

Oregon Educators Benefit Board Meeting Minutes October 6, 2015

The Oregon Educators Benefit Board held a regular meeting on July 7, 2015, at the DAS General Services Building, 1225 Ferry Street SE, in Salem, Oregon. Chair Rick Shidaker called the meeting to order at 1:00 p.m.

Attendees

Board Members:

Nancy MacMorris-Adix, Chair
Cherie Maas-Anderson, Vice Chair
Geoff Brown
Heather Cordie (via phone)
Dave Fiore
Ron Gallinat
JJ Scofield
Jaimie Sorenson
Holly Spruance

Board Members Absent:

Bob Stewart
Rick Shidaker

Guests:

Paul Tyo, RBH
Megan Myrick, Willamette Dental
Sophary Sturdevant, Kaiser Permanente
Keith Backman, Kaiser Permanente
Andrea Lindsay, Standard
Ginger Anderson, Regence
Gordon Hoberg, Moda
Courtney Burke, Moda
Robin Richardson, Moda



I. Welcome and Introduction of New Board Members - Video Recording 0:0:22

Chair Nancy MacMorris-Adix introduced the new OEBB Board members, **Geoff Brown** and **JJ Scofield**.

Paul Tyo, Reliant Behavioral Health, addressed the Board regarding Reliant Behavioral Health's critical incident response for the students and staff at Umpqua Community College regarding the incident that occurred on October 1, 2015.

II. **Welcome and Approval of July 7, 2015, and August 21, 2015, meeting synopses (Attachments 1a and 1b) – Video Recording 0:12:20**

MOTION - Video Recording 0:12:35

Ron Gallinat moved to accept the July 7 and August 21, 2015, Board meeting synopses. Cherie Maas Anderson seconded the motion. The motion carried 8 - 0.

III. **Overview of 2015 Open Enrollment Activities and Next Steps – Video Recording 0:13:12**

Denise Hall presented an overview of the 2015 Open Enrollment period. This was a mandatory open enrollment. More detailed data will be presented to the Board at the December 2015, meeting.

IV. **Strategies on Evidence and Outcomes Workgroup (SEOW) Update & Recommendation for Enhanced/Clarified Preventive Colon Cancer Benefit (Exhibit A)- Video Recording 0:20:17**

Nancy MacMorris-Adix presented an update on the Strategies on Evidence and Outcomes Workgroup.

Kim Hickman presented information on coverage on colorectal cancer screening.

MOTION - Video Recording 0:41:54

Ron Gallinat moved to accept the recommendation of the SEOW committee and consultants to align the coverage criteria for colorectal cancer screenings at the preventive level between Moda and Kaiser. Jaimie Sorenson seconded the motion. The motion carried 8 - 0.

V. **Administrative Rules – Video Recording 00:42:41**

Heidi Williams presented Division 30 – Plan Design Development and Selection (Bronze Medical Plan Offering) and requested to file Division 30 as a permanent rule

MOTION – Video Recording 0:45:04: Ron Gallinat moved to file Division 30 as a permanent rule with the Secretary of State. Jaimie Sorenson seconded the motion. The motion carried 8 - 0.

VI. Administrative Review Committee (ARC) Update – Video Recording 0:55:38

Ron Gallinat presented information on two appeals that recently came before the Administrative Review Committee.

VII. OEBB Director Recruitment Status Update & Refresher on Recruitment Plan Timelines Approved in August (Attachment 3) – Video Recording 1:03:12

Ben Milner, DHS HR provided an update on the recruitment for the OEBB Director position.

VIII. 2015-16 Proposed Schedule, Committee Assignments and Work Plan for Board (Attachment 4a, 4b & 4c) – Video Recording 1:14:43

Chair Nancy MacMorris-Adix assigned Geoff Brown to the SEOW.

Denise Hall reviewed the upcoming Board calendar for 2015 –2016 and the Board Work Plan for October 2015 through April 2016.

IX. Other Business/Board Roundtable

Dave Fiore asked questions regarding the ACA to the Towers Watson. Towers Watson will include the answers to his questions in the ACA update at a future Board meeting.

Jaimie Sorenson suggested that a portion of a Board meeting to a discussion on the Bronze Plan.

Chair Nancy MacMorris-Adix read a proclamation acknowledging Denise Hall for her dedication and work for OEBB for the past 8 years.

X. General Public Comment

There being no further business to come before the Board, Chair MacMorris-Adix adjourned the meeting at a 2:45

SECTION B-1: ADMINISTRATIVE SERVICES QUESTIONNAIRE

1.1 Company Background

1.1.1.a Indicate the type of proposal you are submitting:
(check box)

- Medical, Integrated Pharmacy, Vision
- Medical, Integrated Pharmacy
- Medical, OPDP Pharmacy, Vision
- Medical, OPDP Pharmacy
- Vision Only
- OPDP Pharmacy only

1.1.1.b. If applying for medical (with or without Vision and Pharmacy), please indicate whether your organization is applying as: (check box)

- Statewide PPO
- Regional PPO
- CCM
- HMO

1.1.2 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>

1.1.3 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

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

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

1.1.6 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]

1.1.7 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]

1.1.8 For any subcontracted service, do you hold the subcontractor to the same standards for Member Services, Access to care and Claims Payment?
[100 words]

1.1.9 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			

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

	Year your company began providing these services	Number of employer clients with over 100 employees	Number of employer clients with over 10,000 employees	Number of members covered under a commercially insured product (employers with 100 or more employees)
Medical (including behavior health,	<i>Decimal.</i>	<i>Decimal.</i>	<i>Decimal.</i>	<i>Decimal.</i>

addiction services and alternative care)				
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>

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

1.1.12 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 Manager	Medical Director	Pharmacist	Implement Manager	Member Services Supervisor	Claims Team Supervisor or OEBC staff contact	Membership Accounting or Financial Supervisor
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 your proposed implementation project plan for OEGB 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 Confirm that an implementation manager and support team will be assigned to lead and coordinate the implementation activities with OEGB. Describe the support team.

Yes, Explain

No, Explain

1.2.6 Will the implementation project manager (PM) be dedicated to the OEGB implementation?

Yes

No, Explain

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

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

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

- You will consider services that have been prior-authorized by OEGB's current vendors but not completed as of the effective date to be pre-authorized under your proposed plan(s).
- You will provide pre-enrollment materials to OEGB members at no additional fee/expense
- You will have a customer service line available to OEGB members X days prior to the effective date.

1.2.9 Describe how you plan to staff and train the assigned OEGB team members (claims, customer service, account management) to handle the onboarding of up to 150,000 members all at once?

[500 words]

1.3 Member Services

1.3.1 Describe how your member service philosophy aligns with OEGB goals and the Triple Aim and the ways the organization carries out this philosophy.

[500 words]

1.3.2 Confirm that the proposed member services team for OEGB will handle each service you are proposing. If not, please indicate who will be. Describe any instances where calls are accepted by the proposed OEGB member services team, but are transferred to another service team for any reason.

	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			

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

	Medical	Pharmacy	Vision
Member Services Location(s)			
Dedicated unit (Only calls for OEGB will be serviced)			
Designated unit (Only calls for OEGB and specified other Accounts will be serviced)			
Not a Dedicated or Designated unit			
Number of member service representatives at each location			
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?			

1.3.4 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 hours from 7:30 a.m.– 5:30 p.m. Monday – Friday PST?**

	Medical	Pharmacy	Vision
No IVR used. All calls answered by a Live person during regular 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"/>

1.3.5 Call Documentation and Tracking System:

	Response
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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?	

1.3.6 Do claims and member services staff have access to the same systems?

- Yes
- No

1.3.7 Explain how your proposed member services unit supports non-English speaking Members? List the languages that are supported.

250 words

1.3.8 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)

1.3.9 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:

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

		Medical	Pharmacy	Vision
1	What was the Average Phone Response Time in seconds			
2	What was your average turnaround time for ID cards? (Defined as the average number of business days between acceptance of a data file and 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?			

1.3.11 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						
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1.3.12 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.

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

		Toll-free Number	Email	Mobile 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			

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

- Yes: Average Response Time: _____
- No

[500 words]

1.3.15 Do you have a member chat function on your member portal? If yes, describe how it is staffed and what quality assurance procedures are in place to ensure accurate communication with the member. What other technologies are available to members to receive assistance?

Yes: [100 words] ,

No

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

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

1.4.6 Describe the member ID transfer process to an external vendor such as mental health, substance abuse, weight management or wellness program or a PBM. Include what assurances are incorporated for timeliness and accuracy.

[100 words]

1.4.7. Confirm that you can provide the following: Check each one that applies.

1	Send administration invoices to OEBC within 30 days after the last day of the month.	Yes, can currently provide	Will be able to provide as of 10/ 2016	No Cannot provide
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2	<p>Send supporting documentation in Excel format listed on one row as follows:</p> <ul style="list-style-type: none"> i. Eligible Employee Name; ii. OEGB E-Number (Eligible Employee ID); iii. Entity Name (Group ID); iv. Entity Number (Class ID); v. Employee Type (Class Description); and, vi. Carrier Premium amount by coverage for period of coverage 			
3	<p>Establish a reconciliation and audit process for Carrier Premium payments that accurately reflects eligibility information provided by OEGB.</p>			
4	<p>Ensure the monthly eligibility information in the Contractor's computer systems and databases matches the OEGB eligibility information as transmitted</p>			
5	<p>Submit an additional report "Unresolved Discrepancy Report" listing any unresolved discrepancies discovered by Contractor's reconciliation of the OEGB "Carrier Report" and "Retroactive Adjustment Repo</p>			
6	<p>The "Unresolved Discrepancy Report" must contain the following on one row in Excel format:</p> <ul style="list-style-type: none"> i. Member Name; ii. OEGB E-Number; iii. Entity Name (Group ID); iv. Entity Number (Class Description); v. Member Type (Subgroup); vi. Coverage; vii. Type of Plan; viii. Carrier Premium Amount by plan; ix. Period of coverage; and, x. Description of the discrepancy. 			
7	<p>Contractor shall accept payment via electronic fund transfer (EFT) and allow OEGB twenty-one (21) days from start of coverage month to collect OEGB Premiums, reconcile funds to eligibility files and generate payment to the Contractor.</p>			
8	<p>Contractor shall provide a secure electronic transmission of Carrier Premium billing in Excel format that provides the capability to review data at Member level; and a reporting system offering electronic based financial reports or an online reporting system offering internet based financial reporting for purposes of generating quarterly and annual financial reporting statements</p>			

1.5 Claims Processing

1.5.1 Describe the proposed claims team structure. Are claims processing teams separate from the member services team? Or do claims processors also answer member calls?

1.5.2 Confirm that the claims processing team proposed for OEGB will handle each service you are proposing- Medical, Pharmacy, Vision. If not, please indicate who will be.

1.5.3 Respond to the following table regarding claims processing team structure:

	Response
Designated or dedicated to OEGB?	
# 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	

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

	Medical		Vision	
	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				

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

	Medical	Pharmacy	Vision
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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			

1.5.6 Do you have a disaster recovery plan for claim operations? Has it been tested or implemented?

- Yes, Explain
- No, Explain

1.5.7 Do you have a business continuity plan for claim operations? Has it been tested or implemented?

- Yes, Explain
- No, Explain

1.5.8 What percentage of claims were automatically adjudicated (no manual intervention of any kind) by your system?

Percent Medical – 2014 ___%
Percent Pharmacy – 2014 ___%
Percent Vision – 2014 ___%

1.5.9 Overall, what percentage of all claims processed are subject to a random internal audit review?

Percentage-2014___%

1.5.10 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 (if applicable)
- None

1.5.11 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]

1.5.12 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	Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- 1.5.13 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	Vision			

- 1.5.14 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]

- 1.5.15 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.

- 1.5.16 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]

- 1.5.17 Provide an overview of your internal audit procedures to safeguard against fraud or billing irregularities.
[500 words].

- 1.5.18 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].

- 1.5.19 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 vendor partners to 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 OEBB.

- 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 Please confirm your ability to generate PPACA compliant SBCs, including the integration of plan data for carve-out vendors (e.g., pharmacy).

Confirm

Not Confirm, Explain

1.6.4 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		
Member satisfaction		
Other		

1.6.6 Describe your plan's philosophy, approach and actions which demonstrate how members' healthcare needs are a high priority. [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 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"/>

1.6.12 Does your plan combine projected price information to provide members’ with access to information about the price of services, benefit design, deductibles, coinsurance, etc. on your website? Please explain.

Yes, describe [500 words]

No, describe [500 words]

1.6.13 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 OEGBB '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"/>

1.6.14 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			
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"/>

1.6.15 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				

1.6.16 Confirm that you will agree to provide OEGBB 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]

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

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

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

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

1.6.20 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

1.6.21 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 – OEGB member portal
<input type="checkbox"/>	Open Enrollment materials

1.6.22 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 OEGB Members?

1.6.23 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

[500 words]

1.7 Technology Capabilities

1.7.1 Can you accommodate the use of OEGB'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 OEGB achieving its vision.
[500 words]

1.7.3 Which of the following services are currently available through your website for all proposed coverages (Medical, Pharmacy, Vision)? 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>	
Submit electronic prior-authorization and referral requests?	<i>Yes/No</i>	
Submit electronic claims?	<i>Yes/No</i>	
Check claims status online and/or electronically	<i>Yes/No</i>	
Respond to member questions?	<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>	
Medical Vendors Only		
Input virtual medical records for their patients?	<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>	
Access to other tests results (e.g. reports on x-ray. MRI, Cats Scans) and other prescribed items?	<i>Yes/No</i>	
Confirm Members can:		
Complete Health Assessment 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 Confirm that Proposer's Disaster Recovery Plan includes a section specific to IT security. Describe your data protection protocols including protections for data in transit and for data at rest within your systems.

Confirmed, Describe [250 words]

Not confirmed. Describe [50 words]

1.8.5 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]

1.8.6 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 OEBC population. 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 standard monthly, quarterly, semi-annual and annual Financial Reports in Part D, Attachment 10.

- Confirmed,
- Not confirmed.

1.10 Performance Guarantees

OEBB 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, OEBB expects your commitment to providing Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results for OEBB members. If your enrolled OEBB member population is less than 100, you may use overall book of business results. 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 OEBB Members using a mutually-agreeable instrument.

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

1.10.2 Confirm that you agree to allow OEBB to audit your reported performance guarantee results, including an independent or mutually agreed upon third-party audit if requested by OEBB. 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]

SECTION B-2: 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 initiatives not yet included in OEBB's 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.
[500 words]

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. How have you measured the results of these innovations?
[1000 words]

2.1.4 How does the plan make cost and quality information available to Members? Please be sure to address the following in your response:

- 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 procedure and service 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]

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 2015	Number of PCP's** in 2015	Number of PCP's ** in PCPCH as of 4/2016
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 2015	Number of PCP's** 2015	Number of PCP's ** in PCPCH as of 4/2016
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. Outside Oregon, these types of service settings may be known as Medical Homes.

** **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 For the Plans proposed in this RFP, what percentage of the Providers in your 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 For the plans proposed in this RFP, what percentage of Members in Oregon were 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 practicing in PCPCHs and provide an annual report showing your 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 and provide an annual report showing your 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 and provide an annual report showing your progress?

- 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 and provide an annual report showing your progress? 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.

[500 words]

2.2.10 Describe how Providers participating in your Plan support 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?

[250 words]

2.2.13 Describe how your Plan ensures translators are available in the medical offices or other care locations for non-English speaking OEGB Members.
[250 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 (PCPH) or other Primary Care Providers (PCP). Please include samples of patient communications in Section D. Attachment 10.
[250 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.) through direct integration at the plan level or at the PCPH/provider level.
[250 words]

2.3 Improving Health Outcomes

OEGB seeks to improve outcomes for Members with chronic conditions. Toward this goal, OEGB 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, high blood pressure, high cholesterol, heart disease, depression, osteoporosis 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 as directed by OEGB.
[250 words]

2.3.2 OEGB’s current Plan Designs promote care for many conditions with no barriers/cost sharing. 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. 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.
[500 words]

2.3.3 OEGB is dedicated to seeing measureable achievements in the following areas: reducing tobacco use and obesity rates, increasing screening for depression, substance abuse and other addictions, and increasing physical activity rates. OEGB expects Plans to make their best efforts to increase Member 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 rates	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.						
Confirm your agreement to adhere to specific targets for improved outcomes in these areas. OEBC expects Contractor partners to commit to guarantees related to achieving certain levels of improvement in key health outcomes.						

2.3.4 Confirm your Plan’s willingness to work with OEBC and other OEBC vendors to identify and support statewide efforts to identify and implement consistent evidence-based clinical guidelines for major conditions and promote these with your 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 success in linking adherence to clinical guidelines to Provider payment incentives. Describe the success your plan has achieved resulting from these efforts.

[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 care, renal failure, orthopedics and perinatal/maternity care.

[1000 words]

2.3.9 Describe your Plan’s success with reducing preventable hospital admissions and readmissions. Include reduction strategies, how performance is tracked and monitored how you report results on reduced hospitalizations.

[500 words]

2.3.10 Describe the approaches your Plan uses to identify high-utilizers and provide enhanced care management, to these Members. Describe what specific steps you will take to further these approaches for OEBC 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) including Telemedicine, nurse lines, etc. Describe the success of these programs within your plan and how you empower Providers to provide the right care to the right people at the right time.

[500 words]

2.3.12 Provide specific examples that describe how your Plan has coordinated care management activities with employers' short-term and long-term disability vendors, 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 educate and engage Members in general and individually with specific health and wellness tools and programs,

[500 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 OEBC Members would directly benefit.

[250 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. Describe any reference based pricing benefits you have implemented, your communication of the program to members and providers, and the results of program. 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 [250 words]

No: Explain [250 words]

2.4.3 Indicate whether your Plan has experience in administering a program to address preference sensitive procedures. For example, a higher copayment/cost sharing for certain preference sensitive procedures (knee arthroscopies, spine surgeries). Describe the program you have implemented, the procedures you have targeted, your communication of the program to Members and providers, and the results of the program.

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 [250 words]

No: Explain [250 words]

2.4.5 Describe 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]

2.4.6 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]

2.4.7 Describe how your Plan engages Providers in issues related to Member satisfaction, Member engagement and access to care. Be sure to describe how training and technical support for these tools is shared with Providers.
[500 words]

2.4.8 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 Confirm that you have an online Personal Health Assessment (PHA) that will be available to OEGB Members and that you can provide reporting to OEGB on Members/spouses who have completed the PHA. Please identify which Personal Health Assessment Questionnaire you use in your description or explanation below?

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

2.5.2 Describe how you report aggregate results of the PHA to OEGB and how you provide feedback and direction to Members on their specific results.
[250 words]

2.5.3 Describe the wellness services that are included in your proposal as well as any additional wellness program offerings you would like OEGB to consider.
[500 words]

2.5.4 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 wellness programs in the future.
[500 words]

2.5.5 Describe your Plan's strategies to encourage Members to have age-appropriate preventive screenings based on the USPSTF recommendations. How do you measure the success of these strategies?
[500 words]

2.5.6 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).

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

2.5.7 Indicate whether your Plan's online PHA is customizable. Please provide a copy of your Personal Health Assessment Questionnaire & the 2015 Summary Report in Part D, Attachment 10.

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

2.5.8 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, included in the premium and requires program participants to 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
Confirm that your proposals include a statewide weight management program for OEGB Members and dependents. Describe the program elements, accessibility, and locations if applicable	
Program services are available at the worksite	
Program services include an online alternative during non-work hours	
Program services include local community resources and meetings	
No requirement that participants purchase products, such as special meals	
Program communications are approved by OEGB	
You will track and provide reports on claims costs for participants, over specified time	
Program incorporates Member's individual health and wellness goals	
You will track and provide reports on participation levels over specified time including unique Member counts	

2.5.9 OEGB has implemented several innovative benefits and programs aimed at supporting Member wellness and health improvement and intends to continue these programs as part of any new health offering. Confirm your ability to incorporate and administer these programs for each of the following:

	Response
Weight Watchers program	Yes/No
Living Well-a chronic disease self-management program	Yes/No
Healthy Team Healthy U: 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 (an on-line program for depression)	Yes/No

2.5.10 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]

2.5.11 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]

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

[500 words]

2.5.13 Confirm that your Plan will provide a dedicated wellness coordinator at no additional fee to coordinate with OEGB's wellness initiatives?

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

No: Explain [100 words]

2.5.14 Confirm that your proposed plan designs include a wellness visit (covered in full, with no cost to Members). A Wellness visit is a broad-based appointment with a Provider 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. (Note: this is separate from and in addition to federally required preventive care visits)

[500 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, 2016, what percentage of your network providers use federally certified Electronic Health Records (EHRs)?

Hospitals Percentage ___%

Labs: Percentage ___%

Non-Hospital Based Providers: Percentage ___%

2.6.2 Explain how your Provider 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. 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 Provider types, such as physicians, hospitals, etc.

[500 words]

2.6.6 Provide examples that illustrate how your organization has used Health Information Technology to advance quality of care or improved outcomes.

[500 words]

2.6.7 Describe your Plan's strategy and timeline for expanding meaningful use (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 Provide examples that illustrate how your organization supports 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 that your proposed plan includes for OEBB Members. 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 OEBB'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 proposed provider reimbursement arrangements include features that will drive transformation, reward improved outcomes and support the Triple Aim.

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)?

	Statewide PPO/HMO Network		Coordinated Care Model	
	Voluntary Turnover	Involuntary Turnover	Voluntary Turnover	Involuntary Turnover
2014	%	%	%	%
2015	%	%	%	%

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, 2018.
[500 words]

2.7.5 Are any of the networks proposed for OEGB 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 and how your organization believes it can comply with OEGB '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 OEGBs 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 or other more limited networks that support high quality, affordable care 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,		<i>Single, Pull-down list.</i> 1: In place,	

	2: Being developed, 3: No Plans to develop		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 other network limitations that support high quality, affordable care 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 of the application	○	○	○	○
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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 OEGB is penalized for physicians' referral practices:

2.7.14 Describe how your Plan manages the DME and other medical supplies and items without creating undue barriers for members to ensure their medical needs are met timely.
[500 words]

2.7.15 Describe how your Plan uses data to provide feedback to 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	PCPH	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 OEGB			
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

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	Hours of Operation during the week?	Hours of Operation after hours and on weekends

	appointment.		
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 Plan Year 2018-19 and beyond. OEBC 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 offering 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, Plan Year 2017-18.

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

No.	Measure	Measure Data Source: Claims, Medical Records / Charts, Surveys,	Currently Measure Yes/No	Willing to Negotiate PGs in the future? 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
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

No.	Measure	Measure Data Source: Claims, Medical Records / Charts, Surveys,	Currently Measure Yes/No	Willing to Negotiate PGs in the future? 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 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 Members 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 track 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?	Yes/No.
How often did your personal doctor spend enough time with you?	Yes/No.
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?	Yes/No.
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?	Yes/No.
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?	Yes/No.
Smoking Cessation	Comply
How often have you been advised to quit using tobacco by a provider in your health plan?	Yes/No.
How often have you been advised to quit using tobacco by a provider in your health plan? Medications recommended.	Yes/No.
How often have you been advised to quit using tobacco by a provider in your health plan? Strategies recommended.	Yes/No.
Aspirin Use	Comply
Do you take an aspirin daily? (qualified population)	Yes/No.
Has your provider discussed the benefits/risks of taking aspirin daily to avoid strokes?	Yes/No.
Flu Shots	Comply
Have you had a flu shot since September 1, 2013?	Yes/No.
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?	Yes/No.
Coordination of Care	Comply
How often did your personal doctor seem informed and up to date about the care you got from other providers?	Yes/No.

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. The first reporting year (2017-18) will establish a

baseline. The second reporting year (and thereafter) if Contractor does not score in the 75th HEDIS percentile for this measure, a performance improvement target of 10 (ten) percent reduction in the gap between the baseline score and benchmark will be established with a minimum improvement of 3 (three) percentage points depending on the size of the gap. Targets are calculated using the Minnesota method.

[250 words]

Chronic Conditions - Asthma	Contractor shall score in or above the Quality Compass National >75 th percentile in Medication Management for People with Asthma HEDIS measure.
Chronic Condition- Diabetes	Contractor shall score in the Quality Compass National >75 th percentile in HEDIS measure for HbA1c testing for members with diabetes
Chronic Condition- Diabetes	Contractor shall score in the Quality Compass National >75 th percentile in HEDIS for HBA1c poor control (HbA1c9) for members with diabetes
Chronic Condition- Diabetes	Contractor shall score in the Quality Compass National >75 th percentile in HEDIS measure for Eye Exams for members with diabetes
Chronic Condition- Diabetes	Contractor shall score in the Quality Compass National >75 th percentile in HEDIS Measure for medical attention for Nephropathy for members with diabetes
Chronic Conditions - Cancer	Contractor shall score in the Quality Compass National >75 th percentile in the HEDIS measure for Breast Cancer Screening
Chronic Conditions - Cancer	Contractor shall score in the Quality Compass National >75 th percentile in the HEDIS measure for Colorectal Cancer Screening
Immunizations	Contractor shall score in the Quality Compass National >75 th percentile in the HEDIS measure for Combo 10
Immunizations	Contractor shall score in the Quality Compass National >75 th percentile in the HEDIS measure for Adolescent Immunization
Weight Management	Contractor shall score in the Quality Compass National >75 th percentile in the HEDIS measure for Adult BMI Assessment
Weight Management	Contractor shall score in the Quality Compass National >75 th percentile in the HEDIS measures for Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (ages 2-17)

2.8.10 Indicate whether performance is measured, benchmarked, or reported on a client specific basis for any of the following: Also indicate whether you are able to offer Performance Guarantees for any of the following measures

	Measured	Reporting results with benchmarking	Reporting results to Providers	Public reporting	Willing to Guarantee?
a. Specialty Referral Rate	<i>Single, Pull-down list.</i> 1: Yes, 2: No, 3: Not tracked	<i>Yes</i> <i>No</i> <i>notes</i>			
b. Inpatient Admission Rate	<i>Single, Pull-down list.</i> 1: Yes, 2: No, 3: Not tracked				
c. Average Length of Stay	<i>Single, Pull-down list.</i> 1: Yes, 2: No, 3: Not tracked				
d. Emergency Room Visits	<i>Single, Pull-down list.</i> 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)	Single, Pull-down list. 1: Yes, 2: No, 3: Not tracked				
i. IT Capacity (use of e-health visits, etc.)	Single, Pull-down list. 1: Yes, 2: No, 3: Not tracked				
Comments	50 words. Nothing required				

2.9 Case Management and Care 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 Provide a brief overview of the unique attributes of the disease and chronic condition management programs that are included in the proposed plans. Be sure to include any policies or programs 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 commercial population (non-Medicare/Medicaid) 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 included in proposal	Number of Members identified for management	Percent of Members who have a care plan that has been created or updated in the past 12 months.
Arthritis	Yes/No.	###	%

Asthma	<i>Yes/No.</i>	###	%
Cancer			
Chronic pain management	<i>Yes/No.</i>	###	%
Congestive heart failure	<i>Yes/No.</i>	###	%
Chronic obstructive pulmonary disease (COPD)	<i>Yes/No.</i>	###	%
Coronary artery disease (CAD)	<i>Yes/No.</i>	###	%
Depression	<i>Yes/No.</i>	###	%
Diabetes	<i>Yes/No.</i>	###	%
Renal disease	<i>Yes/No.</i>	###	%
Hyperlipidemia	<i>Yes/No.</i>	###	%
Hypertension	<i>Yes/No.</i>	###	%
Musculoskeletal (including back pain)	<i>Yes/No.</i>	###	%
Obesity	<i>Yes/No.</i>	###	%
HIV	<i>Yes/No.</i>	###	%
Multiple Sclerosis	<i>Yes/No.</i>	###	%
Others (Describe)	<i>Yes/No.</i>	###	%

2.9.4 Are you willing to offer any performance guarantees on achieving target ROI for specific disease management programs? If so, describe.

2.9.5 Describe the ways in which Members are identified for your Care Management and Care Management Programs, including your strategies and criteria for risk stratification
Be sure to include the percent of Members who were identified as potentially appropriate for both Case and Care Management in 2015 and of those identified, the percent of Members who were actively involved in Case and Care Management Programs in 2015.
[500 words]

2.9.6 Describe the staffing model for both the Case and Care Management Program's. Indicate whether you contract with an outside vendor or use internal staff for the programs. Include their location, hours of operation, and professional credentials as well as the ratio of nurses to Members in Case and Care Management.
[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.

	Documented Return on Investment	Supportive Data (if lengthy can be added to the attachments Section in Section D #10)
--	---------------------------------	---

Arthritis		
Asthma		
Cancer		
Chronic pain management		
Congestive heart failure		
Chronic obstructive pulmonary disease (COPD)		
Coronary artery disease (CAD)		
Depression		
Diabetes		
Renal disease		
Hyperlipidemia		
Hypertension		
Musculoskeletal (including back pain)		
Obesity		
HIV		
Multiple Sclerosis		
Others (Describe)		

2.9.8 Describe how Care Management Program staff coordinate with and support the work of Providers directly caring for Members with chronic conditions. 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.

[500 words]

2.9.9 Describe how your Plan integrates medical, disease management and wellness data with the clinical programs your organization offers to support or improve members' health?

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 reviews pharmacy data, including specialty pharmacy data, to assist Disease Management program staff in proactively engaging both Members chronic conditions and their treating Providers. Include specific example for the following conditions: rheumatoid arthritis, multiple sclerosis, hemophilia, HIV and renal failure in your response.

[500 words]

2.10 Utilization and Case Management Programs

The Board is seeking health plan partners who have developed unique programs and approaches in addition to standard Utilization and Case Management programs.

2.10.1 Confirm that penalties for failure to prior authorize services for in-network services are the Provider’s responsibility.

Confirm

Not confirm, Explain

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

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

	Do you utilize?	Response [100 words each]
Percentage of eligible participants who received pre-admission counseling	Yes/No.	
Percentage of services/procedures denied for pre-certification	Yes/No.	
Percentage of procedures that are denied for payment in the prior-authorization process	Yes/No.	
Percentage of eligible participants who received post-discharge counseling	Yes/No.	
Percentage of eligible participants who were transitioned to active Case Management	Yes/No.	
Percentage of eligible participants who were transitioned to other health management programs (health	Yes/No.	

coaching, behavioral management)		
Other	Yes/No.	

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. How will care be transitioned for OEBC Members that are currently receiving care for services at practitioners or facilities that are not in your proposed network. Describe the proposed approach for the initial implementation of OEBC Members as well as ongoing new Member transition of care events.

[500 words]

2.10.8 Does your Plan provide utilization profile reports to individual practitioners, group practitioners, or hospitals on the parameters listed below? 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"/>

2.10.9 Provide an overview of 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]

2.10.10 A. Provide the percentage of commercial, Medicare and Medicaid Members identified as potentially appropriate for Case Management in 2015. B. Of those identified in each category, provide the percentage of Members who were actively case-managed in 2015.

	Commercial	Medicare	Medicaid
A: Percentage identified as appropriate for Case management			

B. Percentage who were actively case managed			
--	--	--	--

2.10.11 Is your Plan accredited by URAC and/or NCQA? If “yes” specify the specific programs that have received accreditation (e.g. Utilization Management, Case Management, Care Management)

Yes [500 words]

No [100 words]

2.10.12 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]

2.10.13 Does your Plan monitor and improve patient compliance with prescribed drug therapy? If “Yes,” describe how your Plan program works to improve 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

2.11 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 Is your organization NCQA accredited? If not, by when do you anticipate obtaining your accreditation?

Yes

No, Anticipated Accreditation date:

2.11.2 Confirm your Plan provides data to and receives reports from the Oregon Healthcare Quality Corporation (OHQC) to measure quality of care in Oregon and promote use of evidence-based guidelines

Yes, If yes, include your organization’s requirements for provider participation in OHQC’s collaborative quality initiatives.

No, If No explain why you do not submit data to OHQC

[500 words]

2.11.3 Confirm your Plan ensures patient safety through your provider and facility contracts and policies by including a requirement for them to participate in the Patient Safety Commission’s work.

Yes, If yes, include your organization’s requirements for provider participation in the Patient Safety Commission.

No, If No explain why you do not submit data to OHQC

[500 words]

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

[1000 words]

2.11.5 Explain how you measure provider and facility quality and support improvement. [1000 words]

2.11.6 Do you have a procedure for monitoring and responding to provider sanctions and complaints?
Yes, describe [500 words]
No

2.12 Benefit Design

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

2.12.1 Provide specific examples that demonstrate your Plan’s flexibility and innovative responses to addressing the needs of your clients . Identify limitations as well.
[500 words]

2.12.2 OEBB expects your Plan’s claims 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.

Services (see Definitions)	Your Experience in administering this benefit [100 words]	Your ability to administer this benefit for OEBB [100 words]
Additional Cost Tier		
Wellness Visit		
Preventive Care		
Chronic Condition Visits to a PCPCH		

2.12.3 Confirm that your proposed plan designs EXACTLY match the plan designs requested in Exhibit 3.

Confirmed,

Not confirmed, identify discrepancies [500 words] 2.12.4 Confirm that you can administer all requested OEBB plan deductibles, Carryovers, Maximum Out of Pocket Limits and benefit accumulators on an OEBB plan year basis: October 1- September 30.

Confirmed,

Not confirmed, identify discrepancies [100 words] 2.12.5 Confirm that you are able to administer a qualified High Deductible Health Plan and that pharmacy claims accumulate to the deductible and maximum out of pocket amounts.

Confirmed, Describe the frequency with which pharmacy claims are applied to the medical deductibles/maximum out of pocket limits (daily, weekly). [100 words]

Not confirmed, identify discrepancies [100 words]

2.12.6 Confirm your willingness to work with OEBC on mid-year benefit changes as needed.

- Confirmed,
 Not confirmed, identify inabilities [100 word]

2.12.7 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]

2.12.8 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.

[500 words]

2.13 Cost & Quality Transparency

2.13.1 Describe your Cost Transparency tools that educate Members on both the total cost and the Member's share of cost of certain treatments, procedures and provider visits. Do your cost transparency tools reflect regional averages or do they reflect your Plan's specific contracted rates for providers?

[500 words]

2.13.2 What is the source of your pricing and quality data, and how frequently is each data source updated?

200 words.

2.13.3 Are you able to incorporate Member-specific accumulators (cost-sharing and health account balances) into the pricing results?

1: Yes,

2: No, please explain: [100 words]

2.13.4 For which procedures do you have adequate data to support cost and quality information for Reference-based pricing, use of COE's, or other network limitations or exceptions?

[200 words]

2.13.5 For what procedures/services do you provide quality data through the Member self-service tool?

500 words.

2.13.6 Are quality measures communicated to Members for both individual providers and facilities?

1: Yes,

2: No, please explain: [100 words]

2.13.7 Describe your interactive decision support tools (internet, mobile app) that help Members compare treatment options

250 words

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

2.14 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 around \$xxx million for the 20XX-XX Plan Year and the Governor's Budget limits OEGB cost growth starting in the 2015-16 plan year, holding per Member cost increases to 3.4 percent.

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

	Response [500 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	

2.14.2 If your Plan's current payment methodologies do not promote the Triple Aim (i.e., include elements noted in the table above) but are expected to in the future, please describe your initiatives and the proposed timeline for implementation. [500 words]

2.14.3 For each of the payment methodologies used by your plan (as indicated in 2.14.1), describe the methodology used to measure financial impact and Return on Investment (ROI). Indicate how this is determined for both prospective savings and retrospective performance evaluation. (200 words per methodology)

2.14.4 For each of the payment methodologies used by your plan (as indicated in 2.14.1), please provide the most recent assessment of the financial impact, clinical outcomes and quality improvement achieved.(200 words per methodology)

2.14.5 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]

2.14.6 What new payment methodologies have you developed to support the integration of behavioral and physical health?
[500 words]

2.15.5 Administration

2.15.1 Describe your success in auditing do not pay (never) events.
[100 words]

1.15.2 What percent of recoveries was retained for administration in 2014? Include subrogation and overpayments.
[Percentage-2014 __%]

2.15.3. Confirm that your proposal includes claim fiduciary services.
 Confirmed,
 Not confirmed, explain: [100 words]

2.15.4 What kind of support is available to Members requiring care out of state but within the US? How are those claims administered?
[500 words]

2.15.5 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]

2.16 Questions for CCMs ONLY:

2.16.1 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]

2.16.2 How do you ensure that the Member can adequately access the PCP/PC team within their assigned PCPCH?"
[100 words]

2.16.3 Describe how physical and behavioral health providers for Members with both physical and behavioral health issues coordinate Care Management. Do providers utilize a single care management plan and if so, how is that developed and shared between the providers? Describe your role, if any, in the development or management of this plan including a description of any contractual requirements, oversight, systems, technical support, role of care coordinators and/or patient navigators, etc.
[500 words]

SECTION B-3: Pharmacy Benefit Management Questionnaire

3.0 Pharmacy Definitions

These definitions apply to all questions, grids and other requests in this RFP. Unless noted otherwise, these definitions will be included as part of OEGB's contract should you be selected as the ASP.

Please confirm your agreement with the below definitions. Succinctly explain any deviations.

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 OEGB and such source will be mutually agreed upon by Proposer and OEGB. 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.

Single, Radio group.

- 1: Agree to meet,
- 2: Do not agree to meet. Explain deviations: [50 words]

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.

Single, Radio group.

- 1: Agree to meet,
- 2: Do not agree to meet. Explain deviations: [50 words]

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.

Single, Radio group.

- 1: Agree to meet,
- 2: Do not agree to meet. Explain deviations: [50 words]

3.0.4 Dispensing Fee means an amount paid to a pharmacy for providing professional services necessary to dispense medication to a Member.

Single, Radio group.

- 1: Agree to meet,
- 2: Do not agree to meet. Explain deviations: [50 words]

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.

Single, Radio group.

- 1: Agree to meet,
- 2: Do not agree to meet. Explain deviations: [50 words]

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).

Single, Radio group.

- 1: Agree to meet,
- 2: Do not agree to meet. Explain deviations: [50 words]

3.0.7 **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.

Single, Radio group.

- 1: Agree to meet,
- 2: Do not agree to meet. Explain deviations: [50 words]

3.0.8 **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.

3.0.9 **Multi-Source** means a legend drug or OTC that is manufactured by more than one labeler.

Single, Radio group.

- 1: Agree to meet,
- 2: Do not agree to meet. Explain deviations: [50 words]

3.0.10 **Multi-source Brand Drugs**-A brand drug that has part but not all of its patent removed.

3.0.11 **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.

3.0.12 **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.

Single, Radio group.

- 1: Agree to meet,
- 2: Do not agree to meet. Explain deviations: [50 words]

3.0.13 **Single-Source** means a legend drug manufactured by one labeler.

Single, Radio group.

- 1: Agree to meet,
- 2: Do not agree to meet. Explain deviations: [50 words]

3.0.14 **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.

Single, Radio group.

- 1: Agree to meet,
- 2: Do not agree to meet. Explain deviations: [50 words]

3.0.15 **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.

Single, Radio group.

- 1: Agree to meet,
- 2: Do not agree to meet. Explain deviations: [50 words]

3.0.16 **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 under this Program Agreement 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 "yes" or "no" as to your organization's ability to comply. Any Proposer not complying with the requested bid specifications may be eliminated from this RFP process. **Please review the Definitions in 3.0 above before responding to the Pharmacy Questionnaire.**

Proposer agrees to the following:

3.1.1 Confirm that all Definitions above apply to all questions, grids, pricing proposal and other responses your organization provided as part of this RFP. Confirm these definitions will be included as part of OEGB's contract should you be selected as the ASP.

Single, Radio group.

- 1: Confirmed,
- 2: Not Confirmed. Explain deviations: [50 words]

3.1.2 The 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]

3.1.3 To load all current prior authorizations, open mail order refills, specialty transfer files, and accumulator files that exist for current members from the existing Contractor 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]

3.1.4 To waive 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, bidirectional data integration, including non-standard data integration formats.

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed, explain: [50 words]

3.1.5 To provide monthly data transmissions (may include feeds to data warehouses) to OEBC'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]

3.1.6 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 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 That 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 That 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 That 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 That Proposer 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 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 To 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 To notify OEBC at least 90 days in advance regarding termination of a current pharmacy chain or in

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed, explain: [50 words]

3.1.17 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 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 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 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 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 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 Bidder agrees that upon termination of the contract, to 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>	[100 words] Nothing required

	1: Yes, 2: No	
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 Please provide the following general information on your clients 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>

3.2.4 Are you able to coordinate with current PBM or OPDP to issue a single ID card? If so, with which vendors have you successfully integrated?

Single, Radio group.

1: Yes,

2: No, please explain [50 words]

3.3 Transition/Implementation

3.3.1 Provide a description of how existing mail order members would be transitioned over 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?

[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 Do you send targeted member letters that identify areas of savings opportunities? What is 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 Does your website have the capability to allow physicians to:

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	<i>Single, Radio group.</i> 1: Yes, 2: No, please explain	100 words.

3.4.3 What online and mobile device capabilities are available to members? Provide the URL, app name

	Website	Mobile Device	Comments
a. URL/Mobile App Name	<i>Yes/No.</i>	<i>Yes/No.</i>	50 words.
b. Mail Service order status check	<i>Yes/No.</i>	<i>Yes/No.</i>	50 words.
c. Medication profile	<i>Yes/No.</i>	<i>Yes/No.</i>	50 words.
d. Pricing: Retail	<i>Yes/No.</i>	<i>Yes/No.</i>	50 words.
e. Pricing: Mail	<i>Yes/No.</i>	<i>Yes/No.</i>	50 words.
f. Pricing: Specialty	<i>Yes/No.</i>	<i>Yes/No.</i>	50 words.

g. Alternative drugs within a therapeutic class	<i>Yes/No.</i>	<i>Yes/No.</i>	<i>50 words.</i>
h. Pharmacy locator	<i>Yes/No.</i>	<i>Yes/No.</i>	<i>50 words.</i>
i. EOB	<i>Yes/No.</i>	<i>Yes/No.</i>	<i>50 words.</i>
j. Specialty Drug services	<i>Yes/No.</i>	<i>Yes/No.</i>	<i>50 words.</i>
k. Summary Cost Statement (e.g., FSA)	<i>Yes/No.</i>	<i>Yes/No.</i>	<i>50 words.</i>
l. Drug pricing information at different retailers within the Rx network	<i>Yes/No.</i>	<i>Yes/No.</i>	<i>50 words.</i>
m. Drug pricing information at the same retailers within the Rx network (e.g., different locations of the same chain)	<i>Yes/No.</i>	<i>Yes/No.</i>	<i>50 words.</i>
n. Pricing information for the cost of injectable products	<i>Yes/No.</i>	<i>Yes/No.</i>	<i>50 words.</i>

3.4.4 How do you communicate your formulary list and formulary updates, specifically formulary deletions, to prescribers, and members? (Check all that apply)

	Response	Other (explain)
a. To Prescribers	<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
c. To OEBC	<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
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?
[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 at mail when a generic is available? If yes, what discount is applied?

250 words

3.4.9 Which of the following services are currently available through your website

Confirm Member can:	Check those that apply
Perform an OEBC-specific formulary search?	<input type="radio"/>
Perform an OEBC-specific formulary comparison (e.g., brand vs. generic)?	<input type="radio"/>
Track mail order status?	<input type="radio"/>
Track specialty pharmacy fills and status?	<input type="radio"/>
Search for a pharmacy, including mapping software?	<input type="radio"/>
Obtain drug pricing information?	<input type="radio"/>
Review and print personal drug profiles?	<input type="radio"/>

3.5 Plan Administration

3.5.1 OEBC is seeking a Contractor partner that is flexible and capable of facilitating changes, innovative design administration and capable of responding quickly to the requested changes, throughout the plan year. Provide examples on your capability that you have or can implement immediately to meet flexibility and administrative responsiveness.

[500 words]

3.5.2 What is the average turnaround time for programming standard plan design changes for clients similar to OEBC? Please include your definition of standard plan design changes and examples of plan design changes that would be considered non-standard.

[500 words]

3.5.3 Confirm your capability to administer the following benefit types. Indicate the percentage of Employers in your book of business that have implemented these types of approaches. Are there added costs for custom benefits? 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.)	Yes/No.	Yes/No.	100	100

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>
k. 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 payment from PBM and full reconciliation?

50 words

3.5.5 Confirm your willingness to work with OEGB on mid-year benefit changes as needed.

Single, Radio group.

1: Confirmed,

2: No, explain: [100 words]

3.5.6 Confirm that you will provide OEGB with full authority to "turn-off" any point-of-sale edits (e.g., quantity limit, step therapy) that OEGB does not want to implement or continue.

Single, Radio group.

1: Confirmed,

2: No, explain: [10 words]

3.5.7 Confirm that you will not automatically enroll OEGB in any programs that involve any type of communications with members or alterations of members' medications, without express written consent from OEGB.

Yes/No.

3.5.8 Briefly 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 OEGB 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 OEBB 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,
- 2: Not Attached

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	<i>10 words.</i>
# of participating independent pharmacies	<i>Decimal.</i>
# of participating chain pharmacies	<i>Decimal.</i>
Network description	<i>250.</i>
Chains excluded from the network	<i>100 words.</i>

3.6.3 Confirm that OEBB 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 you are proposing for OEBB. Provide prior year results.

	Mail Service Facility #1	Mail Service Facility #2	Mail Service Facility #3	Mail Service Facility #4
a. Location	<i>50</i>	<i>50</i>	<i>50.</i>	<i>50.</i>
b. Operating Hours	<i>50.</i>	<i>50.</i>	<i>50.</i>	<i>50.</i>
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	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>
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?	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>

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 Please 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 that 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 that 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 Briefly 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 facility is 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 pharmacy 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 their 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 that 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 that 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 facility you are proposing for OEBC. Provide prior year results.

250 Words

Complete the following table for your proposed specialty pharmacy facility:

	Specialty Facility #1	Specialty Facility #2	Specialty Facility #3	Specialty Facility #4
a. Name/Location	50	50.	50.	50.
b. Operating Hours	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	<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 OEBC?	<i>Total OEBC %</i>	<i>Total OEBC %</i>	<i>Total OEBC %</i>	<i>Total OEBC %</i>
h. What was the dispensing accuracy rate for 2013 and 2014, respectively?	<i>2013</i> <i>2014</i>	<i>2013</i> <i>2014</i>	<i>2013</i> <i>2014</i>	<i>2013</i> <i>2014</i>
i. What percentage of prescriptions shipped in 2014 were filled manually by a pharmacist or technician?	<i>Pharmacist</i> <i>Technician</i>	<i>Pharmacist</i> <i>Technician</i>	<i>Pharmacist</i> <i>Technician</i>	<i>Pharmacist</i> <i>Technician</i>

3.8.2 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].

3.8.3 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

3.8.4 Provide a description of how existing specialty drug patients would be transitioned over 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? How are those members taking these medications informed?

[500 words]

3.8.5 Are partial fill programs available for new starts? Do they target certain drugs? If yes, please provide the drugs that are targeted. Please let us know of additional programs of this or similar methodology that could be implemented in the future. If no, is there any intent to implement this type of program? Do you have the capability to implement this type of program?

[500 words]

3.8.6 Outside of simply cost, what are the criteria used to designate a prescription as a specialty medication for your program?

[500 words]

3.8.7 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 please describe your approach to capping inflation for these products, and what happens should inflation exceed these caps.

[500 words]

3.8.8 Confirm that 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

3.8.9 Does your organization offer Utilization Management or other programs to proactively address new specialty drugs entering the market? If so, please describe.

[250 words]

3.8.10 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]

3.8.11 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]

3.8.12 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]

3.8.13 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]

3.8.14 What is your standard day's supply for specialty products? Can OEBC customize the allowable day's supply up to 90 days?

[100 words]

3.8.15 Please confirm that auto refill is not a standard for specialty drugs refills.

Single, Radio group.

1: Agree to meet,

2: Do not agree to meet. Briefly 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. Please include formulary in Part D: Final Submission Documents, Section #10-Attachments and Checklists.

[500 words]

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 that 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 that you can match OEGB'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, please list.
[200 words]

3.9.7 Confirm that you agree that 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 that you agree that 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

3.9.9 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 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 other competitors in managing medication utilization, compliance, and outcomes.

[500 words]

3.10.2 Please describe any key initiatives your program will be launching or is implementing over the next two years, from a cost management and/or, clinical/care management perspective.

[500 words]

3.10.3 Confirm that OEGB 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 For the following conditions, please describe the programs included in your proposal to OEBC.

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, 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	.
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	.
Depression	<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	.

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	
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	
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	

3.10.4 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]

3.10.5 Describe how you integrate medical, disease management, and wellness data with the clinical programs your organization offers?

[500 words].

3.10.6 Which disease states/conditions are you able to offer clinical performance guarantees (medication possession ratio, gaps in care closures, etc.) for OEBC? Please 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

3.10.7 Do you have a program to monitor and improve patient compliance with prescribed drug therapy?

	Response
a. At retail	Unlimited.
b. At mail	Unlimited.
c. Brand name to generic	Unlimited.

3.10.8 Please explain your Prior Authorization (PA) and Standard Therapy (ST) denial process from the perspective of the member at both MAIL and RETAIL. Include standard turn-around-times for each.

[500 words]

3.10.9 Describe how compounded products are managed.

[500 words].

3.10.10 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]

3.10.11 Are certain compounds excluded or subject to prior authorization?

Single, Radio group.

1: Yes: [50 words],

2: No: [50 words]

3.10.12 How are compounded kits managed?

Single, Radio group.

- 1: Managed with Coverage: [100 words],
- 2: Managed with No Coverage [100 words],
- 3: Not Managed: [50 words]

3.10.13 Do you also account for compounds submitted under the medical benefit?

Single, Radio group.

- 1: Yes: [100 words],
- 2: No: [100 words]

3.10.14 Confirm that 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

Yes/No.

3.11 Data, Reporting and Analysis

3.11.1 What type of reports are included in your standard reporting package? Please upload a sample of your standard reporting package. **(ADD TO ATTACHMENTS LIST)**

[500 words]

Single, Pull-down list.

- 1: Attached,
- 2: Not Attached

3.11.2 Describe your standard process and turn-around time for ad hoc reporting requests.

[100 words]

3.11.3 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/employers.

[250 words]

3.11.4 Please describe your data protection protocols including protections for data in transit and for data at rest within your systems.

[250 words]

3.11.5 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 Do you share data with Truven Data Warehouse for other clients? If so, for how many clients? Are there any limitations placed on client data shared with data warehouse(s) or other entities? If so, please describe.

[100 words]

3.12.2 Please describe how you would work with OEBC's selected medical vendors in the following are

		Response (250 words each)
--	--	---------------------------

Disease Management and Gaps in Care	Describe how you will work with OEBC's selected medical vendors to coordinate Disease Management efforts including sharing file feeds and member engagement efforts	
Gaps in Care	Describe how you will share information and accept information from OEBC's medical and/or dental vendors to identify potential gaps in care. Describe how you will work with OEBC's vendors in efforts to close gaps in care	
Wellness Programs	Describe how you will share and accept information from OEBC's medical and wellness vendors. Will you agree to work with these vendors on wellness program initiatives?	
Compliance Monitoring	Describe how you will share and accept information from OEBC's medical vendors in order to increase medication compliance efforts.	

[500 words]

3.12.3 What member facing resources do you have that may be coordinated with OEBC's medical, wellness, and health management vendor?

[100 words]

3.12.4 Detail your experience coordinating with third party health management/wellness vendors to report outcomes and improve health-related measures relative to effective drug therapy management. What internal tools/resources (web portal, designated pharmacist, etc.) will you make available to external condition management vendor(s)? Please note any restrictions to and costs associated with these capabilities.

- a. Standard response time guidelines
- b. Notification of denial and appeal rights
- c. Qualifications for determining the need for pharmacist/physician review

[500 words]

3.13 Performance Requirements

3.13.1 OEBC expects your commitment to providing Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results for the overall business and if available, OEBC specifics. 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 OEBC Members using a mutually-agreeable instrument.

3.13.2 Confirm that you will be able to track and monitor pharmacy performance (i.e., generic dispensing, reversals, controlled substance dispensing, etc.) including Contractor's management of the network, providing performance reports upon request to OEBC

3.13.3 OEBC's intent is to have quality services for its Members, and would expect service level targets to be met. Performance Requirements will be finalized during the contracting process but these would be minimum

expectations. Please confirm you can meet the expectations for Pharmacy in **Part C-Attachment 4**. Review and respond to each of the requirements that pertain to Pharmacy (see below). Attach to final submission as requested.

- Section 1-Items 1-b,1-g, 1-i,1-j and 1-k
- Section 3 Items 3-o and 3-p
- Section 4 Item 4-g
- Section 8-Item 8-i

3.14 Patient Protection and Affordable Care Act - Pharmacy Benefits

3.14.1 Please describe your position on medications noted in the Patient Protection and Affordable Care Act (PPACA) relative to coverage of preventive care services. Please 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). Please note 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,xx) 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 that you agree to 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 requires the 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 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.
- 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 Your organization will allow OEGB, or OEGB's consultant, the right to review the internal testing completed for OEGB'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. Briefly explain: [50 words]

3.15.4 Your organization will allow OEBC, or OEBC's consultant, 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. Briefly explain: [50 words]

3.15.6 Proposer 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.
Yes/No.

3.15.7 Confirm that rebate audits will include the top 5 pharmaceutical manufacturers and/or 50% of rebate spend.

Single, Radio group.

- 1: Agree to meet,
- 2: Do not agree to meet. Briefly explain: [50 words]

3.15.8 Confirm that 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]

3.15.9 Confirm that you agree that 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]

3.15.10 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*
Agree to meet,
- 2: Do not agree to meet. Briefly explain: [50 words]

3.16. Geo Access (FROM OEBC RFP)

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]

DRAFT to Board 10-06-15

OEBB Director Recruitment Plan		
TASK	RESPONSIBLE PARTY	COMPLETION DATES
Complete "Overview of OEBB Director Recruitment"	OHA Human Resources, OEBB Recruitment Planning Workgroup (RPW)	August 11, 2015
Draft <i>Job Posting, Sourcing Plan & Recruitment Timelines</i> sent to OEBB Board for review and consideration	OHA	August 19, 2015
Job Posting, Sourcing Plan and Recruitment Timeline Approved by Board	OEBB	August 21, 2015
Open & Distribute Job Announcement	OHA and OEBB	August 24, 2015
Advertising & Outreach conducted	OHA and OEBB	August 24 – September 22, 2015
Develop Interview Questions	OHA and OEBB RPW	August 24 – September 22, 2015
Recruitment Closes	OHA	September 22, 2015
Processing of Applications & Applicant Summary	OHA	September 25, 2015
Select Candidates for Interview	OHA & OEBB RPW	September 28, 2015
Contact Candidates to Set Up Interview Times	OHA	September 29, 2015
First-round Video Interviews	OEBB Board and OHA Director of Health Policy and Analytics	October 15, 2015
Second-round In-person Interviews	OEBB Board and OHA Director of Health Policy and Analytics	November 3, 2015
Reference Checks Conducted on Finalist	OHA HR	November 5 – November 9, 2015

TASK	RESPONSIBLE PARTY	COMPLETION DATES
Preliminary Appointment Offer	OEBC Board and OHA Director	November 10, 2015
Security Check on Finalist	OHA HR	November 10 -- 13
Appointment Decision & Announcement	OEBC Board	November 17, 2015
New Director on Board		On or before December 1, 2015

**OEBB Board Work Plan
(November 2015 – April 2016)**

Meeting Date	Potential Topics	Notes
November 3, 2015	Second/final round interviews of OEBB director candidates & identify top candidate	Executive Session
	Review and discuss latest drafts of administrative, medical and pharmacy RFP questionnaires and identify areas for SEOW to begin looking into further and preparing recommendations	Initial areas for further research are identified and added to SEOW work plan starting in December 2015
November (TBD), 2015	Announce and Appoint OEBB Director	Special telephone conference call
December 1, 2015	Introduce OEBB Director	
	Partial Year Data Dashboard – Cost and Utilization Update	
	2015-16 Enrollment Numbers	
	Healthy Futures Update	
January 5, 2016	Retreat -- Review, discuss and approve Board mission, vision and guiding principles	
February 2, 2016	Board begins discussions outlined on RFP Process and Timeline Document	
	2015 Customer Service Surveys Results – Heidi Williams and BOW	
	Affordable Care Act (ACA) Update	
	Review of bronze plan options – current use, consider alternatives	
March 1, 2016	2014-15 Data Dashboard – Towers Watson	
	TBD	RFP preparation?
April 5, 2016	Renewal Status Update – Towers Watson	
	TBD	RFP preparation?
April 19, 2016	Preliminary Renewals – Towers Watson	
	TBD	RFP preparation
April 26, 2016	Final Renewals – Towers Watson	
	TBD	RFP preparation