submitted on a timely basis or do not meet all the requirements will be included in a report to OEBC Admin. |

| Report # | Deliverable Title | Deliverable Description | Performance Measurement & Methodology | Reporting Frequency and Due Date | Agree to Report/ Put Fees at Risk |
|----------|-------------------|--|---------------------------------------|----------------------------------|-----------------------------------|
| | | 5. Number & causes of Readmissions divided by 0-3 months and more than 3 months post-surgery for BMI 35 – 39.9 with 1 or 2 life threatening comorbidities, BMI 40 – 49.9 with 1 or 2 comorbidities, BMI ≥ 50 with or without comorbidities and BMI ≥ 60 ; and, 6. Total Bariatric Surgery Cost (including facility and professional cost reported separately and reported by facility (de-identified). 7. Further outcome measures as identified by SEOW and approved by Contactor | | | |

4. Program Management and Membership Services Reports

| Report # | OEBB Deliverable Title | OEBB Deliverable Description | Performance Measurement & Methodology | Reporting Frequency & Due Date | Agree to Report/ Put Fees at Risk |
|----------|---|--|---|--|---|
| 4-b | Weight Management Program Participation Report | Report including quarterly and YTD participation data identifying. i) the number of unique OEBB Members (broken out by subscriber, spouse/partner and dependent) who are enrolled in a Weight Management Program at their work, online; and community meetings; ii) the total number of unique OEBB Members per Plan Year (broken out by subscriber, spouse/partner and dependent) who have re-enrolled in Weight Management Program stratified by the number of sessions re-enrolled for (for example 1, 2, 3, or 4 sessions); and, iii) the number of unique new OEBB Members (broken out by Subscriber, spouse/partner and dependent) who are enrolled in a Weight Management Program. | Report shall use Weight Management Program claims data and be in OEBB template format in Exhibit 9-i. | Quarterly aggregated data report due within 45 days after EOQ. | Agree to Report Confirm Not Confirm |
| 4-c | Weight Management Outcome Measure Report (from Weight Management Program) | 1. Average weight loss per participant (at-work meetings) 2. Number of participants achieving 10 percent weight loss (at-work meetings); 3. Number of participants achieving weight goals; 4. Total pounds lost in aggregate (at-work meetings); and, 5. Member satisfaction survey | Weight Management Program's Report. | Quarterly Weight Management Program's Reports to OEBB. | Agree to Report Confirm Not Confirm |
| 4-a | Tobacco Cessation Program Report | Tobacco Cessation Program's Vital Signs Report shall be sent Quarterly. Contractor shall also include an OEBB Annual Summary Report to include how participants heard about the program, the | Report shall use the OEBB format in Exhibit 9-d. Annual | Quarterly Tobacco Program Vital Signs Report and Annual | Agree to Report Confirm Not Confirm |

| Report # | OEBB Deliverable Title | OEBB Deliverable Description | Performance Measurement & Methodology | Reporting Frequency & Due Date | Agree to Report/ Put Fees at Risk |
|----------|--|--|---|---|--|
| | | <p>program’s satisfaction rate and any other information about Contractor’s efforts to help Members quit using tobacco.</p> <p>Report shall include efforts to decrease tobacco usage during the Plan Year.</p> | <p>reports will have a table or graph that compares the current Plan Year’s Report to the previous two Annual Reports.</p> | <p>Summary Report to OEBB.</p> | |
| 4-b | PCPCH Report | <p>1. Use measurements developed by the Oregon Health Authority or use standards that closely align with them. Reports will contain the following measures both by Provider Networks and county:</p> <ul style="list-style-type: none"> a. The number of contracted medical offices that have adopted the OHA PCPCH standards or other closely aligned standards and measurements; b. The number and percentage of contracted practices meeting PCPCH standards, by tier; c. The number and percentage of Members with designated Providers in PCPCH practices listed out by Tier 1, 2, and 3. | <p>Excel Report with tables or graphs that compare the current Plan Year by quarters to the previous Plan Year (PY 2014-2015 will be the baseline).</p> | <p>OEBB quarterly report due 45 days after EOQ.</p> | <p>Agree to Report Confirm Not Confirm</p> |
| 4-c | Customer Services Complaint and Grievance Report | <p>1. Report the number of OEBB Members who have contacted Contractor’s Customer Service Department;</p> <p>2. Report the reason for the contact (eligibility, benefits and coverage; claims {payment or delays}, Provider, availability, delivery or quality of care/services, customer services or other non-contractual issues) filed during the quarter;</p> <p>3. Contractor shall report the number and reasons for written Grievances. Reporting shall be in accordance with the definitions in OAR 836-053-1070 (3) (a) through (i).</p> | <p>Excel format.</p> | <p>Quarterly within 45 days after EOQ.</p> | <p>Agree to Report Confirm Not Confirm</p> |
| 4-d | Network Provider Access Report | <p>Contractor shall report any material changes in your Provider network to OEBB’s Contract Coordinator soon as you are notified. Material changes include but are not limited to the following:</p> <ul style="list-style-type: none"> (1) Changes in Contractor’s service delivery system that may directly impact the provision of services to Members or affect Provider participation; (2) Expansion or reduction of a Service Area requiring a Contract amendment, particularly related to Provider capacity and service delivery in the affected Service Area; (3) Enrollment of a new population (e.g., roll-over or new Clients); (4) Loss of or addition of a participating Provider, specialty Provider, clinic or hospital that will impact Members. | <p>Excel and/or Word format.</p> | <p>As required.</p> | <p>Agree to Report Confirm Not Confirm</p> |

| Report # | OEBB Deliverable Title | OEBB Deliverable Description | Performance Measurement & Methodology | Reporting Frequency & Due Date | Agree to Report/ Put Fees at Risk |
|----------|------------------------|------------------------------|---------------------------------------|--------------------------------|-----------------------------------|
| | | | | | |

5. Administrative Performance Requirements: Quarterly Performance Requirement Reports are due within 45 days of the EOQ. The Last Quarter's report should reflect Plan Year totals and any amounts owed.

| Report # | OEBB Deliverable Title | OEBB Deliverable Description | Performance Measurement & Methodology | Failure to achieve the standard will result in an annual payment of the agreed Fees At-Risk. |
|----------|------------------------------------|---|--|---|
| 5-a | Claims Processing (Total) Accuracy | Contractor guarantees that at least 98 percent of the claims will be processed without any errors. | Calculated as the total number of audited claims minus the number of claims processed with error, divided by the total number of audited claims. Definition of "error" includes any type of error (coding, procedural, system, payment, etc.), whether a payment or non-payment error. Each type of error is counted as one full error and no more than one error can be assigned to one claim. | Agree to put negotiated fees at risk for this Performance Requirement Confirm Not Confirm |
| 5-b | Claims Financial Accuracy | Contractor guarantees that at least 98 percent of the claims paid will be financially accurate. | Measurement: the ratio of the total dollars paid incorrectly, divided by total dollars paid, subtracted from 100 percent. Contractor will use a sample size large enough to ensure a 95 percent confidence level. | Agree to put negotiated fees at risk for this Performance Requirement Confirm Not Confirm |
| 5-c | Claims Payment Turnaround Time | 1. Contractor guarantees that at least 94 percent of all clean claims will be paid in 10 calendar days or less and 99 percent of all clean claims will be paid within 20 days. Definition: All claims (regardless of who is being reimbursed) are measured from the date the claim was received to the date payment is processed. | 1. Measurement: the total number of claims processed within target calendar days in reporting period, divided by total number of claims processed within the reporting period. 2. Clean claims are those that do not require Contractor to follow-up with | Agree to put negotiated fees at risk for this Performance Requirement Confirm Not Confirm |

| Report # | OEBB Deliverable Title | OEBB Deliverable Description | Performance Measurement & Methodology | Failure to achieve the standard will result in an annual payment of the agreed Fees At-Risk. |
|----------|-----------------------------------|---|--|---|
| | | | Providers or Members before the claim can be processed. | |
| 5-d | Member Claim Appeal Timeliness | Contractor agrees that at least 95 percent of first and second level appeals will be resolved within the Department of Labor or DCBS timeframes. Reporting of the number and reasons for the Appeal shall be in accordance with the definitions in OAR 836-053-1070 (3) (a) through (i) | 95 percent or more of first and second level appeals will be resolved within the Department of Labor or DCBS timeframes. Report shall also include the average number of days to close, the number of first level appeals received, the number approved and the number denied. | Agree to put negotiated fees at risk for this Performance Requirement Confirm Not Confirm |
| 5-e | Telephone Response Time | Contractor guarantees that the average customer service call response time during regular business hours will be no longer than 30 seconds before a live representative answers. Contractor shall report the average response time. | Calculated as the sum of seconds between the first ring of the phone and actually speaking to a live person, divided by the total number of calls. | Agree to put negotiated fees at risk for this Performance Requirement Confirm Not Confirm |
| 5-f | Call Abandonment Rate | Contractor guarantees that 3 percent or less of all incoming calls will be dropped. Report the percent of all incoming calls to member services abandoned. | Calculated as total calls minus the number of terminated calls (callers were disconnected or before contact with a live member service representative), divided by total calls, subtracted from 100 percent. | Agree to put negotiated fees at risk for this Performance Requirement Confirm Not Confirm |
| 5-g | First Call Resolution Rate | Contractor guarantees that at least 90 percent of calls are resolved on the first call. The first call resolution is based on book of business and is measured by the number of concerns that are completed without the need for referral or follow up actions, divided by the total number of calls received. If Contractor is able to measure OEBB business only, the report may be based on OEBB only. | Fees are at risk if at least 90 percent of concerns are not resolved on first contact in aggregate over the Plan Year. | Agree to put negotiated fees at risk for this Performance Requirement Confirm Not Confirm |
| 5-h | Grievance Response and Resolution | Contractor guarantees that at least 95 percent of written grievances by OEBB Members are responded to within seven (7) business days and resolved within 30 calendar days (other than instances where the Member has been notified of a 15-day extension because there is additional information required). | Fees are at risk if written grievances from OEBB Members are not responded to within seven (7) business days from the date received and resolved within 30 days in 95 percent of the cases in aggregate over the Plan Year. | Agree to put negotiated fees at risk for this Performance Requirement Confirm Not Confirm |

| Report # | OEBB Deliverable Title | OEBB Deliverable Description | Performance Measurement & Methodology | Failure to achieve the standard will result in an annual payment of the agreed Fees At-Risk. |
|----------|------------------------------------|--|---|---|
| 5-i | Member Satisfaction (CAHPS) Report | <p>Contractor guarantees that 80% of their Members will respond either “usually” or “always” or eight (8) or above on the combined average of composite and overall measures of the CAHPS (Consumer Assessment of Healthcare Providers and Systems) Survey.</p> <p>If 80% Member Satisfaction is not achieved in the first Contract Year, then the Performance Requirement for Member Satisfaction is based on an improvement of 5% each Contract Plan year thereafter until the 80% satisfaction rate is achieved. Exception: If Contractors member satisfaction rate is below 70%, then a 10% improvement in member satisfaction must be obtained Contract Plan Year over year until a minimum of 80% satisfaction is attained.</p> <p>When benchmarks are released a report showing how Contractor compares to benchmarks within their plan type grouping shall be included in the Annual Report.</p> | Contractor shall use OEBB’s template in Exhibit 9-g for the report. The measurement will be from CAHPS Survey administered on an annual basis. | Agree to put negotiated fees at risk for this Performance Requirement Confirm Not Confirm |
| 5-j | Implementation | Contractor guarantees OEBB’s level of satisfaction with administrator’s implementation will be at 90%. The guarantee shall be measured by OEBB Administration responding eight (8) or above on a scale of one to 10 to the Contractor’s ability to carry out the implementation plan in a timely and accurate manner on the tasks listed under measurement by August 1. | <p>Measured by Contractor’s ability to complete the following functions in an accurate and timely manner according to the detailed work-plan:</p> <ul style="list-style-type: none"> • General materials delivery • Network directories • Web-based service development/delivery • Documents (for example, SPDs, plan documents) • Enrollment testing completed • Audit of account structure • Audit of plan benefits narrative • Test claims for programming • Staff resources obtained and trained | Agree to put negotiated fees at risk for this Performance Requirement Confirm Not Confirm |
| 5-k | Benefit and Plan Design Accuracy | With written OEBB sign-off of the accuracy of OEBB's Plan Designs and/or requested changes and testing, Contractor | Contractor will be responsible for reporting any failure to meet the above | Agree to put negotiated fees at risk for this |

| Report # | OEBB Deliverable Title | OEBB Deliverable Description | Performance Measurement & Methodology | Failure to achieve the standard will result in an annual payment of the agreed Fees At-Risk. |
|----------|---|---|--|--|
| | | guarantees that OEBB's Plan Design will be implemented with 99% accuracy. OEBB and Contractor will mutually agree upon the parameters for measuring plan accuracy. OEBB will be responsible for reporting any failure to meet the above stated guarantee to Contractor on an annual basis. This is measured and reported on a calendar year and OEBB specific basis | stated guarantee to OEBB; although OEBB may identify benefit and plan design inaccuracies and will notify the Contractor to confirm and resolve. OEBB reserves the right to have its Consultant determine whether this measure's target has been achieved. Contractor will allow audits and reviews as described in the Contract's Statement of Work. This is measured and reported annually by Plan Year. | Performance Requirement Confirm Not Confirm |
| 5-1 | Eligibility Loading | All changes to the file layout must be communicated to Contractor at least 30 days prior to the date that Contractor becomes obligated to implement changes to the file, except that for any changes deemed by Contractor to be significant, such changes must be communicated to Contractor at least 90 days prior to the date that Contractor becomes obligated to implement changes to the file. | 98 percent of clean and HIPAA complaint eligibility files sent from OEBB shall be processed within three (3) business days of receipt, and 100 percent within five (5) business days of receipt. Files sent from OEBB that include errors that prevent Contractor from processing the file shall be excluded from this measurement. | Agree to put negotiated fees at risk for this Performance Requirement Confirm Not Confirm |
| 5-m | ID Card Mailing and Accuracy for Open Enrollment and New Entities | Contractor guarantees that at least 95 percent of ID cards will be mailed within five (5) business days after the final clean eligibility download or within five (5) business days of the beginning of the Plan Year for new enrollees who are part of OEBB's annual open enrollment or a new Entity who has joined OEBB. | After verification of a clean eligibility download, 99% of ID cards will be mailed within five (5) business days of the effective date of coverage for all new enrollees. This measure does not apply to retro enrollments. | Agree to put negotiated fees at risk for this Performance Requirement Confirm Not Confirm |

6. Pharmacy Performance Requirements:

| Report # | OEBB Deliverable Title | OEBB Deliverable Description | Reporting Frequency & Due Date | Fees at Risk | Failure to achieve the standard will result in an annual payment of the agreed Fees At-Risk. |
|----------|---|--|--|--|---|
| 6-a | Network Pharmacy Access | 98.5 percent of OEBB Members will have access to pharmacies within the stated mileage standards. As measured by the number of OEBB's Members with access to a retail network pharmacy within two (2) miles in urban areas, five (5) miles in suburban areas and fifteen (15) miles in rural areas of their home zip code (where a pharmacy exists within the specified standard). The denominator is set as the total number of OEBB Members enrolled with Contractor | Annually by December 31. | 1 percent of total base pharmacy administrative fees as defined in the Contract. | Agree to put negotiated fees at risk for this Performance Requirement Confirm Not Confirm |
| 6-b | Claims Adjudication Accuracy | Contractor guarantees 99 percent accuracy with claims adjudication (Total claims <i>minus</i> Total claims with errors <i>divided</i> by total Claims. | Quarterly, 45 business days after EOQ. | 1 percent of total base pharmacy administrative fees as defined in the Contract. | Agree to put negotiated fees at risk for this Performance Requirement Confirm Not Confirm |
| 6-c | Turnaround Time (TAT) for Member Submitted Claims | Contractor guarantees the following TAT for claims: Average of ≤ 15 days clean claims; and, Average of ≤ 30 days for unclean claims as defined in the Contract. | Quarterly, 45 business days after EOQ. | 1 percent of total base pharmacy administrative fees as defined in the Contract. | Agree to put negotiated fees at risk for this Performance Requirement Confirm Not Confirm |
| 6-d | Claims System Downtime | Contractor guarantees less than 1 percent system down time as defined in the Contract. | Quarterly, 45 business days after EOQ. | 1 percent of total base pharmacy administrative fees as defined in the Contract. | Agree to put negotiated fees at risk for this Performance Requirement Confirm Not Confirm |
| 6-e | Mail-Order and Specialty - Prescription Turnaround Time (TAT) | Contractor guarantees that an average of \leq five (5) calendar days for mail order and specialty prescription TAT as defined in the Contract. | Quarterly, 45 business days after EOQ. | 1 percent of total base pharmacy administrative fees as defined in the Contract. | Agree to put negotiated fees at risk for this Performance Requirement Confirm |

| Report # | OEBB Deliverable Title | OEBB Deliverable Description | Reporting Frequency & Due Date | Fees at Risk | Failure to achieve the standard will result in an annual payment of the agreed Fees At-Risk. |
|----------|--|---|--|---|--|
| | | | | | Not Confirm |
| 6-f | Medicare Subsidy Report and RDS (upon request) | Medicare Subsidy report will be provided quarterly to CMS. Retiree Drug Subsidy report annual reconciliation submitted no later than 14 months after year-end to CMS. As defined in the Contract. | Quarterly, 45 business days after EOQ. | 1.25 percent of total base pharmacy administrative fees as defined in Attachment 4, #1 of the Contract. | Agree to put negotiated fees at risk for this Performance Requirement Confirm Not Confirm |

7. OHA 2015-16 Reporting Metrics: This exclude the HEDIS Measures which are in Report 3-a.

| No. | Measure | Measurement Resources | Reporting Frequency and Due Dates |
|-------|--|----------------------------------|---|
| pm-1 | Alcohol or other substance misuse (SBIRT) | Claims | Contractor will begin measuring this during the 2015-16 plan year. An improvement standard for 2016-17 will be jointly agreed upon. |
| pm-3 | Screening for clinical depression and follow-up plan (NQF 0418) | Medical records / charts | Contractor will begin measuring this during the 2015-16 plan year. An improvement standard for 2016-17 will be jointly agreed upon. |
| pm-6 | PC-01: Elective delivery before 39 weeks (NQF 0469) | Other | Contractor will begin measuring this during the 2015-16 plan year. An improvement standard for 2016-17 will be jointly agreed upon. |
| pm-9 | Patient-Centered Primary Care Home Enrollment | Other | Contractor will begin measuring this during the 2015-16 plan year. An improvement standard for 2016-17 will be jointly agreed upon. |
| pm-10 | Developmental screening in the first 36 months of life (NQF 1448) | Claims | Contractor will begin measuring this during the 2015-16 plan year. An improvement standard for 2016-17 will be jointly agreed upon. |
| pm-16 | EHR adoption | Other | Contractor will begin measuring this during the 2015-16 plan year. An improvement standard for 2016-17 will be jointly agreed upon. |
| pm-17 | Prenatal and postpartum care: Postpartum Care Rate (NQF 1517) | Claims; medical records / charts | Contractor will begin measuring this during the 2015-16 plan year. An improvement standard for 2016-17 will be jointly agreed upon. |
| pm-19 | Well-child visits in the first 15 months of life (NQF 1392) | Claims | Contractor will begin measuring this during the 2015-16 plan year. An improvement standard for 2016-17 will be jointly agreed upon. |
| pm-26 | PQI 01: Diabetes, short term complication admission rate (NQF 0272)+ | Claims; other | Contractor will begin measuring this during the 2015-16 plan year. An improvement standard for 2016-17 will be jointly agreed upon. |
| pm-27 | PQI 05: Chronic obstructive pulmonary disease admission (NQF 0275) | Claims, other | Contractor will begin measuring this during the 2015-16 plan year. An improvement standard for 2016-17 will be jointly agreed upon. |

| No. | Measure | Measurement Resources | Reporting Frequency and Due Dates |
|-------|---|-----------------------|---|
| pm-28 | PQI 08: Congestive heart failure admission rate (NQF 0277) | Claims; other | Contractor will begin measuring this during the 2015-16 plan year. An improvement standard for 2016-17 will be jointly agreed upon. |
| pm-29 | PQI 15: Adult asthma admission rate (NQF 0283) | Claims; other | Contractor will begin measuring this during the 2015-16 plan year. An improvement standard for 2016-17 will be jointly agreed upon. |
| pm-32 | Child and adolescent access to primary care practitioners (NCQA) | Claims | Contractor will begin measuring this during the 2015-16 plan year. An improvement standard for 2016-17 will be jointly agreed upon. |
| pm-33 | Effective Contraception use among women at risk of unintended pregnancy | Claims | Contractor will begin measuring this during the 2015-16 plan year. An improvement standard for 2016-17 will be jointly agreed upon. |

8. Healthy Futures and Wellness Programs Reports

| Report # | Deliverable Title | Deliverable Description | Format | Reporting Frequency & Due Date | Agree to Report |
|----------|--|---|---------------|---|---|
| 8-a | Healthy Futures Online Health Assessment Completion Report | Healthy Futures Online Health Assessment Completion Report to include the E-Numbers of Members who have completed their health assessment within the specified timeframe requirements of the Healthy Futures Program. | Excel format. | Monthly by the 15th of the following month. | Agree to Report Confirm Not Confirm |
| 8-b | Personal Health Assessment (PHA) Report | Report including the number of OEBC Members that have completed a PHA and aggregated PHA results. | Excel format. | Annual Report covers 6/1-5/31 with Report due 30 days after the close of that period. | Agree to Report Confirm Not Confirm |
| 8-c | Online Shared Decision-Making Tools Report | Report describing Contractor's online tools to provide support for shared decision making, including tools requiring Member log in on Contractor's website and those that do not require a Member log in on Contractor's website. Contractor shall report web traffic data related to such tools as well as any other information that relates to the number of times the tools are viewed, accessed and used. | Excel format. | Annual Report covers 6/1-5/31 with Report due 30 days after the close of that period | Agree to Report Confirm Not Confirm |

| Report # | Deliverable Title | Deliverable Description | Format | Reporting Frequency & Due Date | Agree to Report |
|----------|--|--|---|--|---|
| 8-d | Team-Based Worksite Wellness Program | Report shall include the following: <ul style="list-style-type: none"> • Post survey result of the Workplace Wellness Program; • # of Members who completed the Program; • # of Members who partially completed the Program • overall results and outcomes, including the impact on OEGB participant population health status; and recommendations for improvements. | Excel and narrative format. The report will include the following: overall results and outcomes; the impact on the OEGB population; and recommendations for improvements. | OEGB Annual Report to be completed by Workplace Wellness Program. Completion date to be negotiated between Contractor Program. | Agree to Report Confirm Not Confirm |
| 8-e | Living Well (Better Choices, Better Health) Participation Report | Report providing participation numbers, completion rate, as well as any outcome or analysis-related information provided by the third-party vendor. Report should include overall results and outcomes, including the impact on OEGB participant population health status; and recommendations for improvements. | Narrative Report. Annual Report will have a table/graph that compares the current Plan Year to the previous two Annual Reports | Annual Report due January 31. | Agree to Report Confirm Not Confirm |
| 8-f | National Diabetes Prevention Program Participation Report | Report providing participation numbers, completion rates, as well as any outcome or analysis-related information provided by the third-party vendor. Report shall include overall results and outcomes, including the impact on OEGB participant population health status; and recommendations for improvements. | Narrative Report. Annual Report will have a table/graph that compares the current Plan Year to the previous two Annual Reports | Annual Report due January 31. | Agree to Report Confirm Not Confirm |

9. Consultant Reports

| Report # | Deliverable Title | Deliverable Description | Format | Reporting Frequency / Due Date |
|----------|---------------------------|--|---------------|--------------------------------|
| 9-a | Monthly Consultant Report | This report includes: <ul style="list-style-type: none"> • Billed, allowed, and negotiated amount | Excel Format. | Due 21 days after EOM. |

| Report # | Deliverable Title | Deliverable Description | Format | Reporting Frequency / Due Date |
|----------|---|--|---------------|--|
| | | <ul style="list-style-type: none"> • Savings; • Access fees; and • Net Savings. <p>For the following categories: Re-pricing Services; Provider Integrity Program Claims Protection Services with a monthly total and amount of Adjustments.</p> | | |
| 9-b | Monthly Consultant Report (Financial Summary) | <p>Report including the following by plan:</p> <ul style="list-style-type: none"> • Enrollment; • Premium; • Incurred Claims; • Administration; and, • Reserve. | Excel format. | Due 21 days after EOM. |
| 9-c | Annual Rate Renewal Reporting Package | <p>Contractor shall provide the following components, at a minimum, as part of the renewal package: For each line of coverage: medical and Rx</p> <ul style="list-style-type: none"> • Incurred claims; • Subscriber months; • Beginning and ending reserve; • Trend factor; • Actuarial Margin; • Fixed costs; <ul style="list-style-type: none"> ○ Administration ○ Portability ○ OMIP • Total projected costs PEPM; • Current premium PEPM; • Adjustments, which may include: <ul style="list-style-type: none"> ○ Plan design ○ Seasonality ○ Legislative mandates ○ New school districts or local governments • Large claims summary over \$50k; | Excel format. | Date to be determined by Annual Renewal Letter. Reporting will be submitted directly to Consultant and not via MyOEBS. |

| Report # | Deliverable Title | Deliverable Description | Format | Reporting Frequency / Due Date |
|----------|-------------------|---|--------|--------------------------------|
| | | <ul style="list-style-type: none"> Mix and contract size by plan and tier; Rate stabilization reserve fund balance; and Current enrollment and premium by plan and tier. <p>Additionally, the Contractor shall provide tiered and composite premium rates by plan by line of coverage:</p> <ul style="list-style-type: none"> Medical Rx | | |

10. Ad Hoc Reports

| Report # | Deliverable Title | Deliverable Description | Format | Reporting Frequency & Due Date |
|----------|-------------------|---|---|---|
| 10-a | Ad Hoc Report | Contractor will provide ad hoc non-scheduled reports that can be broken out to the Employee Group and District level. | Contractor will not commence working on the ad hoc report until OEGB furnishes written notification that it is willing to pay for the cost of the report if a charge is required. | Due at a mutually negotiated response time based on the complexity of the report. |

Attachment I-1- HEDIS Reporting Template
Attachment I-2: Medical Report Templates
Attachment I-3: Definitions for Medical Report Template
Attachment I-4- SEOW Tobacco Cessation Report Template
Attachment I-5- SEOW Maternity Report Template

Attachment I-6- SEOW Hospital Re-admission Report Template
Attachment I-7- CAHPS Report Template
Attachment I-8- Chronic Care Mgmt. Template
Attachment I-9- Weight Mgmt. Report Template
Attachment 10- Geo Access Report

PART D-ATTACHMENT 3

Scope of Work

The following Scope of Work contains the Work that, at minimum, Contractors will be required to perform under any resulting Contracts. This Attachment indicates which Work is not negotiable. It also indicates by the agree/disagree option which Work is open for discussion if you are selected as the ASP. The Proposer must also provide alternative language or a clear explanation of how it would like to change that particular area of the Work. **If a Proposer does not indicate that it would like to potentially modify a specific Work and does not provide alternative language or a clear explanation, the Proposer will lose the right to negotiate that Work if selected as an ASP.**

This Scope of Work, together with the ASPs' proposals, and the final Board-approved plan design(s) and additional administrative and operational requirements will be the basis for negotiating the Contract's Statement of Work and other Contract exhibits.

A. Introduction

An Apparent Successful Proposer (ASP) to this RFP that successfully negotiates a Contract with OEBB is hereafter referred to as the Contractor. The essential areas of work for which the Contractor shall be responsible includes, but are not limited to, the following:

- **Administrative Services:** benefit claim adjudication, coordination of benefits, claim recovery services, resolution of claim disputes, provider network services, certificates of creditable coverage (as specified by HIPAA), customer service, reporting, and accessibility and support of records, information and audits.
- **Basic Medical Management Services:** prior authorization, concurrent review, discharge planning and clinical claims audits, as well as network adoption of evidence-based clinical protocols.
- **Case Management Services:** coordination of care to ensure members receive the right care at the right time; are engaged and understand the care plan; and receive ongoing support from their care team. Case Management includes Members with complex acute care needs who require significant care coordination and ongoing support in order to prevent avoidable future inpatient and Emergency Department (ED) utilization.
- **Care Management Services For Chronic Conditions:** coordination of care to ensure members with one or more chronic or complex medical conditions (including, but not limited to diabetes, chronic obstructive pulmonary disease, congestive heart failure and hypertension) and are at high risk of future inpatient and ED use, and for whom care management services are assessed as likely to have an impact on health status and future service utilization.
- **Pharmacy Benefit Management Services:** pharmacy claims adjudication including Point of Service (POS) processing, pharmacy network management, drug formulary management, prior authorizations, refill exceptions and pharmacy discounts and rebates.
- **Behavioral Health and Addiction Services:** access to appropriate providers, services and

treatments and coordination with the OEGBB-contracted employee assistance program (EAP) vendor to ensure continuity of care.

- **OEGBB Health and Wellness Program Services:** availability of online health assessment, customized plan incentives and program offerings including agreements with and some administrative activities for team-based worksite wellness programs, weight management programs, smoking cessation programs, pre-diabetes programs, chronic care management programs, fitness facility subsidy programs or discounts, and additional or different health and wellness programs as approved by the Board in future Plan Years.
- **Healthcare Reform and Transformation Support Services:** Member access to Patient Centered Primary Care Homes (PCPCH) and coordinated care model (CCM) network health care teams; development of, and ongoing support, to increase use of electronic health records and health information exchange; implementation and ongoing support of patient safety measures; implementation and ongoing support of alternative payment methodologies and other payment reform measures; effective member engagement; and development and ongoing support of partnerships, coordinated efforts, and innovations that support Oregon's health care transformation efforts.

B. Scope of Work Requirements

I. Administrative Services. Contractor shall provide the following Administrative Services:

a. Claims Processing (*Non-Negotiable*)

Contractor will determine whether a benefit is payable under the Plans' provisions in accordance with the plan and benefit designs approved by the Board and will use claim procedures and standards that Contractor develops for benefit claim determination. With respect to these functions, OEGBB delegates to Contractor the discretionary authority to (a) make factual determinations relating to any benefit decision; and (b) determine the validity of charges submitted to Contractor under the Plans. Benefits shall be payable to a Member or to the provider of a Member only if Contractor, at its discretion, determines that such benefits are payable.

If Contractor determines that a benefit is payable, Contractor will issue a check for, or otherwise credit, the benefit payment to the appropriate payee. If Contractor determines that all or a part of the benefit is not payable under the Plans, Contractor will notify the claimant of the denial and of the claimant's right to appeal the denial. This notification will be designed to comply with the Department of Labor (DOL) requirements or Insurance Division rules as applicable to the Plan for claim denial notices and with applicable OEGBB administrative rules.

b. Coordination of Benefits (COB) (*Non-Negotiable*)

If a Member is covered by more than one insurance plan, the benefits available under the Plans will be coordinated with the benefits payable under the other plan, in accordance with the provisions of the Member Handbook.

c. **Claims Recovery** (*Non-Negotiable*)

Contractor will provide recovery services for claims overpayments. Contractor will reimburse OEGB for any overpayments made by Contractor due to processing errors, payment received from third party liability payer, or Contractor's gross negligence as determined by a court or other tribunal. OEGB will not be responsible for recovery costs associated with any administrative activities in collecting overpayments.

Contractor will provide, directly or through a subcontractor, services to recover Plan benefits that were paid and are recoverable by a Plan because payment was or should have been made by a third party for the same medical or prescription expense. This is commonly referred to as "Third Party Liability Recovery" or "Subrogation." Some examples of third parties who are legally responsible for the payment of a health claim include tortfeasors, individuals involved in an accident, liability insurance carriers, automobile insurance carriers, premises medical insurance or worker's compensation carriers.

OEGB delegates to Contractor the discretion and authority to develop and use standards and procedures for claim recoveries, including but not limited to:

1. Whether or not to seek recovery;
2. What steps to take if recovery is pursued; and
3. Under what circumstances to compromise a claim or settle for less than the full amount of the claim.

Contractor will not pursue any recovery if any applicable law does not permit it, or if recovery would be impractical. Contractor may choose to initiate litigation in Contractor's name to recover payments, but Contractor has no obligation to pursue litigation. If Contractor initiates litigation, OEGB will cooperate with Contractor in the litigation.

If the Agreement terminates, or if Contractor's recovery services terminate, Contractor will continue to recover any payments Contractor is in the process of recovering.

d. **Resolution of Claims Disputes and Appeals** (*Non-Negotiable*)

Informal Resolution of Claim Disputes. If a Member believes that Contractor has issued a claim denial that is inconsistent with the terms of the Member Handbook, they may contact Contractor customer service staff to seek an informal resolution of the dispute. If Contractor determines that a claim denial was issued in error, Contractor will reprocess the claim to correct the error.

Claim Appeals. If Contractor denies a claim under a Plan, the Member shall have the internal appeal rights set forth in the Member Handbook in addition to any rights which are required under OEGB's rules referenced in *Part D, Attachment 1* of this RFP (Legal Terms and Conditions), Section W (Benefits Claims), or under other applicable law. Internal claim appeals shall be handled as described below.

OEBB delegates to Contractor the discretionary authority to construe and interpret the terms of the Plans to make factual determinations relating to any benefit decision. For claim denials that Contractor issues, Contractor will notify the Member of Contractor's determination and of their right to appeal the denial to Contractor. Contractor's notice to the claimant will describe the internal appeal rights set forth in the Member Handbook and will be designed to comply with the applicable DOL requirements.

External Review of Claim Appeals. As Contractor shall set forth in the Member Handbooks, Members shall have access to external review of claim appeals under ORS 743.857 to 743.864 and OAR 836-053-1300 to 836-053-1365.

Benefit Claim denials that are issued at the final level of internal review may be eligible for external review as set forth in the Member Handbook and Contractor shall prepare and submit such cases to the external review organization.

Also, Benefit Claim appeals can be escalated to OEBB per OAR 111-080-0030 when the member believes it is a covered benefit of their Benefit Plan.

e. **Provider Network**

Contractor will make available to Members a Network of Providers to deliver the health services covered by the Plan. Contractor will provide Members with internet access to directories of Network Providers and with periodic updates or telephonic access to the information in the directories. Contractor shall make a hard copy of the directory available to a Member upon request.

Contractor shall require access standards in its provider contracts that are in line with those in HB 2468 (2015). OEBB will develop reporting requirements once the Oregon Department of Consumer and Business Services (DCBS) has developed the standards for the large group market.

The composition of the Network may change at any time. Contractor will give OEBB notice of material changes in advance, or as soon as reasonably possible, along with a plan to ensure appropriate member access to services and transfer of care occurs timely and seamlessly. Contractors shall require an agreed upon percentage of PCPCHs in the network be OHA certified and an agreed upon number of covered lives to be served by the PCPCH. Contractor shall comply with network adequacy standards for large groups set by DCBS in accordance with HB 2468.

Contractor will work toward ensuring contracted physicians, Providers and facilities render quality care at sustainable payment levels. Unsustainable reimbursement rates would be determined by Contractor within reasonable ranges, for example those that are higher than regional reimbursement for the same services without any demonstration of improved health outcomes or rational for higher rate reimbursement. Providers that do not meet this standard will be reimbursed at the out of network rate. Contractors are strongly encouraged to require pay for performance reimbursement methods in Provider contracts to improve health outcomes.

Contractor will review all contracted fees of its Networks on a regular basis.

Contractor will inform OEGB staff when adjustments are made to the fees, no less frequently than annually or more frequently if changes occur in the Network impacting fees. Furthermore, Contractor will produce ad hoc reports when reasonably requested by OEGB that relate to current and future costs associated with Contractor's Network.

AGREE: _____

DISAGREE: _____ **Requested Modification:** _____

f. Customer Service

Contractor shall provide a dedicated toll-free telephone line for OEGB Members if enrollment exceeds 10,000 members or Contractor has 80% of the service area's enrollment as well as a TTY line and other measures that meet the requirements of the Americans with Disabilities Act, at no additional cost. Member Representatives will transfer non-English speaking Members to a Member Representative who speaks the member's language fluently or to a Language Interpretive Services Vendor.

Contractor's Member Service Representatives shall at minimum maintain prevailing industry standards for call centers servicing similar populations. The lines shall be available on regular business days between the hours of 7:30 a.m. and 5:30 p.m. Pacific Time Monday through Friday (except for nationally recognized holidays). OEGB will be notified at least five (5) business days in advance of special events affecting customer service phone coverage. Contractor shall ensure that its Customer Service lines are staffed by trained Member Service Representatives who are knowledgeable about OEGB's Benefit Plans and can provide Member education about Contractor's OEGB Plans.

Contractor shall maintain a recording or written record of all customer service telephone conversations for use by OEGB in the event of Member disputes. Recordings will be maintained for 12 months, or if a dispute is in process, until the dispute is resolved whichever is greater.

Contractor shall provide Members access to Contractor's website 24 hours per day, seven days per week, 365 days per year providing a secure environment for customer service including, but not limited to: the ability to search for physicians and other health care providers and facilities, medical offices and hospital locations; research cost of procedures by location or provider; and health and well-being information. In addition, Contractor shall develop or obtain a tool, accessible through the Contractor's website that allows Members to compare provider cost for common services as well as compare network provider quality performance. Information shall be available for services representing at least 50% of OEGB spend.

Contractor shall provide toll-free access to a medical advice line for non-emergency medical advice that is staffed by qualified medical practitioners. This service will

operate 24 hours per day, seven days per week, 365 days per year. The service will have a local access number and a toll-free number (interpreter service available), and a TTY line. All calls will be recorded.

AGREE: _____

DISAGREE: _____ **Requested Modification:** _____

g. Marketing and Member Communication

Marketing

Contractor agrees to limit their marketing to the following permitted activities:

- 1) Distribution of marketing materials with general information on the specific carrier or Benefit Plans not specific to OEGB programs or Benefit Plans;
- 2) Distribution of marketing materials with information on OEGB programs or Benefit Plans that have been approved by OEGB;
- 3) Participation in conferences and events hosted by outside organizations that represent a segment of OEGB Members;
- 4) Participation in OEGB informational meetings conducted by an OEGB representative during the annual plan selection and open enrollment periods;
- 5) Hosting of website that provides Members with specific information on OEGB-sponsored Benefit Plans and the OEGB Healthy Futures Program that includes a health assessment and wellness programs provided by the Contractor or as approved by the Board; and
- 6) All media or legislative inquiries and the proposed responses regarding OEGB programs or Benefit Plans must be forwarded to the OEGB Communications Coordinator and must be authorized prior to responding.

AGREE: _____

DISAGREE: _____ **Requested Modification:** _____

Member Communications

- 1) Subject to OEGB approval before being posted electronically on Intranet site or being distributed to OEGB Members or Entities, the Contractor shall create the

Summary of Benefits, Member Handbooks and any other publications for use in the administration of OEBB health insurance benefits.

2) Contractor shall provide the following services in a timely fashion, not to exceed the timelines established in this Exhibit 4 and OEBB Administrative Rules:

i. issue an Identification (ID) Card to each enrolled individual or family within five (5) business days of receiving the Membership enrollment download and provide ID card replacement or additional ID cards as requested.

ii. issue information within five (5) business days of receiving the Membership enrollment download regarding how to access the Member Handbook, Provider Directory and other OEBB-related information electronically.

AGREE: _____

DISAGREE: _____ **Requested Modification:** _____

h. Reporting

The reports required in **Part D-Attachment 2** of this RFP represent the minimum reporting requirements under the Contract and will be provided at no cost to OEBB. Contractor will notify the OEBB Contracts Coordinator when reports have been submitted to MyOEBB. Reporting needs are subject to change to meet the needs of the Board, Board workgroups or committees, the Oregon Health Authority and OEBB management.

OEBB intends to align its measurement activities to the extent appropriate with the recommendations developed by the Health Plan Quality Measure Workgroup formed by HB 2118 (2013).

AGREE: _____

DISAGREE: _____ **Requested Modification:** _____

i. Records, Information, and Audits

a. Records.

Contractor will keep records relating to the services Contractor provides under this Agreement for the period described in **Part D-Attachment 1, Section J** to this RFP.

b. Access to Information.

If OEBB needs information that Contractor has in its possession to administer the Plans, Contractor will give OEBB access to that information at no cost, as long as the information relates to Contractor's services under the Agreement and OEBB gives Contractor reasonable prior notice of the need for the information.

Contractor will also provide reasonable access to Plan information to a third party providing services to OEBB, such as an auditor or other consultant, upon OEBB's request. Before Contractor will provide such access, however, a third party which is not the State of Oregon must sign any of Contractor's applicable information disclosure agreements provided they are reasonable and necessary to protect and safeguard the information provided.

AGREE: _____

DISAGREE: _____ **Requested Modification:** _____

c. Audits.

During the term of the Agreement, and for any run-out period following its termination, OEBB's Consultant or the State of Oregon may, at no cost to OEBB, audit Contractor to assess its performance under the terms of the Agreement. The place, time, type, duration and frequency of all audits must be reasonable. Upon completion of the audit, OEBB will provide Contractor with a copy of the final audit report.

AGREE: _____

DISAGREE: _____ **Requested Modification:** _____

d. Data Sharing and Transfer (*Non-Negotiable*)

OEBB and Consultants and/or vendors agree to complete business associate agreements with Contractor, prior to data being delivered.

Data will include at minimum the following (see Part D: Attachment 2 for more details):

- a.) Data warehousing - all data related to eligibility, claims, or services received by OEBB Members as specified by OEBB and is available electronically, and other data specified by OEBB;
- b.) Extract data as mutually agreed upon to other program vendors and researchers;
- c.) Standard financial management reporting and analysis;

- d.) Production of scheduled reports by Plan administrator;
- e.) Key financial, utilization and quality of care benchmarks appropriate to OEBC, Benchmark OEBC to similar groups or commercial book of business;
- f.) Contractor's performance to each of the requested guarantees; and
- g.) Provide reports specific to OEBC's population with comparative data from Contractor's commercial book of business.

II. *Basic Medical Management Services.* (Non-Negotiable). Contractor shall provide the following Basic Medical Management Services:

a. Clinical Protocols

Contractor shall identify and implement clinical protocols (treatment guidelines) with its provider network that are evidence-based, designed to maximize patient health status, clinical outcomes and efficiency. Such protocols shall not be limited to practice guidelines used for prior authorization and concurrent review processes, and shall draw upon guidelines adopted by Oregon Health Care Quality Corporation (Q-Corp), those recommended by the Oregon Health Authority and other appropriate sources.

b. Prior Authorization

Prior authorization is required for selected services and facility admissions, consistent with the Plans, the Health Evidence Review Commission (HERC) guidelines or Contractor's general practice guidelines. As appropriate, Contractor will perform a prior authorization to determine the level of care before an admission occurs or prior to a selected procedure is performed to assess the clinical indications and appropriateness of services requested or planned. Contractor may request a second opinion when clinical indications are not clearly established, or when the indications given for a procedure or treatment do not clearly meet Contractor's approved criteria.

c. Concurrent Review

Contractor will have qualified medical practitioners review medical and surgical inpatient hospital and skilled nursing facility stays. They will review cases to determine the appropriateness of the setting, level of care and length of stay. The reviewer will conduct an initial review and certification of the admission and follow the case concurrently. If the reviewer is unable to certify the request or certify a continuation of the hospital stay, the Contractor's medical director will conduct a review of the case to determine medical necessity of the facility admission or transfer, course of treatment and continued stay.

d. Discharge Planning

Contractor will have qualified medical practitioners coordinate discharge planning services with physicians, hospitals and other health care providers (such as community health workers and non-traditional health care workers) to complete an episode of care. Services typically used in discharge planning will include skilled nursing facilities, home health care agencies and hospice. Cases that require post

discharge follow-up will be referred to case management and other community resources as appropriate.

e. **Clinical Claims Audits**

Contractor will review claims that exceed a dollar threshold, as mutually agreed upon by Contractor and OEBB, in billed charges for Clinical appropriateness and potential excessive billing. Contractor will also review injectable and biotechnology medical drug and pharmacy claims for Clinical appropriateness using pharmacy technician reviewers. Analysis may include provider billings, clinical information, provider contracts, coding conventions and payment rules. The qualified medical practitioner reviews the DRG, case rate, coding, code modifiers and identifies issues related to contractor interpretation, unbundling, duplicate billings, billing errors, and billing maximization. Negotiated payment and appropriate transfer of patient care is expected with out-of-state providers and facilities. These reviews should be conducted prior to actual claim payment, lowering the amount paid.

III. Case Management Services. (Non-Negotiable). Contractor shall provide the following Case Management Services that fully integrates medical, behavioral, acute care and patient education into a seamless experience, ensuring Members receive the right care at the right time, are engaged and understand their care plan and receive ongoing support from their care team:

- a. Contractor will provide certain case management services including the evaluation of inpatient, outpatient and ancillary services, Member education and, where appropriate, coordination and facilitation. These case management services address the needs of Members with complex acute care needs, at high risk of future inpatient utilization, at significant risk for declining health status and high medical expenses, as well as Members with acute and chronic care needs requiring significant care coordination and ongoing support, in order to prevent avoidable future inpatient and ED utilization.
- b. Contractor will consider the indicators listed below to determine eligibility for case management services. Contractor will work with Members to actively engage in case management services with the goal of improving or stabilizing the member's health, and securing appropriate and cost-effective health care services and supplies for the diagnosis and/or treatment of the Member's condition. Indicators include, but are not limited to, the following:
 1. Cases involving one or more of the following:
 - Transplants
 - Rare diseases
 - End stage renal disease
 - Severe brain injury
 - Severe burns
 - Cerebral vascular accident with deficits

- High-risk obstetrics
 - Multiple trauma and spinal cord injuries
 - High-risk infants and children
 - Ventilator dependent patients
2. Complex hospital course, length of stay, or unplanned hospital admissions.
 3. High cost case reviews.
 4. Multiple emergency department visits.
 5. Excessive dispensing of Schedule II drugs.

IV. *Care Management Services.* (Non-Negotiable). Contractor shall provide the following Care Management Services for Members with one or more chronic conditions who are at high risk of future inpatient and ED use, and for whom care management services are assessed as likely to have an impact on health status and future service utilization:

- a. Contractor's population-based care management programs identify Members with chronic disease and through the use of disease specific interventions attempt to alter the course of the disease. Contractor qualified medical practitioners will assess Members' health status, develop a plan of care, provide interventions specific to the disease process, and collect data to evaluate the effectiveness of the program. Contractor's standardized treatment strategies will ensure appropriate utilization and evidenced-based care across the continuum.
- b. Contractor's Care Management Services will coordinate care management with that provided by Patient Centered Primary Care Homes (PCPCHs) and specialists such that the Contractor supports PCPCH and specialists providing care management, and avoids the provision of duplicative care management services. Contractor shall develop protocols for coordinating care management services with PCPCHs and communicate them to PCPCHs, allowing flexibility on a case-by-case basis as dictated by the needs and preferences of Members eligible for and receiving such services.
- c. Contractor's care management programs will target but not be limited to , Members with one or more of the following chronic conditions and at risk of inpatient utilization:
 1. Asthma and COPD
 2. Diabetes
 3. Coronary Artery Disease
 4. Chronic Obstructive Pulmonary Disease
 5. Heart Failure
 6. Congestive Heart Failure
 7. Depression
 8. Chronic Pain
 9. Kidney (Renal Disease)
 10. Cancer
 11. HIV
 12. Musculoskeletal

13. Opioid use (pain management)
 14. Obesity management
- d. Care management engagement strategies will include, at minimum, the following:
 1. Motivational interviewing;
 2. Teaching Member self-management skills;
 3. Multiple attempts using different methods to engage Members;
 4. Cross-training to support multi-condition management; and,
 5. Identification of and coordination with community supports.
 - e. All health-related material Contractor mails to Members from the medical management department will include contact telephone numbers to the case and care management programs. A variety of information about case and care management services for chronic conditions will be located prominently on the Contractor Member website. Contractor will work closely with participating providers to refer Members for possible intervention and case or care management program participation.
 - f. Contractor's engagement strategies for telephonic case and care management programs will normally include three outreach phone calls, a letter and a follow up phone call. When making initial contact with potential participants, Contractor will provide a comprehensive mailing with educational materials even if the Member does not enroll in the program at the first contact. Contractor will continually monitor systems and re-contact Members following events such as hospitalization. Contractor will ensure that these strategies coordinate with and do not duplicate those services provided directly by a Member's PCP.

To provide access for Members who work during normal business hours, Contractor's qualified medical practitioners will be available to work with Members, at minimum, in the evening from 5:00 – 7:00 pm PST to encourage participation.

- h. Contractor case and care manager staff shall include nurses, social workers and any other licensed staff deemed appropriate for case and care management activities. Staff shall be trained to support patients with multiple conditions and trained and skilled in patient engagement techniques and in patient-centered care planning.

V. *Pharmacy Benefit Management Services.* Contractor shall provide the following Pharmacy Benefit Management Services: ***(Non-Negotiable)***

- a. Contractor will provide pharmacy benefit management services and will determine which pharmacies will be Network Pharmacies while ensuring sufficient member access. Contractor shall satisfy the RFP requirements for prescription drug services.
- b. Contractor's pharmacy benefit management services will include a mail order pharmacy program for Members, including website access and the necessary forms and procedures to obtain mail order prescriptions.

- c. Contractor will electronically process the claims of Network Pharmacies in accordance with the Member Handbooks and the Network Pharmacy's participation agreement.
- d. Contractor will furnish a drug formulary for the purpose of copayment and coverage determination that aligns with the proposed plan's pharmacy tiers and ensures whenever possible that each tier contains medications within a category. The formulary shall allow for access to prescription drugs outside the formulary in special circumstances and shall be reviewed at least annually.

Contractor will have a Prior Authorization process that includes refills for lost or stolen prescription, or beyond a 30-day supply in the event the member will not have access to Network Pharmacy for an extended period of time, and allows coverage of certain medications in the event documented evidence is submitted that the member has tried other alternatives that have not been effective in treating the condition. Prior authorization services must be included in the RFP proposed pharmacy rates.

- e. **Pharmacy Rebate Services.** Under the pharmacy rebate program Contractor will negotiate, directly or indirectly, with drug manufacturers regarding the terms of the rebate program and arrange for the payment of rebates on certain prescription drug services utilized by Members that will be directly passed through to OEBC and include a minimum rebate guarantee.

VI. Behavioral Health and Addiction Services. Contractor shall provide the following Services: *(Non-Negotiable)*

Contractor shall provide administrative and utilization management services for behavioral health and addiction services coverage consistent with the Plans. To the highest extent possible, Contractor shall encourage co-location of physical and behavioral health care professionals in community settings or within the medical clinics and integrated care delivery. Integrated care delivery shall include use of an integrated medical record and shared treatment plan. Members shall have access to the full continuum of behavioral health and addiction services integrated through the application of evidence-based practice, with a focus on health promotion and prevention, early intervention, and community supports to help improve the health and well-being of members.

VII. OEBC Health and Wellness Program Services. Contractor shall provide the following Health and Wellness Program Services either through direct vendor contracts or subcontracts:

- a. **Healthy Futures Model** -- Contractor shall provide health tools that will allow OEBC Members to comply with the required components of OEBC's Healthy Futures Program. Tools for Healthy Futures will be accessible through Contractor's website and must include, at minimum, an online health assessment (HA), health conversation modules (or e-lessons), and other supporting information as required by OEBC.
- b. **Weight Management Program** -- Contractor shall provide a weight management program for Members that includes education about healthy eating, physical

activity, and other factors related to weight management. The weight management program must include electronic tools as well as hard copy material as appropriate. Contractor shall also provide group-based meetings in local communities, At Work meetings (if supported by the Entity and there is sufficient enrollment) and online meetings. Payments should be made through the standard claims adjudication process and reports provided on the number of sessions, unique number of member participants and total weight loss each quarter.

- c. **Tobacco Cessation** -- Contractor shall provide a tobacco cessation program for Members that includes no cost access to resources to assist tobacco users to quit. Examples of resources that should be included in the program are, but are not limited to: access to telephone consultation, web coaching, over-the-counter smoking cessation products and prescription medications when certain criteria are met by the member.
- d. **Team-Based Worksite Wellness Program** -- Contractor shall provide a team-based worksite wellness program that encourages employees to regularly meet and complete group and individual learning activities to promote better health. Program tools will be available electronically and in hard copies as the specific program requires.
- e. **Pre-Diabetes** -- Contractor shall provide a diabetes prevention program comparable to the program currently offered. OEBC partnered with contracted carriers and Community Connection of Northeast Oregon (CCNO), representing 12 counties, and Family YMCA of Marion and Polk Counties (YMCA) to pilot the Diabetes Prevention Program (DPP). Participants in the programs attend 16 weekly and six monthly maintenance sessions at no cost. OEBC's contracted carriers subcontract for services related to the DPP benefits and assist with other functions, such as outreach and reporting.
- f. **Chronic Care** -- Contractor shall provide a diabetes prevention program comparable to the program currently offered. Better Choices, Better Health is an online self-management course developed by Stanford University to assist people in dealing with problems associated with chronic medical conditions. The six-week interactive workshops are led by trained facilitators and include approximately 25 participants. OEBC members and dependents age 18 or older enrolled in an OEBC medical plan can participate at no cost.
- g. **Behavioral support** -- Contractor shall provide an behavioral support program for adults with depression comparable to the program currently offered. MoodHelper is a secure, private online program for adults with depression, designed and tested by researchers at Kaiser Permanente and available to members of OEBC. MoodHelper offers interactive tools and the option of connecting by telephone with trained coaches who will work with Members on applying the cognitive behavioral methods and lessons they learn on the website to day-to-day life.
- h. **Other Health and Wellness Programs.** Contractor shall implement and administer additional health and wellness programs as approved by the Board in future Plan Years.

AGREE: _____
DISAGREE: _____ Requested Modification: _____

VIII. Healthcare Reform and Transformation Support Services. Contractor shall support Healthcare Reform and Transformation by, at minimum, doing the following: (Non-Negotiable)

- a. **Patient-Centered Primary Care Homes** -- Contractor agrees to support the medical home concept by increasing the number of Patient-Centered Primary Care Homes in its Network and supporting PCPCHs in achieving the highest level of medical home certification, as defined by OHA or other commonly used guidelines, through the use of enhanced fees, supplemental payments and/or technical assistance support.
- b. **Electronic Medical Records (EMRs)** -- Contractor will increase utilization of robust and interactive electronic medical records systems as reflected in CMS' meaningful use objectives, which include, but are not limited to, the electronic exchange of health information between providers. Contractor also agrees to actively participate in statewide and local efforts to develop and facilitate the health information exchange between providers and EMR systems.
- c. **Patient Safety** -- Contractor agrees to not pay for "hospital-acquired conditions" (HACs) identified by Medicare guidelines. Contractor also agrees to add language to its provider, ambulatory surgical center, facility and hospital contracts that:
 - 1. Prohibits the hospital from charging Contractor or an OEBC Member for HACs identified by Medicare guidelines;
 - 2. Requires hospitals to adopt the "Guidelines for Non-Payment of Serious Adverse Events" developed by the Oregon Association of Hospitals and Health Systems (or similar guidelines for hospitals outside Oregon);
 - 3. Requires hospitals to participate in the Oregon Patient Safety Commission's Adverse Events Reporting Program for Hospitals (or similar programs for hospitals outside Oregon);
 - 4. Requires hospitals to use a surgical checklist that is consistent with the Oregon Surgical Safety Checklist as recommended by the Oregon Patient Safety Commission (or a similar checklist for hospitals outside Oregon) and that shall include critical elements appropriate to the patient population; and.
 - 5. Prohibits early elective inductions and elective C-sections.
- d. **Payment Reform** -- OEBC endorses innovative payment models that move away from fee-for-service reimbursement and reward providers for high quality care, improved patient health status and reduced costs. Contractor will develop and

implement payment models that may include (but are not limited to) pay-for-performance, global budgets with shared savings or shared risk, episode-based payment, capitation and other reimbursement methods that support innovative models and system transformation such as the Patient Centered Primary Care Home model. All innovative payment models shall either make savings distributions contingent on quality performance or include a quality incentive opportunity. By the end of Contract Year three (3), 30% of Contractor's payments shall be made through population-based payment contracts.

- e. **Member Engagement** -- Contractor shall provide required services in a manner that meaningfully and actively engages members in a culturally and linguistically appropriate manner. Contractor shall support network provider efforts at patient activation through training, provision of standardized assessment tools, and requirements for network provider deployment of different activation strategies based on assessment results. Further, Contractor shall make tools to support shared-decision making available to network providers and to Members. Such tools shall advise Members of the potential benefits and risks associated with different treatment options.
- f. **Coordination with Other Service Providers** -- Contractor shall, when appropriate for Member care, coordinate care with other services providers such as, but not limited to, dental providers or carriers, vision providers or carriers and employee assistance program (EAP), disability, and long term care benefit or service providers.

IX. Health Care Innovations (Non-Negotiable)

Contractor shall have processes and procedures in place or under development for implementation by Plan Year two (2) to improve service delivery systems, increase quality of care, improve patient health outcomes, increase efficiency and cost savings, provide transparency of costs and quality to Members and facilitate the electronic exchange of health care information among Providers. There are three major areas of interest:

- a. **Price and Quality Transparency** -- These innovations provide useful and easily accessible cost and quality information to guide Members in understanding their own out-of-pocket costs for services, and in comparing the quality and safety of Providers. They may include decision-support tools to help Members understand the availability, cost, and quality.
- b. **Promotion of Evidence-Based Practices and Measurement of Clinical Outcomes and Quality of Care** --
These include the implementation of evidence-based best practices, HERC clinical guidelines and performance measures in managing both the cost and quality of care for all segments of OEBC's populations.
- c. **Innovations in Care Management, Benefit Design and Provider Payment** --
These include specialized chronic care models, benefit design structures and incentives or provider payment arrangements that foster improved patient outcomes and improved delivery of care. These innovations also include provider information systems that promote the rapid exchange of patient health care information among multiple Providers, support administrative efficiencies and streamline use of network resources. It also includes incentive systems to improve clinical outcomes for

chronically ill and other vulnerable or high risk populations that support prevention and self-management of conditions.

X. Performance Requirements:

a. Contractor agrees to adhere to the following expectations and levels of effort:

1. **Benefit and Program Collaboration:** Contractor shall attend and participate in various meetings at OEGB's request and shall work with OEGB and other meeting attendees to review and evaluate OEGB benefits and programs to collaborate on establishing criteria and benchmark reporting and monitoring. Contractor acknowledges that collaboration efforts may result in program and reporting changes over time and that such changes will be addressed in future contract amendments or letters of understanding.
2. **Quality Activities Participation:** Contractor shall actively participate in the Oregon Healthcare Quality Corporation's (Q-Corp) initiatives and to work collaboratively with the Oregon Health Authority (OHA) Health Evidence Review Commission (HERC) and partners to adopt coverage and clinical guidelines mutually agreed to by OEGB. Contractor shall include the guidelines in its Providers' contracts as they are renewed or amended. Contractor shall participate, in quality improvement activities promoted by the Oregon Health Authority and OEGB.
3. **Leapfrog:** Contractor shall make its Best Efforts for its contracted hospitals to participate in Leapfrog, a voluntary program for hospitals that requires transparency and easy access to health care information. Contractor shall make its Best Efforts to increase Leapfrog participation by approaching non-reporting hospitals to discuss potential participation in the program and demonstrate improvement on an annual basis in the 3-b report in the Reporting and Performance Requirement Exhibit.
4. **Patient-Centered Primary Care Homes:** Contractor shall adopt the Patient-Centered Primary Care Home (PCPCH) Standards and Measurements developed by the Oregon Health Authority or use standards that closely align with them in a substantive manner for PCPCHs in their network. Contractor agrees to continue developing and implementing the patient-centered medical home concept as described below.
 - a. Contractor shall assist Providers within its delivery system to establish PCPCHs as stated in ORS 414.655 and OAR Chapter 409 Division 55. Contractor shall expand the availability of PCPCHs recognized by the OHA to the maximum extent feasible;
 - c. Providers that have been determined by OHA to meet PCPCH standards in Oregon Administrative Rules, and are approved by Contractor, shall be compensated by Contractor for providing PCPCH services based on the level or tier of the PCPCH. Compensation provided to recognized PCPCHs must be higher than that paid to non-recognized

PCPCHs. Contractor shall use an alternative payment methodology that supports the OHA goal of improving the efficiency and quality of health services by decreasing the use of fee-for-service reimbursement models. Contractor may pay each recognized PCPCH a tiered payment amount; and,

- d. Contractor shall promote and assist other Providers to communicate and coordinate care with the PCPCH in a timely manner using electronic health information technology to the maximum extent feasible.
5. **Meaningful Use of EMRs, Health Information Exchange:** Contractor acknowledges the importance of utilizing robust and interactive electronic medical record systems as reflected in the Federal Meaningful Use (MU) objectives, including the electronic exchange of health information between Providers. Contractor shall make its Best Efforts, when entering into or renewing its Provider contracts, to request its Providers to adopt and demonstrate the use of certified EMRs. Contractor shall participate in local and statewide efforts to facilitate the health information exchange between Providers and EMR systems.
 6. **E-prescribing:** Contractor supports the implementation of e-prescribing access for all Providers and shall work with OEBB to discuss implementation requirements and applicable fees.
 7. **Oregon Health Authority (OHA):** Contractor shall collaborate with OEBB and other programs within the OHA to promote OHA directives and programs, including the Coordinated Care Model Principles and related Framework for Procurement and Contracting.
 8. **Patient Safety:** For directly contracted hospitals in Oregon, Southern Washington, and Western Idaho, Contractor shall:
 - (a) Not pay for “hospital-acquired conditions (HACs)” identified by Medicare guidelines as identified at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/index.html> which OEBB and Contractor shall automatically update during the term of this Contract to reflect changes to Medicare guidelines.
 - (b) Use its Best Efforts to include the following language in its contracts with hospitals:
 1. Language that specifically prohibits the hospital from charging Contractor or an OEBB Member for HACs identified by Medicare guidelines as identified at in paragraph 9(a) above as updated by CMS from time to time;
 2. Language that requires Oregon hospitals’ participation in the Oregon Patient Safety Commission’s Adverse Events Reporting Program (or similar program for hospitals outside Oregon), and to show a commitment to patient safety by working collaboratively and substantively with the Oregon Patient Safety Commission and others to

advance patient safety;

3. Language that requires hospitals to use a surgical checklist that is consistent with the Oregon Surgical Safety Checklist (or a similar checklist for hospitals outside Oregon) that shall include critical elements appropriate to the patient population. Furthermore, the surgical checklist used shall encourage full communication among the surgical staff regarding patient needs in the following three phases of care: prior to administration of anesthesia, prior to the first surgical incision, and prior to the patient leaving the operating room; and,

4. Language that requires hospitals to adopt the “Guidelines for Non-Payment for “Serious Adverse Events” developed by the Oregon Association of Hospitals and Health Systems, <http://oregonpatientsafety.org/reporting-programs/hospitals> (or similar guidelines for hospitals outside Oregon).

- (c) Report progress on Contractor’s efforts to amend contracts with Oregon, Southern Washington and Western Idaho hospitals to add language to preclude Contractor from paying for “Serious Adverse Events”;
- (d) Make its Best Efforts to include language in all its contracts as they are renewed or amended with ambulatory surgery centers, nursing facilities, and retail pharmacies that requires participation in applicable Oregon Patient Safety Commission’s Adverse Events Reporting Programs;
- (e) Make its Best Efforts to include language in all its contracts as they are renewed or amended with ambulatory surgery centers, nursing facilities, and retail pharmacies that requires the organizations to meet or exceed the quality targets and meet or exceed at least one of the targets for quality or timeliness for the Oregon Patient Safety Commission’s Adverse Events Reporting Program; and,
- (f) Make its Best Efforts to include language in all its contracts as they are renewed or amended with ambulatory surgery centers, nursing facilities, and retail pharmacies that requires the organizations to provide timely written notification to patients and families when a serious adverse event occurs (in accordance with ORS 442.837).
- (g) Contractor shall not include in OEGBB’s utilization, costs, or any other factor that determines the plans’ premium rates. OEGBB does not cover any services or costs associated with Never Events.

9. **Preventive Services:** Contractor shall provide all services to enrolled Members that have received an A or B recommendations from the U.S. Preventive Services Task Force (USPSTF) as identified at <http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm>, which will be automatically updated during the Term of this Contract to reflect changes to USPSTF Recommendations. Contractor shall make its Best Efforts to encourage screenings for obesity according to the USPSTF guidelines. Contractor shall provide the services without Member cost sharing if obtained in-network.

10. **Administrative Simplification:** Contractor acknowledges that there are significant opportunities to improve the efficiency and timeliness of administrative processes and transactions between Providers and health plans. Therefore, Contractor shall:
- (a) Continue its active participation in administrative simplification efforts undertaken by the Oregon Health Authority, the Department of Consumer and Business Services and the Oregon Health Leadership Council;
 - (b) Comply with the rules of the Department of Consumer and Business Services requiring uniform standards for insurers; and,
 - (c) Use its Best Efforts to include language in all its contracts with professional and institutional Providers as those contracts requiring them to conduct all administrative transactions electronically in accordance with standards promulgated from time to time by the federal Department of Health & Human Services described at <https://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/TransactionCodeSetsStands/index.html>; the Oregon Health Authority, and the uniform standards adopted by the Oregon Department of Consumer and Business Services including but not limited to ID 12-2011, 16-2011 and 03-2012.

11. **Payment Reform:** Contractor shall reimburse hospitals for services using Medicare Severity Diagnosis Related Groups (DRGs) for inpatient services and Ambulatory Payment Classification (APC) for outpatient services; except that Contractor may substitute alternative payment methods such as population-based budgets with shared savings or shared risk, e p i s o d e - b a s e d p a y m e n t , capitation, or other alternative payment methods, but shall not reimburse hospitals based on percentage of billed charges. This requirement does not apply to type A or type B hospitals as referenced in ORS 442.470, or rural critical access hospitals.. Contractor shall annually attest, on the form and in the manner prescribed by the OHA, to Contractor's compliance with ORS 442.392, 442.394, 243.256 and 243.879 [sections 3, 4, 6, and 8 of Chapter 418, 2011 Oregon Laws].

OEBB endorses innovative payment models that move away from fee-for-service reimbursement and reward for cost and quality outcomes. Contractor will develop and implement payment models that may include (but are not limited to) population-based budgets with shared savings or shared risk, e p i s o d e - b a s e d p a y m e n t , capitation and other reimbursement methods including Patient Centered Primary Care Home supplemental payments, as developed and amended, from time to time, by the Oregon Health Authority.

12. **Post-Hospitalization:** Contractor shall work towards reducing re-admissions and report on its efforts to decrease re-admission rates.
13. **Maternity/Newborn:** Contractor shall provide OEBB with its goals to decrease the numbers of elective C-sections and early inductions (those before 39 weeks that do not meet the medically necessary indicators set by JCAHO and elective early inductions between 39 and 41 weeks (based on criteria approved by the OEBB Strategies and Evidence Workgroup). Contractor shall employ all reasonable measures to reduce primary and repeat cesarean deliveries and elective inductions at <39 weeks of gestation. Contractor shall make its Best Efforts to encourage the

reduction of elective inductions to be enforced by facility policy, and all questionable inductions or exceptions to be subject to facility clinical review.

Contactors shall make its Best Efforts to include language in all its birthing hospital contracts as they renew requiring them to pursue “Baby Friendly” Certification. Contractor shall report on their efforts to decrease the numbers of elective C-sections and early inductions and their efforts to encourage birthing hospitals to become “Baby-Friendly” certified.

XI. Procedures for Member Handbook Approval (Non-Negotiable)

The procedures for Member Handbook approval outlined below include the procedures by which the 2016 and subsequent Plan Years’ Member Handbooks (also referred to as Certificates or Evidences of Coverage or Benefit Handbooks) will be drafted, reviewed and approved. This part of the document, together with the ASPs’ proposals and the final Board-approved plan design(s), will be the basis for negotiating the Contract’s Procedures for Member Handbook Approval Exhibit as well as other related exhibits.

The purpose of this part of the Contract is to set forth the procedures the Contractor shall follow to prepare the Member Handbooks required by this Contract for each Plan Year. The Member Handbook(s) describe the obligations of Contractor to OEBC’s Members who are enrolled with Contractor and requirements Members must satisfy in order to receive benefits. The Member Handbooks contains the terms and conditions that Members need to know, and are legally entitled to rely upon, about the Contractor’s benefits, limitations and procedures.

The benefit summaries below, which are included in the resulting Member Handbooks, are summaries of answers to the most frequently asked questions about benefits. The charts do not fully describe benefits, the benefit limitations, or exclusions in full. To see what is covered for each benefit (including exclusions and limitations), for complete explanations, and for additional benefits that are not included in this summary, OEBC will refer Members to the Member Handbooks for more specific information regarding deductibles, copayments, coinsurance, exclusions and limitations, and benefits.

The Member Handbooks include, but are not limited to, the summary of benefits for the plan design applicable to the Member. The plan designs are listed below. These will be amended for each renewal Plan Year.

A. Procedure for Preparation of the Member Handbooks for 2016 and All Subsequent Plan Years: Contractor shall establish an implementation plan (including any necessary OEBC actions) to meet the deliverable dates below with respect to development of the Member Handbooks for the 2016 Plan Year and all subsequent Plan Years under this Agreement. All material made available to or distributed to OEBC members will be approved by OEBC prior to availability or distribution. Dates in the chart will be adjusted and occur on an annual cycle for each additional renewal beyond the 2016 Plan Year.

Deliverable

Deliverable Date

1. Letter of Agreement. OEGB and Contractor sign a non-binding Letter of Agreement with the rates and a summary of benefits for all plan designs for the upcoming Plan Year. December 9, 2015
2. First Draft. Contractor furnishes OEGB with a draft of the 2016 Plan Year Member Handbook for each plan design. ~~May, 2016~~ May, 2016
3. Language Approved. Following review by OEGB, Contractor submits final language for approval by OEGB. Upon approval in writing by OEGB, the Member Handbook shall be deemed incorporated in the Contract upon written receipt of OEGB approval. July 15, 2016
4. Publication. Contractor posts the Member Handbook as approved by OEGB to its website and provides hard copies upon request. August 1, 2016
5. Distribution. Contractor mails newly enrolled Members a welcome letter online and how to request a hardcopy free of charge. October 1, 2016

B. Procedure for Amending Member Handbooks in the Middle of a Plan Year:

At OEGB's request, or as required by an amendment to the Contract, Contractor shall make changes to its Member Handbooks by furnishing OEGB with a red-line draft of the Member Handbook with the requested changes. Any changes with an effective date in the Middle of the Plan Year must express in the amended Member Handbook the effective date of each change and must describe the benefits both before and after the effective date of each change. Following review and written approval of the Member Handbook changes by OEGB, the amended Member Handbook shall be deemed incorporated in the Contract upon receipt of OEGB approval. Within three business days of receiving written approval from OEGB, Contractor shall post the amended Member Handbook to its Web site and make hard copies available upon request.

C. Benefit Summaries:

Contractor shall develop Member Handbooks for the 2016 Plan Year following the OEGB-approved plan designs described in Exhibit 3 (which will be based on all or parts of the proposals selected by OEGB during the RFP process in addition to the final plan designs selected).

PART D-ATTACHMENT 5 Mandatory Minimum Requirements Checklist

By execution of this checklist, I, as the authorized representative of [Proposer], hereby certify that I have read, understand and agree to the Mandatory Minimum Requirements below and am duly authorized to submit this Proposal and to bind Proposer to each of the terms and provisions hereof.

Proposer Signature

By: _____ Date: _____
(Authorized Signatory, Title)

| | |
|--------------------------|--|
| <input type="checkbox"/> | Proposer’s proposal is in compliance with Oregon law and the Proposer satisfies all insurance licensure requirements related to financial solvency, capital holdings and applicable licensure types for the financial arrangements included in its proposal. |
| <input type="checkbox"/> | Proposer has completed, obtained and performed all other registrations, filings, approvals, authorizations, consents, or examinations required by any government or governmental authority for its acts contemplated by this proposal and resulting Contract. |
| <input type="checkbox"/> | Proposer agrees to the Legal Terms and Conditions in Part D, Attachment 1 , except to the extent the Proposer has indicated in Part D, Attachment 1, its desire to negotiate a specific term or condition, provided that the term or condition is negotiable. |
| <input type="checkbox"/> | Proposer agrees to the Reporting and Performance Requirements in Part D, Attachment 2 , except to the extent the Proposer has indicated they cannot provide a report or do not agree to put fees at risk for a particular performance requirement and, therefore, wish to negotiate those items if selected as an ASP. |
| <input type="checkbox"/> | Proposer agrees to the Scope of Work in Part D, Attachment 3 , except to the extent the Proposer has indicated in Part D, Attachment 3, its desire to negotiate a specific Work item, provided that that Work is negotiable. |
| <input type="checkbox"/> | Proposer agrees to the Insurance Requirements in Part D, Attachment 4 to the RFP, except to the extent the Proposer has indicated a desire to negotiate a specific requirement in Part D, Attachment 4. |
| <input type="checkbox"/> | Proposer agrees to the use of the Sample Form of Contract in Exhibit 4 . |
| <input type="checkbox"/> | Proposer has submitted all required responses to questionnaire items in Part B, Attachments 1-4 for the area(s) they are proposing: Administration, Medical, Pharmacy and Vision Questionnaire , and agrees that its responses are final. |
| <input type="checkbox"/> | Proposer has submitted financial proposal(s), Part C Attachments 1-3 consistent with Exhibit 3 and, if chosen as an ASP, agrees to negotiate a Contract in conformance with Part C Attachments 1-3 and its proposal. |

Timeline for OEGB Medical/Rx RFP

| Month, Year | Day | RFP Process | Responsible Party |
|--------------------|--------|---|--|
| April 2015 | 7 – 24 | Staff and consultants to continue to work with OHA and subject matter experts to finalize proposed questionnaire | OEGB staff and consultants and OHA Alignment Group |
| April 2015 | 28 | Board to review and approve scoring methodology and RFP components | OEGB staff, board and consultants |
| May 2015 | 6 | Staff and consultants finalize RFP questions, content, scoring and benefit structure options | OEGB contracts staff, consultant |
| May 2015 | 12 | OEGB sends final draft RFP to DOJ for review | OEGB contracts staff |
| May 2015 | 26 | Final RFP draft returned from DOJ | DOJ |
| June 2015 | 2 | Board reviews and approves medical, pharmacy and vision RFP offering and any changes to benefits/service areas to be included in the RFP, and weighted scoring values that will be applied to the RFP submissions | OEGB board |
| June 2015 | 4 | Complete RFP to Towers Watson for Proposal Tech | OEGB staff |
| June 2015 | TBD | Hewlett-Packard (H-P) begins MyOEGB system updates | OEGB benefit staff, H-P |
| June and July 2015 | | Develop Selection Committee packets, reference check questions, etc. | OEGB contracts staff |
| July 2015 | 8 | RFP posted on ORPIN | OEGB contracts staff |

Timeline for OEGB Medical/Rx RFP (post release)

| Month, Year | Day | RFP Process | Responsible Party |
|---|-----------|---|--|
| August 2015 | 7 | RFP Selection Committee meeting to review conflicts of interest, questions and scoring tables, etc. | OEGB staff, consultants Selection Committee |
| September 2015 | 2 | Proposals due | Proposers |
| September | 16 | Begin Scoring and Evaluation | OEGB staff, consultants Selection Committee |
| October 2015 | 6 | Update Board on status | OEGB staff |
| October | 14 | Scoring of Proposals Complete | OEGB staff, consultants Selection Committee |
| November 2015 | 3-5 | Proposer interviews and presentations | OEGB staff, consultants Selection Committee |
| November | 11 | Proposer Scoring Finalized | Consultants |
| December 2015 | 2 | Final scores and ASP(s) presented to the Board | Consultants and OEGB staff |
| December | 2 | OEGB Board approves ASP(s) | Board |
| December 2015 through April 15, 2016 | | Contract negotiations and final contracts completed | OEGB staff, consultants, contractors and Department of Justice (DOJ) |

PART B-3- Pharmacy Benefit Management Questionnaire

3.0 Pharmacy Definitions

These definitions apply to all questions, grids and other requests related to Pharmacy Benefits in this RFP. Unless noted otherwise, these definitions will be included as part of OEBB's contract should you be selected as the ASP. Proposers are required to use the words and definitions below in the responses provided when applicable.

3.0.1 **Average Wholesale Price** or “AWP” means the “average wholesale price” for the actual package size of the legend drug dispensed as set forth in the most current pricing list in Medi-Span's Prescription Pricing Guide (with supplements). Proposer must use a single nationally recognized reporting service of pharmaceutical prices for OEBB and such source will be mutually agreed upon by Proposer and OEBB. Proposer will use the manufacturer's full actual 11-digit NDC to determine AWP for the actual package size on the date the drug is dispensed for all legend drugs dispensed through retail pharmacies, mail service pharmacies and specialty pharmacies. Repackaging which has the effect of inflating AWP is explicitly prohibited. “Price shopping”, meaning the Proposer's use of multiple AWP reporting services in order to select the most advantageous AWP price as a means to inflate discount calculations, is prohibited.

3.0.2 **Brand Drug** means a legend drug or OTC with a proprietary name assigned to it by the manufacturer and distributor and so indicated by Medispan© (or mutually agreed upon nationally recognized publication if unavailable). Brand Drugs include Single-Source Brand Drugs and non-MAC Multi-Source Brand Drugs.

3.0.3 **Compound** means a prescription that meets the following criteria: two or more solid, semi-solid, or liquid ingredients, at least one of which is a covered drug that are weighed or measured then prepared according to the Prescriber's order and the pharmacist's art.

3.0.4 **Dispensing Fee** means an amount paid to a pharmacy for providing professional services necessary to dispense medication to a Member.

3.0.5 **Generic Drug** means a legend drug or OTC that is identified by its chemical, proprietary, or non-proprietary name that is accepted by the U.S. Food and Drug Administration as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient and so indicated by Medispan© (or mutually agreed upon nationally recognized publication if unavailable). Generic Drugs include all products involved in patent litigation, Single-Source Generic Drugs, Multi-Source Generic Drugs, Multi-Source Brand Name drugs subject to MAC, House Generics, DAW 0 claims and Generic drugs that may only be available in a limited supply.

3.0.6 **House Generic** means those Brand Drugs submitted with DAW 5 code in place of their generic equivalent(s) and for which, therefore, pharmacies are reimbursed at Generic Drug rates, including MAC, as applicable, for these drugs (e.g., Amoxil v. amoxicillin).

3.0.7 **Maximum Allowable Cost (MAC)** means a payer or PBM-generated list of products that includes the upper limit or maximum amount that a plan will pay for generic drugs and brand names drugs that have generic versions available (multi-source brands).

3.0.8 **MAC List** means the list of drugs designated from lists established by Proposer for which reimbursement to a pharmacy shall be paid according to the MAC price established by Proposer for such list.

3.0.9 **Member Copay** - Members will pay the lowest of the following: plan copay/coinsurance, plan-negotiated discounted price plus dispensing fee, usual and customary (U&C), or retail cash price.

3.0.10 **Multi-Source** means a legend drug or OTC that is manufactured by more than one labeler.

3.0.11 **Multi-source Brand Drugs**-A brand drug that has part but not all of its patent removed.

3.0.12 **Paid Claims** - Defined as all transactions made on eligible members that result in a payment to pharmacies or members from OEBC or OEBC member copays. (Does not include reversals, rejected claims and adjustments.) Each unique prescription that results in payment shall be calculated separately as a paid claim.

3.0.13 **Rebates** means any compensation or remuneration of any kind received or recovered from a pharmaceutical manufacturer attributable to the purchase or utilization of covered drugs by eligible persons, including, but not limited to, incentive rebates categorized as mail order purchase discounts; payments due to inflation caps or other performance arrangements, credits; rebates, regardless of how categorized; market share incentives; promotional allowances; commissions; educational grants; market share of utilization; drug pull-through programs; implementation allowances; clinical detailing; rebate submission fees; and administrative or management fees. Rebates also include any fees that Proposer receives from a pharmaceutical manufacturer for administrative costs, formulary placement, and/or access.

3.0.14 **Single-Source** means a legend drug manufactured by one labeler.

3.0.15 **Single-Source Generic Drug** shall mean a new Generic Drug introduction manufactured by one labeler during the exclusivity period, not to exceed six (6) months.

3.0.16 **Specialty Drug** means drugs that meet a minimum of three or more of the following characteristics: (a) produced through DNA technology or biological processes; (b) target chronic or complex disease; (c) route of administration could be inhaled, infused or injected; (d) unique handling, distribution and/or administration requirements; (e) are only available via limited distribution model to Specialty Pharmacy provider(s), per manufacturer requirements; and (f) require a customized medication management program that includes medication use review, patient training, coordination of care and adherence management for successful use such that more frequent monitoring and training may be required.

3.0.17 **Prescription Drug Transparency** means full disclosure of network pricing, of Network Pharmacy contracts and any Spread retained by Contractor, of flat administration fees or percentage of monthly drug spend paid to Contractor by manufacturer, and of all Rebates; the ability to audit all pricing, including

Rebate contracts; and that the only revenue that Contractor shall derive is the fully disclosed per Paid Prescription Drug Claim administration fee and additional charges as described in the final Contract.

3.1 Minimum Requirements

The following are OEGB's core requirements. Please include your responses within this form. Indicate "Confirm" or "Not Confirm" as to your organization's ability to comply. **Please review the Definitions in 3.0 above before responding to the Pharmacy Questionnaire.**

3.1.1 Confirm you proposal will be based on a Transparent arrangement with full (100%) pass through of all discounts, dispensing fees and rebates (i.e., no spread allowed), including minimum guarantees for each component.

Single, Radio group.

1: Confirmed,

2: Not confirmed, explain: [50 words]

3.1.2 Confirm all current prior authorizations, open mail order refills, specialty transfer files, and accumulator files that exist for current members from the existing Contractor will be imported at NO charge to OEGB (with no charges being deducted from the implementation allowance for file loading or IT).

Single, Radio group.

1: Confirmed,

2: Not confirmed, explain: [50 words]

3.1.3 Confirm any charges or fees to OEGB or their medical plan claims administrators for establishing a connection with a Third Party Administrator/Claims processor for real-time, bi-directional data integration, including non-standard data integration formats will be waived.

Single, Radio group.

1: Confirmed,

2: Not confirmed, explain: [50 words]

3.1.4 Confirm monthly data transmissions will be provided (may include feeds to data warehouses) to OEGB's chosen vendors at no charge and two full, annual electronic claims files, in NCPDP format, at no charge as needed. Proposer will also interact/exchange data with all vendors as needed at no additional charge.

Single, Radio group.

1: Confirmed,

2: Not confirmed, explain: [50 words]

3.1.5 Confirm each distinct pricing guarantee (including rebates) will be measured, reconciled and reported on a component (e.g. retail brand, retail generic, mail order brand, mail order generic, and specialty) basis only and guaranteed on a dollar-for-dollar basis with 100% of any shortfalls recouped by OEGB. Surpluses in one component may not be utilized to offset deficits in another component.

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed, explain: [50 words]

3.1.6 Confirm a Retail/Mail Order unit cost equalization meaning that Mail Order unit costs prior to member cost-sharing, dispensing fees, and sales taxes charged will be no greater than the unit cost for the same NDC-11 at Retail.

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed, explain: [50 words]

3.1.7 Confirm no minimum charges will apply for mail order, specialty or retail claims.

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed, explain: [50 words]

3.1.8 Confirm all claims and plans will be included in all guarantee reconciliations unless specifically noted otherwise.

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed, explain: [50 words]

3.1.9 Confirm no alterations to financial guarantees will be made on formulary drug exclusions. OEBC has the right to opt in or opt out of any formulary drug exclusions without penalty.

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed, explain: [50 words]

3.1.10 Confirm pricing will not change if OEBC's drug mix changes. Your organization does NOT have the ability to revise rebate, brand or generic discount guarantees if there is a shift in mix.

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed, explain: [50 words]

3.1.11 Confirm you will never switch a medication with a lower ingredient cost to a higher ingredient cost regardless of rebate impact.

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed, explain: [50 words]

3.1.12 Confirm you will be able to adjudicate all retail claims including point-of-sale and paper claims at the lowest of: (a) the contracted discount plus dispensing fee; (b) Maximum Allowable Cost (MAC) plus dispensing fee or (c) the Usual and Customary (U&C) price (including the pharmacy's sales price, if any) plus dispensing fee. Proposer agrees that if selected as a winning Proposer, the Contract language will specify that claims adjudicate at the point of sale using the guaranteed methodology proposed.

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed, explain: [50 words]

3.1.13 Confirm you will adjudicate all retail claims according to the “lowest of” logic such that Members always pay the lowest of the applicable copayment, the contracted price and/or the pharmacy’s Usual and Customary (U&C) amount (including the pharmacy’s sale price, if any). Contractors will not be allowed to adjudicate based on “zero balance logic” or on a minimum copayment amount, and retail pharmacies will not be allowed to collect a minimum payment.

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed, explain: [50 words]

3.1.14 Confirm that generic discount guarantees should include all generic drugs (i.e., Single Source Generics, Multi-Source Generics, Multi-Source Brand Name drugs subject to MAC, Patent Litigated Claims, House Generics, DAW (Dispense As Written) claims, Limited Supply Drugs).

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed, explain: [50 words]

3.1.15 Confirm you will pass through 100% of monies received from pharmaceutical companies. Include pass through of all drug company revenues associated with other pharmaceutical manufacturer or third-party payments, including, but not limited to, formulary rebates, payments related to administrative fees, market share, specialty pharmacy, aggregate utilization rebates (e.g., “book of business”), purchase discounts, payments due to inflation caps or other performance arrangements, educational payments, information sales, and all other revenues from drug companies or other third parties, regardless of how it is labeled or structured.

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed, explain: [50 words]

3.1.16 Confirm you will notify OEBC at least 90 days in advance regarding termination of a current pharmacy chain or in an area where there is no other pharmacy location within 30 miles.

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed, explain: [50 words]

3.1.17 Confirm that you will not remove any drug products, brand or generic, from the formulary or preferred drug listing, with the exception of FDA recalls or other safety issues, without 90 day notification and prior approval from OEBC. Proposer must provide a detailed disruption and financial impact analysis at the same time.

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed, explain: [50 words]

3.1.18 Confirm that U&C claims will be excluded from retail discount and dispensing fee guarantee reconciliations (U&C not applicable for mail order).

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed, explain: [50 words]

3.1.19 Confirm that financial guarantees and/or pricing (including but not limited to all financial elements such as fees, rebates, discounts, reconciliation methodologies, definitions, etc.) will not change in the event of change in enrollment for the term of the proposed contract. If you disagree with this statement, please indicate thresholds for changes, pricing impacts, and measurements.

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed, explain: [50 words]

3.1.20 Confirm that financial guarantees and/or pricing (including but not limited to all financial elements such as fees, rebates, discounts, reconciliation methodologies, definitions, etc.) will not change in the event of a change in overall health and welfare or pharmacy benefit strategy for the term of the proposed contract. If you disagree with this statement, please indicate thresholds for changes, pricing impacts, and measurements.

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed, explain: [50 words]

3.1.21 Confirm that financial guarantees and/or pricing (including but not limited to all financial elements such as fees, rebates, discounts, reconciliation methodologies, definitions, etc.) will not change in the event of patent expirations, actions by drug manufacturers or wholesalers, recalls or withdrawals, actions by retail pharmacies, brand products moving off-patent to generic status, unexpected generic introductions, or changes made by PBM to your standard formulary for the term of the proposed contract. If you disagree with this statement, please indicate thresholds for changes, pricing impacts, and measurements.

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed, explain: [50 words]

3.1.22 Confirm that pricing may not change during the term of the contract at bidder's discretion (“right to change”).

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed, explain: [50 words]

3.1.23 Confirm that upon termination of the contract, Contractor will provide all necessary documentation, claims files, prescription history and other data needed for the successful transition of the program to the next Contractor within a reasonable timeframe and at no additional cost to OEBC. This includes, but is not limited to, all open mail order and specialty pharmacy refills, prior authorization histories and at least six months of historical claims data. Two sets of each of these files must be supplied. This agreement must be included in your Contract if awarded the business.

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed, explain: [50 words]

3.2 Company Profile

3.2.1 OEBC expects a completely transparent pharmacy program. Do you or your parent company fully own and operate any of the following?

| | Yes/No | If No, Explain and provide subcontractor |
|--|--|--|
| a. Mail order pharmacies | <i>Single, Pull-down list.</i> 1: Yes, 2: No | [100 words] Nothing required |
| b. Specialty pharmacies | <i>Single, Pull-down list.</i> 1: Yes, 2: No | [100 words] Nothing required |
| c. Rebate contracting and administration | <i>Single, Pull-down list.</i> 1: Yes, 2: No | [100 words] Nothing required |
| d. Clinical program administration | <i>Single, Pull-down list.</i> 1: Yes, 2: No | [100 words] Nothing required |
| e. Customer service centers | <i>Single, Pull-down list.</i> 1: Yes, 2: No | [100 words] Nothing required |
| f. Other (please explain any other subcontracting relationships) | <i>Single, Pull-down list.</i> 1: Yes, 2: No | [100 words] Nothing required |

3.2.2 Provide the following information on your pharmacy book of business and volume for the prior year and current year to date.

| | Prior Year | 2015 Year to Date |
|--|-----------------|-------------------|
| a. Number of covered members at retail. | <i>Decimal.</i> | <i>Decimal.</i> |
| b. Number of covered members at mail. | <i>Decimal.</i> | <i>Decimal.</i> |
| c. Number of mail order pharmacies | <i>Decimal.</i> | <i>Decimal.</i> |
| d. Percent capacity at which the mail order service centers are functioning (5% must be entered as 5.00) | <i>Percent.</i> | <i>Percent.</i> |
| e. Number of annual prescriptions filled through your mail order facility | <i>Decimal.</i> | <i>Decimal.</i> |
| f. Number of specialty mail order pharmacies | <i>Decimal.</i> | <i>Decimal.</i> |

3.3 Transition/Implementation

3.3.1 Describe how existing mail order members would be transitioned to your mail order facility to minimize disruption. Are you able to accept an open refill file from the existing mail order pharmacy? What drugs are not eligible to be transferred through an open refill file process? How are those members taking these medications informed and transitioned?

[500 words.]

3.3.2 Describe your process for transferring step therapy information during the implementation process.

[500 words]

3.4 Communication

3.4.1 Indicate whether you send targeted member letters that identify areas of savings opportunities, and the frequency of communication.

| | Response | Comments |
|----------------------|--|-----------|
| a. Targeted mailings | <i>Single, Radio group.</i> 1: Yes, confirmed upload, 2: No | 50 words. |
| b. Frequency | <i>Single, Radio group.</i> 1: Quarterly, 2: Annually, 3: Other, describe | 50 words. |
| | | 50 words. |
| d. Additional fees | <i>Single, Radio group.</i> 1: Yes additional cost, provide cost, 2: No additional cost for member letters | 50 words. |

3.4.2 Indicate whether your website has the capability to allow physicians to do the following

| Provider Function | Your current capabilities | Comments |
|---|---|------------|
| a. Submit and complete prior authorization requests on-line | <i>Single, Radio group.</i> 1: Yes, 2: No, please explain | 100 words. |
| b. Submit initial prescription | <i>Single, Radio group.</i> 1: Yes, 2: No, please explain | 100 words. |
| c. Submit refill prescriptions | <i>Single, Radio group.</i> 1: Yes, 2: No, please explain | 100 words. |

| | | |
|----------|--|------------|
| d. Other | Single, Radio group. 1: Yes, 2: No, please explain | 100 words. |
|----------|--|------------|

3.4.3 Indicate the online and mobile device capabilities that are available to members. Provide the URL and app name.

| | Website | Mobile Device | Comments |
|---|---------|---------------|-----------|
| a. URL/Mobile App Name | Yes/No. | Yes/No. | 50 words. |
| b. Mail Service order status check | Yes/No. | Yes/No. | 50 words. |
| c. Medication profile | Yes/No. | Yes/No. | 50 words. |
| d. Pricing: Retail | Yes/No. | Yes/No. | 50 words. |
| e. Pricing: Mail | Yes/No. | Yes/No. | 50 words. |
| f. Pricing: Specialty | Yes/No. | Yes/No. | 50 words. |
| g. Alternative drugs within a therapeutic class | Yes/No. | Yes/No. | 50 words. |
| h. Pharmacy locator | Yes/No. | Yes/No. | 50 words. |
| i. EOB | Yes/No. | Yes/No. | 50 words. |
| j. Specialty Drug services | Yes/No. | Yes/No. | 50 words. |
| k. Summary Cost Statement (e.g., FSA) | Yes/No. | Yes/No. | 50 words. |
| l. Drug pricing information at different retailers within the Rx network | Yes/No. | Yes/No. | 50 words. |
| m. Drug pricing information at the same retailers within the Rx network (e.g., different locations of the same chain) | Yes/No. | Yes/No. | 50 words. |
| n. Pricing information for the cost of injectable products | Yes/No. | Yes/No. | 50 words. |

3.4.4 Indicate how you communicate your formulary list and formulary updates, specifically formulary deletions, to prescribers, members, and OEBC? (Check all that apply)

| | Response | Other (explain) |
|-------------------|--|-------------------------------|
| a. To Prescribers | Multi, Checkboxes. 1: Newsletter, 2: Targeted mailing to affected population only, 3: Email, 4: Published on website, 5: Explanation of Benefits, 6: Other | 100 words Nothing required |
| c. To OEBC | Multi, Checkboxes. 1: Newsletter, 2: Targeted mailing to affected population only, 3: Email, 4: Published on website, | 100 words Nothing required |

| | | |
|---------------|---|---------------------------------------|
| | 5: Explanation of Benefits, 6: Other | |
| d. To Members | <i>Multi, Checkboxes.</i> 1: Newsletter, 2: Targeted mailing to affected population only, 3: Email, 4: Published on website, 5: Explanation of Benefits, 6: Other | <i>100 words.</i> Nothing required |

3.4.5 Are all formulary deletions communicated or only select deletions? If only select deletions are communicated, explain why and how these are selected.
[100 words]

3.4.6 How will you handle communication to members of formulary disruption changes due to a change in vendors resulting from this RFP? Confirm that you will not assess charges for these communications.

3.4.7 If a therapeutic switch has been approved by the MD, is it your policy to make an outbound phone call to the member prior to an alternative Rx being dispensed? If no, please explain.

Single, Radio group.

1: Yes,

2: No, explain: [50 words]

3.4.8 If a generic isn't available, is a brand dispensed? If yes, what copayment is applied? Does your organization ever dispense a Multi-Source Brand when a generic is available? If yes, what discount is applied?

250 words

3.5 Plan Administration

OEBB is seeking a Contractor partner that is flexible and capable of facilitating changes, innovative design administration and responding quickly to the requested changes, throughout the plan year. Provide examples of your ability to successfully facilitate and implement changes and innovations quickly in response to an employer or plan sponsor's request.

3.5.1 What is the average turnaround time for programming standard plan design changes for clients similar to OEBB? Include your definition of standard plan or benefit design changes and examples of changes that would be considered custom.

[500 words]

3.5.2 Confirm your ability to administer the following benefit types. Indicate the percentage of Employers or Plan Sponsors in your book of business that have implemented these types of approaches. Are there added costs for custom plan or benefit design changes? If so, please specify.

| | Confirm ability to administer (Y/N) | Is the administration fee included in base admin fee (Y/N) | Price if not included | Number of Employer Clients |
|--|-------------------------------------|--|-----------------------|----------------------------|
|--|-------------------------------------|--|-----------------------|----------------------------|

| | | | | |
|---|----------------|----------------|-------------------|-------------------|
| a. Account based health plans (e.g., HDHPs, HSAs, etc.) | <i>Yes/No.</i> | <i>Yes/No.</i> | <i>100</i> | <i>100</i> |
| | | | | |
| c. Expanded Tier Structures (4th and 5th tiers) | <i>Yes/No.</i> | <i>Yes/No.</i> | <i>100</i> | <i>100</i> |
| | | | | |
| e. Value Based Design | <i>Yes/No.</i> | <i>Yes/No.</i> | <i>100</i> | <i>100</i> |
| | | | | |
| g. Custom Utilization Management Programs | <i>Yes/No.</i> | <i>Yes/No.</i> | <i>100</i> | <i>100</i> |
| h. Custom Preventive Drug Lists | <i>Yes/No.</i> | <i>Yes/No.</i> | <i>Unlimited.</i> | <i>Unlimited.</i> |
| i. Rebates adjudicated at the point of sale | <i>Yes/No.</i> | <i>Yes/No.</i> | <i>Unlimited.</i> | <i>Unlimited.</i> |
| j. Other | <i>Yes/No.</i> | <i>Yes/No.</i> | <i>Unlimited.</i> | <i>Unlimited.</i> |

3.5.3 Do you allow the use of pharmaceutical coupons which serve to decrease or eliminate member out of pocket costs for either retail or mail order? Explain

YES/NO (250 words)

3.5.4 How much time passes before rebate payments from the manufacturer or PBM are received, full reconciliation is completed, and rebates are sent to Employers or Plan Sponsors? Specify the length of time or range for each of these three processes.

50 words

3.5.5 Confirm your willingness to work with OEBC on mid-year benefit changes as needed.

Single, Radio group.

1: Confirmed,

2: No, explain: [100 words]

3.5.6 Confirm you will provide OEBC with full authority to "turn-off" any point-of-sale edits (e.g., quantity limit, step therapy) that OEBC does not want to implement or continue.

Single, Radio group.

1: Confirmed,

2: No, explain: [10 words]

3.5.7 Confirm you will not automatically enroll OEBC in any programs that involve any type of communications with members or alterations of members' medications, without express written consent from OEBC.

Yes/No.

3.5.8 Describe how you capture, review and monitor the correct entry of usual and customary (i.e. "lower of" pricing).

[200 words]

3.5.9 Describe your ability to bring Group Purchasing Organizations (GPOs) pricing to eligible OEBC Members as well as projected savings from these programs.

[500 words]

3.5.10 Do you send receipts to members that show total cost, amount paid by member and amount paid by the plan for each prescription?

100 words.

3.6 Retail Network

3.6.1 We have provided a claim transaction file with this RFP. Please conduct a **retail network disruption** analysis utilizing your broadest pharmacy network (>59,000 pharmacies) and populate the following table in the following format as an attachment in Excel for current retail pharmacies that are not in your network. Retail network disruption analysis must be consistent with your pricing proposal.

RETAIL NETWORK DISRUPTION ANALYSIS

| Pharmacy in the OEBC network that is not in your network | City, State | Number of unique members at this pharmacy | Claim count | Nearest pharmacy in your network | Miles to your nearest network pharmacy | Additional Notes |
|--|-------------|---|-------------|----------------------------------|--|------------------|
| <<Proposer should list all that apply>> | | | | | | |

Single, Pull-down list.

1: Attached in Part D ,Attachment 10, Attachment Checklist

2:Not Attached, If not explain reason for not attaching. [100 words]

3.6.2 Describe the retail pharmacy network structure (including the network name) you are proposing. Include in your description any distinguishing features and the number of independent and chain pharmacies in the network. Also list any major chains excluded from the network.

| | Response |
|---|------------|
| Network Name | 10 words. |
| # of participating independent pharmacies | Decimal. |
| # of participating chain pharmacies | Decimal. |
| Network description | 250. |
| Chains excluded from the network | 100 words. |

3.6.3 Confirm OEBC members will be able to fill a 90 day supply of a medication at retail pharmacies
Yes/No

3.7 Mail Order Operations

3.7.1 Describe the Mail Service facility(ies) you are proposing for OEBC. Provide prior year results.

| | Mail Service Facility #1 | Mail Service Facility #2 | Mail Service Facility #3 | Mail Service Facility #4 |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| a. Location | 50 | 50 | 50. | 50. |
| b. Operating Days and Hours (provide hours in PST) | 50. | 50. | 50. | 50. |
| c. Capacity (Annual average of the # of claims paid per day/maximum capacity of claims paid per day) | Percent. | Percent. | Percent. | Percent. |
| d. Fill accuracy (based in Rx's dispensed over the most current 12 months) | Percent. | Percent. | Percent. | Percent. |
| e. Turn Around Time | 50. | 50. | 50. | 50. |
| f. What is the current prescription volume capacity and what percentage of the total would be represented by OEBC? | 50. | 50. | 50. | 50. |
| g. What was the dispensing accuracy rate for 2013 and 2014, respectively? | 50. | 50. | 50. | 50. |
| h. What percentage of prescriptions shipped in 2014 were filled manually by a pharmacist or technician? | Percent. | Percent. | Percent. | Percent. |

3.7.2 Does the mail order program's system coordinate with the retail network on a real-time basis? If not, explain.

Single, Radio group.

1: Yes,

2: No (explain): [50 words]

3.7.3 Describe your ability to accept electronically prescribed medications within your mail service pharmacies. Note that ability to receive faxes is not considered an electronic prescription in this question. [50 words]

3.7.4 Confirm you take action (e.g. notify member and/or physician) if a member attempts to reorder an Rx with no refills remaining.

Single, Radio group.

1: Confirmed,

2: No, explain: [50 words]

3.7.5 Confirm prescriptions orders are never returned to members without either a telephonic or electronic notification to member and/or physician notification.

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed, explain: [50 words]

3.7.6 Describe your policy regarding prescription orders received without payment information:

Single, Radio group.

- 1: Not filled and prescription returned to member,
- 2: Pharmacy calls Member and obtains credit card or other form of payment authorization,
- 3: Credit extended and prescription is filled (describe credit amount extended): [100 words] ,
- 4: Other, discuss: [100 words]

3.7.7 Explain how members are notified when a mail order prescription is delayed in each of the following circumstances: (OEBC too)

| | Response |
|---|----------|
| A prescription requiring clarification from the physician or physician's agent (e.g., missing quantity or illegible drug name). | 100 |
| A clean prescription where the delay is due to the Contractor's operational, capacity or drug supply issues. | 100 |
| A clean prescription where the delay is a result of the Contractor's therapeutic switch intervention. | 100 |

3.7.8 Do you have the ability to partial bill a member for a 90 day mail order prescription? If so, are there any additional charges to the plan or member? What requirements/stipulations apply (e.g. credit card on file)?

100 words

3.7.9 Describe your capabilities to support members outside of the United States who require prescriptions filled.

[100 words]

3.7.10 Proposer will be responsible for collecting any outstanding member cost shares for prescriptions dispensed through the mail order facility. Confirm that you will not invoice OEBC for any uncollected member cost shares.

Yes/No.

3.7.11 Confirm your mail order facility(ies) are licensed to ship in all 50 states.

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed, explain: [50 words]

3.7.12 Provide a list of drugs that are not eligible to be filled through your mail order pharmacy.

Upload file

3.7.13 Does your mail order facility(ies) have compounding services? If so, what products, if any, are not available to be compounded at your mail order facility?

[200 words.]

3.7.14 In the case of delayed delivery of mail order prescription due to shortages, explain the process for providing plan members with a short-term retail prescription supply.
100 words.

3.7.15 Does your organization split prescription orders? If yes, describe when that would occur and what communication members would receive to inform them of the split order?
100 words.

3.7.16 Confirm you agree not to pass any increases in mailing/postage fees to OEBC or its Members during the Contract term.

Single, Radio group.

1: Confirmed,

2: Not confirmed, explain: [50 words]

3.7.17 Confirm you will adjudicate all mail order claims at the lesser of: (a) the contracted discount plus dispensing fee or (b) Maximum Allowable Cost (MAC) plus dispensing fee.

Single, Radio group.

1: Confirmed,

2: Not confirmed, explain: [50 words]

3.7.18 Confirm you will adjudicate all mail order claims according to the “lower of” logic such that OEBC Members always pay the lower of the applicable copayment or the contracted price. Contractors will not be allowed to adjudicate based on a minimum mail order copayment.

Single, Radio group.

1: Confirmed,

2: Not confirmed, explain: [50 words]

3.7.19 Confirm you will not charge OEBC or Members for expedited delivery if its organization causes the prescription delay. Contractor agrees to offer any Member experiencing a delay in the delivery of its order the option of filling their prescription at a participating retail pharmacy.

Single, Radio group.

1: Confirmed,

2: Not confirmed, explain: [50 words]

3.7.20 Confirm you agree to offer consistent pricing for all standard mail order prescriptions regardless of the days’ supply.

Single, Radio group.

1: Confirmed,

2: Not confirmed, explain: [50 words]

3.8 Specialty Pharmacy

3.8.1 Describe the specialty pharmacy you are proposing for OEBC. Provide prior year results.
250 Words

3.8.2 Complete the following table for your proposed specialty pharmacy:

| | Specialty Facility #1 | Specialty Facility #2 | Specialty Facility #3 | Specialty Facility #4 |
|--|----------------------------------|----------------------------------|----------------------------------|----------------------------------|
| a. Name/Location | 50 | 50. | 50. | 50. |
| b. Operating Days and Hours using PST. | 50. | 50. | 50. | 50. |
| c. Capacity (# of claims paid per day/maximum capacity of claims paid per day) | <i>Percent.</i> | <i>Percent.</i> | <i>Percent.</i> | <i>Percent.</i> |
| d. Fill accuracy (based in Rx's dispensed over the most current 12 months) | <i>Percent.</i> | <i>Percent.</i> | <i>Percent.</i> | <i>Percent.</i> |
| e. Turn Around Time | 50. | 50. | 50. | 50. |
| f. Percent of specialty claims defined as clean claims as opposed to claims requiring intervention | <i>Percent.</i> | <i>Percent.</i> | <i>Percent.</i> | <i>Percent.</i> |
| g. What is the current prescription volume capacity and what percentage of the total would be represented by OEGB? | <i>Total OEGB %</i> | <i>Total OEGB %</i> | <i>Total OEGB %</i> | <i>Total OEGB %</i> |
| h. What was the dispensing accuracy rate for 2013 and 2014, respectively? | 2013 2014 | 2013 2014 | 2013 2014 | 2013 2014 |
| i. What percentage of prescriptions shipped in 2014 were filled manually by a pharmacist or technician? | <i>Pharmacist Technician</i> | <i>Pharmacist Technician</i> | <i>Pharmacist Technician</i> | <i>Pharmacist Technician</i> |

3.8.3 What is your organization's formulary approach to managing specialty drugs? What is your organization's approach to managing days of supply for specialty drugs (e.g., do you allow, require or encourage 90 day fills of specialty medications in lieu of lower supply options)?

[250 words].

3.8.4 Which of the following programs for managing specialty pharmacy products are included in your premium proposal?

| | Included |
|----------------------|---|
| Prior Authorization | <i>Single, Pull-down list.</i> 1: Yes 2: No |
| Step therapy | <i>Single, Pull-down list.</i> 1: Yes 2: NO |
| Quantity Limits | <i>Single, Pull-down list.</i> 1: Yes 2: No |
| Formulary Management | <i>Single, Pull-down list.</i> 1: Yes |

| | |
|--------|-----------|
| | 2: No |
| Other: | 100 words |

3.8.5 Describe how existing specialty drug patients would be transitioned to your specialty pharmacy to minimize disruption, including those patients whose medication is not considered a specialty drug by OEBC's current Contractor and those taking medications with limited distribution rights. Are you able to accept an open refill file from the existing specialty pharmacy? What drugs are not eligible to be transferred through an open refill file process? Explain your communication and transition process and timeline to those members taking these medications.

[500 words]

3.8.6 Are partial fill programs available for new Members? If not, is there any intent to implement this type of program? Do you have the capability to implement this type of program?

[500 words]

3.8.7 What are the criteria used (excluding cost) to designate a prescription as a specialty medication for your program?

[500 words]

3.8.8 Does your organization have the ability to place inflationary caps on specialty drugs? If yes, list the select therapeutic classes or drugs that are targeted. Also, describe your approach to capping inflation for these products, and what happens should inflation exceed these caps.

[500 words]

3.8.9 Confirm limited distribution drugs, that are not otherwise specialty products are not included in the specialty drug list.

Single, Pull-down list.

- 1: Confirmed,
- 2: Not confirmed

3.8.10 Does your organization offer utilization management or other programs to proactively address new specialty drugs entering the market? If so, please describe.

[250 words]

3.8.11 Describe any innovative contracting approaches (e.g. specialty rebates, outcomes, clinical management, etc.) your organization has with providers, pharmaceutical manufacturers or other parties.

[500 words]

3.8.12 Describe and provide examples of any aggressive dose optimization initiatives and waste management programs currently available to manage the utilization of specialty drugs that differentiates your organization from the marketplace. In addition, please address any new initiatives in development to address this issue.

[500 words]

3.8.13 Describe the process for adding drugs to your specialty drug list. Confirm that you will allow OEBC to approve any addition to the specialty drug list.

[250 words]

3.8.14 Describe the process for deleting drugs from your specialty drug list. Confirm that you agree to notify OEBC and its members 90 days prior to a deletion of a drug from the specialty drug list.

[250 words]

3.8.15 What is your standard days supply for specialty products? Can OEBC customize the allowable days supply up to 90 days?

[100 words]

3.8.16 Confirm auto refill is not a standard for specialty drugs refills.

Single, Radio group.

1: Agree to meet,

2: Do not agree to meet. Explain: [100 words]

3.9 Formulary Management

3.9.1 Describe the formulary you are proposing to OEBC and your formulary management strategies. OEBC's preference is to have vendors committed to providing evidence and value-based formularies. Provide examples of how your proposed formulary includes these principals

[500 words]

3.9.2 Complete a formulary disruption analysis using the detailed encounter level claims attachment file.

A. Use the claims data provided to detail the results of the formulary disruption analysis. All documents associated with the formulary disruption analysis should be labeled "Formulary Disruption." Using the formulary for your organization that will be effective October 1, 2016, utilize the claims detail data provided and assign acute/chronic flags.

B. Please provide the following information for the number of utilizers taking a medication currently flagged as formulary but that is considered non-formulary on your proposed formulary list:

i. Aggregate number of utilizers.

ii. Number of utilizers separated by acute and chronic therapy (using field DXID_DISEASE_DURATION_CD).

C. Please complete a reverse analysis (number of utilizers taking a medication currently flagged as non-formulary that is considered formulary on your proposed formulary list):

i. Aggregate number of utilizers

ii. Number of utilizers separated by acute and chronic therapy (using field DXID_DISEASE_DURATION_CD)

3.9.3 Describe the process and frequency for reviewing drugs for addition/deletion to the proposed formulary. Describe your process for adding and removing a drug to your Preferred Drug List (PDL). Do you utilize information provided by the Drug Effectiveness Review Project (DERP) to make changes to your PDL? How quickly are new drugs added to the formulary?

| | Response |
|---|-----------|
| a. Frequency of formulary updates | 50 words |
| b. Process for determining drug coverage on formulary | 500 words |
| c. How timely are drugs added to the formulary? | 50 words |

3.9.4 Confirm all generics are included in the proposed formulary. If not, provide a list of all generics that are not included.

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed

3.9.5 Confirm you can match OEBS's current 4 tier benefit program including those drugs in the Value Tier.

Confirmed/Not Confirmed

3.9.6 Are any non-Food and Drug Administration (FDA)-approved drugs that predated the FDA included in the formulary and conversely, any non-FDA-approved drugs that predated the FDA in common use today not included in the formulary? If so, specify those drugs included and not included.

[200 words]

3.9.7 Confirm drugs on formulary can be moved to non-formulary a maximum of once per calendar year or as required by the Food and Drug Administration (FDA).

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed

3.9.8 Confirm drugs will not be excluded from coverage unless required by the Food and Drug Administration (FDA) or OEBS.

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed

3.9.9 Confirm brand-to-brand prescription substitutions will be permitted only to promote clinical outcomes and only in circumstances where substituted product results in a lower plan and Member cost. Rebates may not be considered when determining plan or Member cost.

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed

3.9.10 Describe the composition and qualifications of your Pharmacy and Therapeutics (P&T) committee.

| Questions | Responses |
|--|-----------|
| a. Are any voting members employed by your organization? | 20 words |
| b. Are any non-voting members employed by your organization? | 20 words |
| c. How are Pharmacy & Therapeutics (P&T) Committee members vetted for conflict of interest? | 100 words |
| d. Describe any reimbursement or payments made to your Pharmacy & Therapeutics (P&T) Committee. | 100 words |
| e. What frequency does the Pharmacy & Therapeutics (P&T) Committee meet? | |
| f. Explain the role and authority of the P&T committee | |
| g. Explain how your organization handles Food and Drug Administration (FDA) approvals of new specialty drugs between Pharmacy and Therapeutics (P&T) Committee meetings? | 100 words |

3.10 Clinical Management

3.10.1 Describe the specific highlights or elements of your philosophy and/or clinical programs that, you believe, separates your organization's program from others in managing medication utilization, compliance, and outcomes.

[500 words]

3.10.2 Describe any key initiatives your program will be launching or is implementing over the next two years, from a cost management, clinical, or care management perspective.

[500 words]

3.10.3 Confirm OEBC has the ability to implement utilization management rules on an a la carte basis.

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed

3.10.4 Describe the programs included in your proposal to OEBC for the following conditions.

| Condition | Available Programs | Comments 100 words each |
|----------------------|--|----------------------------|
| Rheumatoid Arthritis | <i>Multi, Checkboxes.</i> 1: Step Therapy, 2: Prior Authorization, 3: Quantity per Duration, 4: Dose Optimization, 5: Polypharmacy, 6: Concurrent Drug Utilization Review, 7: Retrospective Drug utilization Review, 8: Medication therapy | . |
| Multiple Sclerosis | <i>Multi, Checkboxes.</i> 1: Step Therapy, 2: Prior Authorization, 3: Quantity per Duration, 4: Dose Optimization, | . |

| | | |
|---------------------|---|---|
| | <p>5: Polypharmacy, 6: Concurrent Drug Utilization Review, 7: Retrospective Drug utilization Review, 8: Medication therapy</p> | |
| High Cholesterol | <p><i>Multi, Checkboxes.</i> 1: Step Therapy, 2: Prior Authorization, 3: Quantity per Duration, 4: Dose Optimization, 5: Polypharmacy, 6: Concurrent Drug Utilization Review, 7: Retrospective Drug utilization Review, 8: Medication therapy</p> | . |
| High Blood Pressure | <p><i>Multi, Checkboxes.</i> 1: Step Therapy, 2: Prior Authorization, 3: Quantity per Duration, 4: Dose Optimization, 5: Polypharmacy, 6: Concurrent Drug Utilization Review, 7: Retrospective Drug utilization Review, 8: Medication therapy</p> | |
| Depression | <p><i>Multi, Checkboxes.</i> 1: Step Therapy, 2: Prior Authorization, 3: Quantity per Duration, 4: Dose Optimization, 5: Polypharmacy, 6: Concurrent Drug Utilization Review, 7: Retrospective Drug utilization Review, 8: Medication therapy</p> | |
| Asthma/COPD | <p><i>Multi, Checkboxes.</i> 1: Step Therapy, 2: Prior Authorization, 3: Quantity per Duration, 4: Dose Optimization, 5: Polypharmacy, 6: Concurrent Drug Utilization Review, 7: Retrospective Drug utilization Review, 8: Medication therapy</p> | |
| Diabetes | <p><i>Multi, Checkboxes.</i> 1: Step Therapy, 2: Prior Authorization, 3: Quantity per Duration, 4: Dose Optimization, 5: Polypharmacy, 6: Concurrent Drug Utilization Review,</p> | |

| | | |
|------------------|--|--|
| | 7: Retrospective Drug utilization Review, 8: Medication therapy | |
| Asthma/Allergy | <i>Multi, Checkboxes.</i> 1: Step Therapy, 2: Prior Authorization, 3: Quantity per Duration, 4: Dose Optimization, 5: Polypharmacy, 6: Concurrent Drug Utilization Review, 7: Retrospective Drug utilization Review, 8: Medication therapy | |
| Pain (narcotics) | <i>Multi, Checkboxes.</i> 1: Step Therapy, 2: Prior Authorization, 3: Quantity per Duration, 4: Dose Optimization, 5: Polypharmacy, 6: Concurrent Drug Utilization Review, 7: Retrospective Drug utilization Review, 8: Medication therapy | |
| Oncology | <i>Multi, Checkboxes.</i> 1: Step Therapy, 2: Prior Authorization, 3: Quantity per Duration, 4: Dose Optimization, 5: Polypharmacy, 6: Concurrent Drug Utilization Review, 7: Retrospective Drug utilization Review, 8: Medication therapy | |

3.10.5 Select the programs you have in place to promote generics outside of the generic substitutions that result from patent expirations. Include generics conversion rates and savings.

Single, Radio group.

- 1: Zero Dollar Generics/Copay Waiver,
- 2: Targeted communications,
- 3: Other, describe:

[1000 words]

3.10.6 Describe how you integrate medical, disease management, and wellness data with the clinical programs your organization offers?

[500 words].

3.10.7 Which disease states/conditions are you able to offer clinical performance guarantees (medication possession ratio, gaps in care closures, etc.) for OEBC? Describe how you would achieve an improvement in population health for these disease states/conditions, and which metrics you would include in the

guarantees (i.e. improved adherence, product selection, A1C improvement, etc.) and the methodology to measure the guarantees.

| Disease/Condition | Guarantee offered | Metrics included in the guarantees | Guarantee measurement methodology |
|-----------------------------|-------------------|------------------------------------|-----------------------------------|
| a. Diabetes | 50 words | 50 words | 100 words |
| b. Hypertension | 50 words | 50 words | 100 words |
| c. Congestive Heart Failure | 50 words | 50 words | 100 words |
| d. Dyslipidemia | 50 words | 50 words | 100 words |
| e. Asthma/COPD | 50 words | 50 words | 100 words |
| f. Depression | 50 words | 50 words | 100 words |
| g. Other | 50 words | 50 words | 100 words |
| h. Other | 50 words | 50 words | 100 words |

3.10.8 Indicate and describe programs you have to monitor and improve patient compliance with prescribed drug therapy?

| | Response |
|--------------------------|-------------------|
| a. At retail | <i>Unlimited.</i> |
| b. At mail | <i>Unlimited.</i> |
| c. Brand name to generic | <i>Unlimited.</i> |

3.10.9 Explain your Prior Authorization (PA) and Standard Therapy (ST) denial process from the perspective of the member for both mail order and retail. Include standard turn-around-times for each. [500 words]

3.10.10 Describe how compounded products are managed. 500 words.

3.10.11 Do you have a cost per claim limit?
Single, Radio group.

- 1: Yes – Client Specific (state amount): [200 words] ,
- 2: Yes – PBM Specific (state amount): [200 words] ,
- 3: No (explain): [200 words]

3.10.12 Are certain compounds excluded or subject to prior authorization?
Single, Radio group.

- 1: Yes: [50 words] ,
- 2: No: [50 words]

3.10.13 How are compounded kits managed?

Single, Radio group.

- 1: Managed with Coverage: [100 words] ,
- 2: Managed with No Coverage [100 words] ,
- 3: Not Managed: [100 words]

3.10.14 Do you account for compounds submitted under the medical benefit?

Single, Radio group.

- 1: Yes: [100 words] ,
- 2: No: [100 words]

3.10.15 Confirm you adjudicate prescription claims for compound medications dispensed at retail and mail order with the same dispensing fees and logic associated with traditional claims; compound drugs will not be subject to a mark up

1: Yes

2: No.

3.11 Data, Reporting and Analysis

3.11.1 What type of reports are included in your standard reporting package? Upload a sample of your standard reporting package. (**See Part D- Attachment 10-Attachments Checklist**)

[500 words]

Single, Pull-down list.

- 1: Attached,
- 2: Not Attached

3.11.2 Refer to the Reporting and Performance Requirements Exhibit in **Part D-Attachment 2-Reporting and Performance Requirements**. Review, Section C and respond to each of the requirements that pertain to Pharmacy. Attach to final submission as requested.

- Section 1-Items 1-a, 1-i, 1-j, 1-k, 1-l
- Section 3 Items 3-k
- Section 5-Items 5a-5-h and 5-k,5-l
- Section 6-All

3.11.3 Describe your standard process and average turn-around time for simple as well as complex ad hoc reporting requests. Include if there is a cost, and how this is calculated.

[100 words]

3.11.4 Provide information on any data breaches you have experienced in the last 36 months including type of breach, number of members impacted, and actions taken to notify members and employers or plan sponsors.

[250 words]

3.11.5 Describe your data protection protocols including protections for data in transit and for data at rest within your systems.

[250 words]

3.11.6 Describe your ability to provide clinical program modeling to evaluate the plan savings, program costs, member impact and rebate impact for OEBC. This modeling should be provided at no charge. Confirm this modeling is also able to demonstrate impact with or without grandfathering of current utilizers of target medications.

[500 words]

3.12 Integration with Other Vendors

3.12.1 Describe how you would work with OEBC's current vendors in the following areas.

- Data Warehouse
- Disease management
- Health Risk Appraisal
- Wellness Programs
- Compliance Monitoring
- Gaps in care programs

[500 words]

3.12.2 What resources do you offer members that may be coordinated with OEBC's medical, wellness, and health management vendor?

[100 words]

3.12.3 Detail your experience coordinating with a third party health or condition management vendor to report outcomes and improve health-related measures relative to effective drug therapy management. What internal tools and resources (web portal, designated pharmacist, etc.) will you make available to external condition management vendor(s) such as Alere or the Diabetes Management Program? Please note any restrictions to and costs associated with these capabilities.

[500 words]

3.12.4 Have you successfully coordinated with other health plan vendors to issue a single ID card? If so, with which vendors have you successfully integrated?

Single, Radio group.

1: Yes, If yes, list successful vendors

2: No, please explain [50 words]

3.12.5 When eligibility data is coming from the medical vendor, please describe the member ID transfer process.

[100 words]

3.13 Performance Requirements

3.13.1 Confirm you will track and monitor pharmacy performance (i.e., generic dispensing, reversals, controlled substance dispensing, etc.) including Contractor's management of the network, providing performance reports on an annual basis and upon request, to OEBC.

1: Yes

2: No.

3.13.3 Review the Pharmacy Performance Guarantees in Part D-Attachment 2 and respond to each of the requirements. OEGB's intent is to have quality services for its Members, and would expect service level targets to be met. Performance guarantees will be finalized during the contracting process but these would be minimum expectations. Confirm you can meet these expectations.

1: Yes

2: No.

3.14 Patient Protection and Affordable Care Act - Pharmacy Benefits

3.14.1 Describe your position on medications noted in the Patient Protection and Affordable Care Act (PPACA) relative to coverage of preventive care services. Explain and provide a list of which drugs are included at no cost-share (e.g., OTC, Rx, brands, generics, single entity, combination products, etc.) and outline any restrictions that apply (such as age, gender, written prescription, quantity limitations). Indicate if your proposed restrictions vary from the US Preventive Services Task Force (USPSTF) recommendations and why.

[500 words]

3.15 Pharmacy Audit

3.15.1 Confirm you will accommodate a pre-or post-implementation audit at your organization's expense, providing a fund (\$xx,000) for the audit in order to verify your readiness to administer the OEGB program. The pre-implementation audit must be completed before the program effective date and the post-implementation audit will be conducted at a mutually agreed upon timeframe post effective date. These audits may include, but not be limited to; ID card production and turnaround time, eligibility, claims processing, customer service, plan design, drug coverage and clinical utilization management program set-up, and overall pricing. The review will be conducted by an audit firm selected by OEGB and would include test claims developed independently by the audit firm to represent OEGB's unique requirements.

Single, Radio group.

1: Agree to meet,

2: Do not agree to meet. Briefly explain: [100 words]

3.15.2 Confirm you will provide operational and financial audit rights including:

- Appropriate access to Maximum Allowable Cost (MAC) rates and the formulary rebate program (both specialty and non-specialty).
- Processes for reporting data to manufacturers, accounting for rebates earned and allocating rebate payments to OEGB (both specialty and non-specialty).
- OEGB's ability to conduct these audits at any time during the Contract term upon 30-days written notice to the Contractor. Contractor may not limit the time period of paid claims to be audited.
- OEGB or mutually agreed upon entity the right to audit at any time not more than once per year (excluding the implementation and Centers for Medicare and Medicaid Services audits) during term of agreement or within 12 months following termination, unless material discrepancy has not been corrected within 90 days, in which case OEGB reserves the right to take corrective action.

- Contractor will take and complete corrective action within 30 days of audit that shows any discrepancy. If action requires additional training, corrective action should be completed within 60 days.

Single, Radio group.

- 1: Agree to meet,
- 2: Do not agree to meet. Briefly explain: [100 words]

3.15.3 Confirm your organization will allow OEBC, OEBC's consultant, or a mutually agreed upon entity the right to review the internal testing completed for OEBC's Plan, if applicable, prior to the effective date of the plan on an annual basis.

Single, Radio group.

- 1: Agree to meet,
- 2: Do not agree to meet. Explain: [50 words]

3.15.4 Confirm your organization will allow OEBC, OEBC's consultant, or mutually agreed upon entity the right to create and submit test claims for OEBC's Plans, without limitations on the number of test claims, as part of a pre or post implementation audit on an annual basis.

Single, Radio group.

- 1: Agree to meet,
- 2: Do not agree to meet. Explain: [50 words]

3.15.5 Confirm you will not withhold any financial recoveries from audits performed on the contracted pharmacy network including mail order and specialty pharmacies. Any recoveries will be disclosed and credited to OEBC.

Agree

Do not agree. Explain [50 words]

3.15.6 Confirm rebate audits will include the top five pharmaceutical manufacturers and 50% of rebate spend.

Single, Radio group.

- 1: Agree to meet,
- 2: Do not agree to meet. Explain: [50 words]

3.15.7 Confirm audit recovery overpayments will not be offset by any potential underpayments identified by the audit.

Single, Radio group.

- 1: Agree to meet,
- 2: Do not agree to meet. Briefly explain: [50 words]

3.15.8 Confirm OEBC will not be responsible nor assessed a charge for any Contractor expenses related to an operational or financial audit, including the costs to provide necessary records.

Single, Radio group.

- 1: Agree to meet,
- 2: Do not agree to meet. Briefly explain: [50 words]

3.15.9 What percent of your network retail pharmacies do you perform on-site audits annually? (# audited network pharmacies / # of total network pharmacies). Do not include desk top audits or any other form of

electronic audit in this calculation. Confirm that you will be able to provide network audit reporting on a quarterly basis.

Single, Radio group.

1: *Percentage*

2.a: Agree to meet,

2.b: Do not agree to meet. Explain: [50 words]

3.16. Geo Access

3.16.1 Provide a GeoAccess report with the following report sections for your retail pharmacies.

A. Report Sections

- i. Title page
- ii. Accessibility Summary: Urban employees **with** access
- iii. Accessibility Summary: Urban employees **without** access
- iv. Accessibility Summary: Suburban employees **with** access
- v. Accessibility Summary: Suburban employees **without** access
- vi. Accessibility Summary: Rural employees **with** access
- vii. Accessibility Summary: Rural employees **without** access

B. Criteria

| | Urban Employees | Suburban Employees | Rural Employees |
|---|---|--|---|
| Persons per Square Mile | Greater than 3,000 | 1,000 to 3,000 | Less than 1,000 |
| Provider Type | Urban Employees | Suburban Employees | Rural Employees |
| <ul style="list-style-type: none"> • Retail pharmacy | Access to Retail pharmacy within 1 mile | Access to Retail pharmacy within 3 miles | Access to Retail pharmacy within 10 miles |

Single, Radio group.

1: Confirmed, uploaded,

2: No (explain): [50 words]