Chair Shaun Parkman will convene a public meeting of the PEBB Board on Tuesday, January 15, 2018, at 10:30 a.m. The meeting will be held in the boardroom of the Health Licensing Office at 1430 Tandem Ave., Ne, Suite 180, Salem, Oregon.

PEBB BOARD AGENDA

I.	10:30 a.m. – 10:35 a.m. Attachment 1 **ACTION**	**Welcome & Approval of December 18, 2018 meeting synopsis** *Shaun Parkman, Chair*
II.	10:35 a.m. – 12:00 p.m. Attachment 2	**PEBB Strategic Planning Next Steps** *Emery Chen and Robert Valdez, Mercer Health & Benefits, LLC*
III.	12:00 p.m. – 12:10 p.m.	**Innovation Work Group Update** *Shaun Parkman, Board Chair & Dana Hargunani, Board Member*
IV.	12:10 p.m. – 12:15 p.m.	**Other Business**
V.	12:15 p.m. – 12:20 p.m.	**Public Comment** **Adjourn**

Public Employees' Benefit Board
Meeting Minutes
December 18, 2018

The Public Employees' Benefit Board held a regular meeting on December 18, 2018, at the DHS Health Licensing Office, Suite 180, 1430 Tandem Ave. Ne, Salem, Oregon 97301. Chair Shaun Parkman called the meeting to order at 9:30 a.m.

Attendees

Board Members:
Shaun Parkman, Chair
Kimberly Hendricks, Vice Chair (via phone for portion of meeting)
Bill Barr (via phone)
Representative Mitch Greenlick (via phone)
Dana Hargunani, MD
Kim Harman (via phone)
Siobhan Martin
Mark Perlman (via phone)
Jeremy Vandehey

Board Members Excused/Absent:
Senator Betsy Johnson

PEBB Staff:
Ali Hassoun, Director
Cindy Bowman, Director of Operations
Rose Mann, Board Policy and Planning Coordinator
Margaret Smith-Isa, Program Development Coordinator

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

View meeting agenda and attachments.
View the meeting recording

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I. Welcome and approval of October 16, 2018 Board meeting and November 15, 2018 Board Retreat minutes (Attachments 1 and 1a)

Chair Shaun Parkman welcomed everyone and asked for a motion to approve the October 16, 2018 Board Meeting Minutes and November 15, 2018 PEBB Retreat Minutes.

MOTION

Siobhan Martin moved to approve the Board meeting minutes of the October 16, 2018 Board meeting and the November 15, 2018 Board Retreat. Bill Barr seconded the motion. The motion carried 7 – 0.

II. PEBB Board Retreat Recap (Attachment 2)

Robert Valdez and Michael Garrett, Mercer Health & Benefits, LLC presented a brief recap of the Board Retreat held on November 15, 2018.

III. Risk-based Capital Report (Attachment 3)

Emery Chen and Robert Valdez, Mercer Health & Benefits, LLC presented a report on risk-based capital and facilitated a discussion.

IV. Utilization Report (Attachment 4)

Emery Chen and Robert Valdez, Mercer Health & Benefits, LLC presented a report outlining the utilization of PEBB members in plan year 2018.

V. Innovation Workgroup Update

Shaun Parkman, IW Vice Chair and Dana Hargunani, IWG Member

VI. Other Business

- **Updating PEBB Commuter Benefit Rule; Temporary Rule (Handout A)**

Linda Freeze, PEBB/OEBB Benefits Manager presented a proposed temporary rule updating the current rule on PEBB Commuter FSA rule and requested Board approval to file the temporary rule with the Secretary of State.

MOTION

Siobhan Martin moved to approve the recommendation to allow PEBB members who have chosen to opt-out of medical/dental benefits one year can rollover their opt-out every open enrollment until they choose to opt-in. Bill Barr seconded the motion. The motion carried 7 – 0.

MOTION

Siobhan Martin moved to approve the recommendation to extend the application deadline for commuter claims to March 31. Dana Hargunani seconded the motion. The motion carried 7 – 0.

II. Public Comment

The Board heard public comment from Toni Joseph.

There being no further business to come before the Board, Chair Shaun Parkman adjourned the meeting at 3:00 p.m.

HEALTH WEALTH CAREER

OREGON PEBB BOARD MEETING

STRATEGY DISCUSSION GUIDE

ATTACHMENT 2
JANUARY 15, 2019

TODAY'S OBJECTIVES

01 Recap of last discussion / timeline

02 Board Input – ACO Development

03 Next steps

RECAP / TIMELINE

DECEMBER MEETING RECAP

RECAP

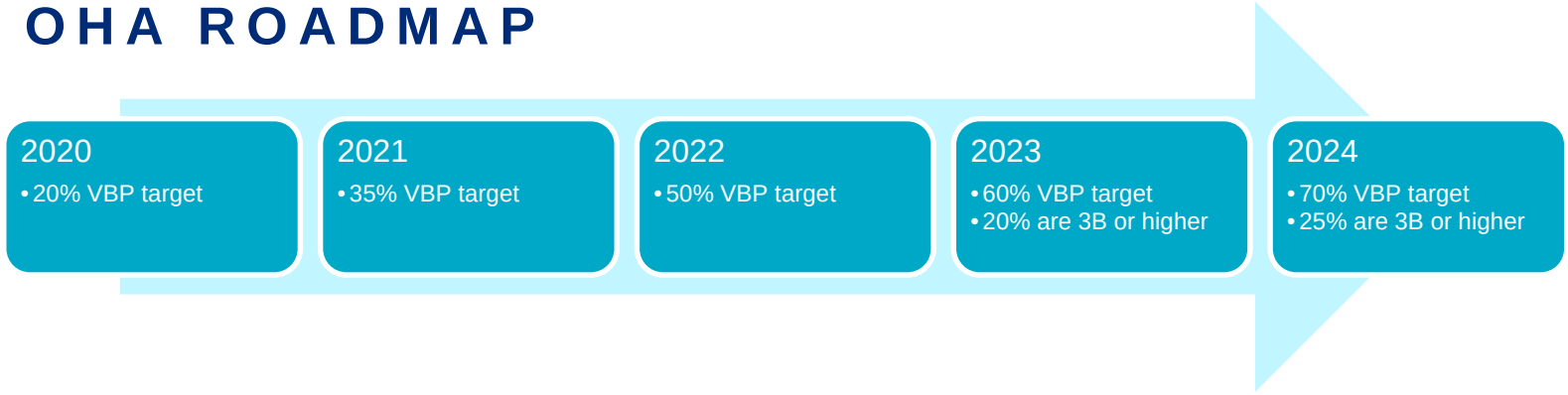
- Direction from Board Retreat indicated several strategies worth exploring
- Discussed long term ACO/CCO strategy, complemented by bridge strategies
- Approach is through carriers (who need to build/buy/align) or procurement
- Mercer proposed draft roadmap for PEBB to follow OHA CCO 2.0
- Different options for achieving ACO/CCO
  - Piggyback on existing OHA CCO arrangements
  - Direct contracts with health systems
  - Contract through carriers with health systems
  - Require carrier to develop and administer full risk-bearing arrangement

TAKEAWAYS AND CALL TO ACTION

- PEBB should set Value-Based Payment (VBP) targets for LAN Category 4
- Align at least as aggressively as CCO 2.0
- Data is needed to establish baseline

PEBB'S ROADMAP VS. OHA'S CCO 2.0

OHA ROADMAP



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

PEBB DRAFT ROADMAP

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

TRANSFORMING INTO AN ACO: RATIONALE

Triple Aim	**Improve the quality of care**		**Improve the patient experience**		**Deliver care more efficiently**	
PEBB Vision	An innovative delivery system in communities statewide that uses evidence-based medicine to maximize health and use dollars wisely	A focus on improving quality and outcomes, not just providing health care	Promotion of health and wellness through consumer education, healthy behaviors, and informed choices	Appropriate provider, health plan and consumer incentives that encourage the right care at the right time and place	Accessible and understandable information about costs, outcomes, and other health data that is available for informed decision-making	Benefits that are affordable to employers and employees
Critical ACO Elements	**Articulate the goals**	**Evaluate the ACO Health Management Capabilities**	**Patient-Centered Care and Communication**	**Quality Management & Improvement**	**Supplier Collaboration**	
	Conduct gap analysis and identify opportunities	**Establish the Financial Reconciliation Methodology**	**Benefit Plan Design**	**Information Sharing and Reporting**	**Attribution**	

ACO Success Measure Areas

PATIENTS

PLAN SPONSOR

DELIVERY SYSTEM

ADMINISTRATOR

TRANSFORMING INTO AN ACO
SAMPLE SUCCESS MEASURES

PATIENTS

- Clear relationship with the care team and the delivery system
- Receives concierge services
- Experiences low hassle factor with administrative (e.g., eligibility, benefits, etc.) and clinical (e.g., accessing care, interacting with the care team, etc.)
- Feels “delighted” with the delivery system
- Has accessible multiple channels to care (e.g., telemedicine, nurse line, emailing, texting, app, etc.)
- Receives education and support from care team that is understandable and actionable
- Uses tools and resources for self-care (e.g., patient decision aids)

PLAN SPONSOR

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

DELIVERY SYSTEM

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

ADMINISTRATOR

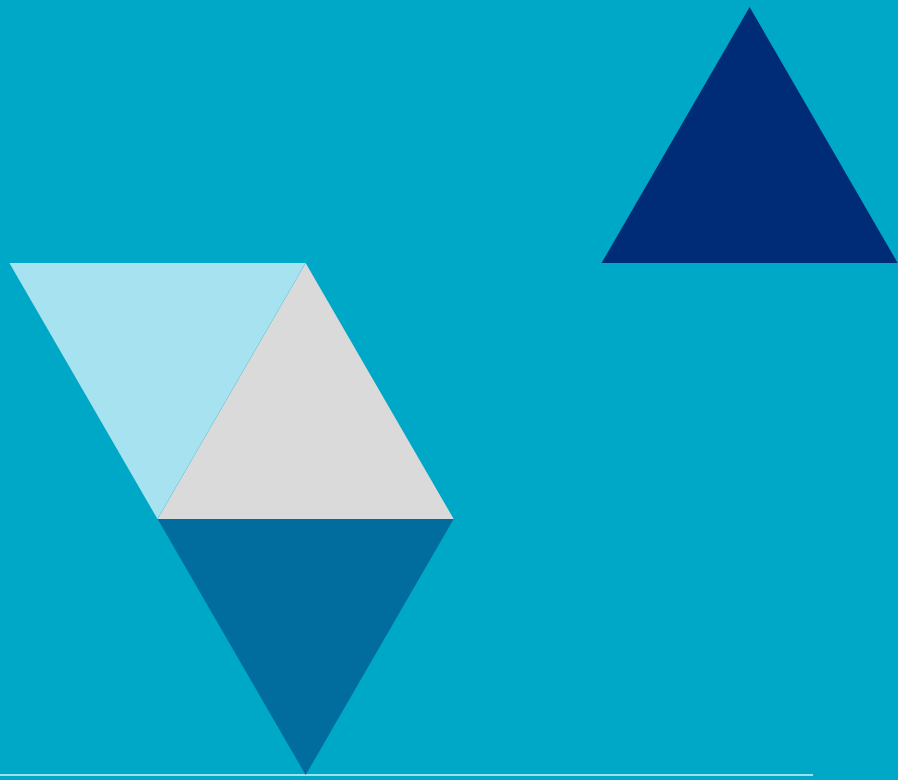
- Administers value based payment methodologies
- Provides timely and accurate data between suppliers
- Vets high quality provider groups
- Establishes clear administrative processes for the ACO/VBC plan design
- Reinforces the communication regarding the ACO/VBC value proposition
- Provides meaningful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

SUGGESTED STRUCTURE FOR ACO DEVELOPMENT

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

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

BOARD INPUT– ACO DEVELOPMENT



ACO BOARD INPUT
OVERVIEW

- Board members were asked to supply responses to various questions regarding the ACO strategy
- The survey was not intended to serve as a vote or commitment, but as a "temperature check" among the group, to ensure everyone's voice is heard as the ACO strategy is discussed and developed
- Through January 13, six board members completed survey
- **Key / Legend:**

ACO BOARD INPUT
ACO GOALS

Which of these best reflects the goals of an ACO?

Achieve better than a 3.4% medical trend rate

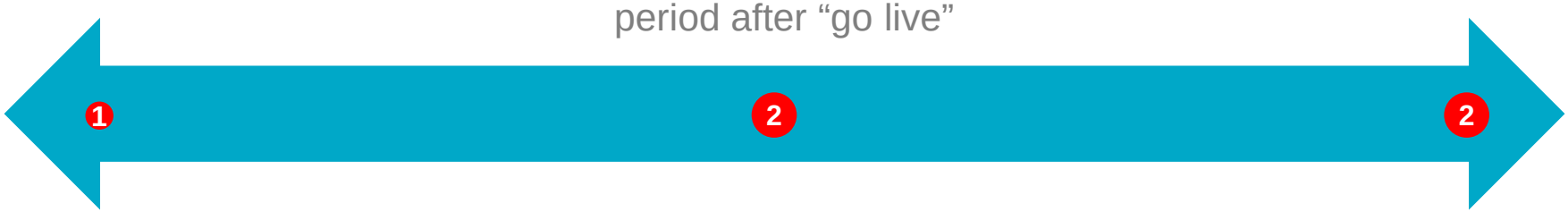
Achieve the Triple Aim of reducing per capita costs, better health of the population, and improving patient/member experience (both quality and experience)

Achieve the Quadruple Aim, which includes the Triple Aim and adds an additional aim of improving the work life of healthcare providers, including clinicians and staff members

ACO BOARD INPUT
ACO FINANCIAL TARGET

Which of these best reflects the financial targets of an ACO?

Require Category 4 – Population Based Payment within which time period after “go live”



Two years – starting 1/1/2023

Three years – starting 1/1/2024

Four years – starting 1/1/2025

*One abstention

ACO BOARD INPUT
ACO CONTRACTING

Which of these is the desired approach for contracting for an ACO?

PEBB executes direct contracts with health systems for graduated risk-bearing ACOs

PEBB contracts through carrier/administrator with health systems for a customized ACO (based on the requirements specified by PEBB) with graduated risk bearing

PEBB requires the carrier/administrator to develop and administer risk-bearing ACO arrangements

*One abstention

ACO BOARD INPUT
ACO STRUCTURE

Do you see ACOs being the sole provider of healthcare in a given county alongside the Statewide (PPO) plan?

Yes

No, CCM plan(s) will still have a place alongside the Statewide and ACO plans

ACO BOARD INPUT
ACO NUMBERS

How many ACOs do you envision?

One statewide ACO

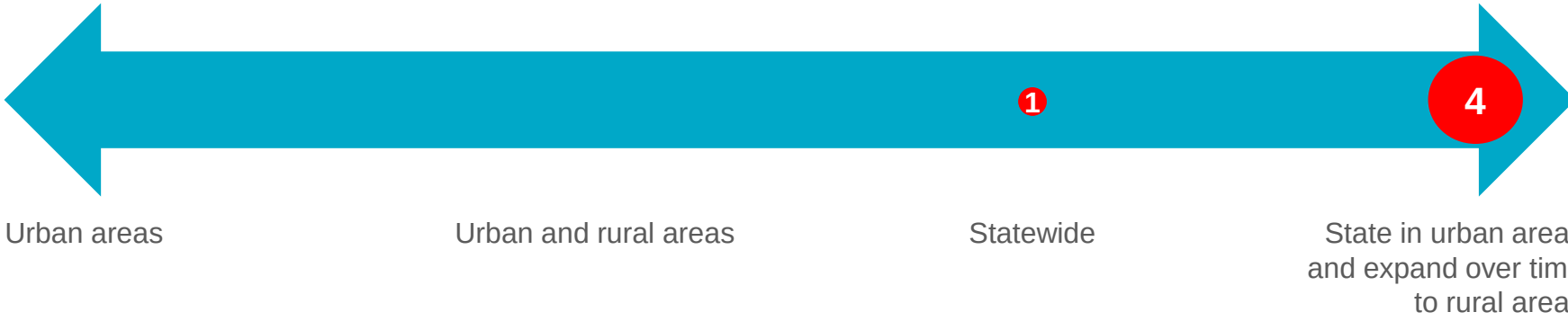
Two ACOs

Three or more ACOs located throughout the State

*Two abstentions

ACO BOARD INPUT
ACO LOCATION

Where do you envision the ACOs to be located?



*One abstention

ACO BOARD INPUT
MEMBER SUCCESS MEASURES FOR AN ACO

Board was asked to rank order its top 5 from the following success measures from the *Member* perspective:

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

*One abstention

ACO BOARD INPUT
PEBB'S SUCCESS MEASURES FOR AN ACO

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

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

ACO BOARD INPUT
HEALTHCARE DELIVERY SYSTEM SUCCESS MEASURES FOR AN ACO

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

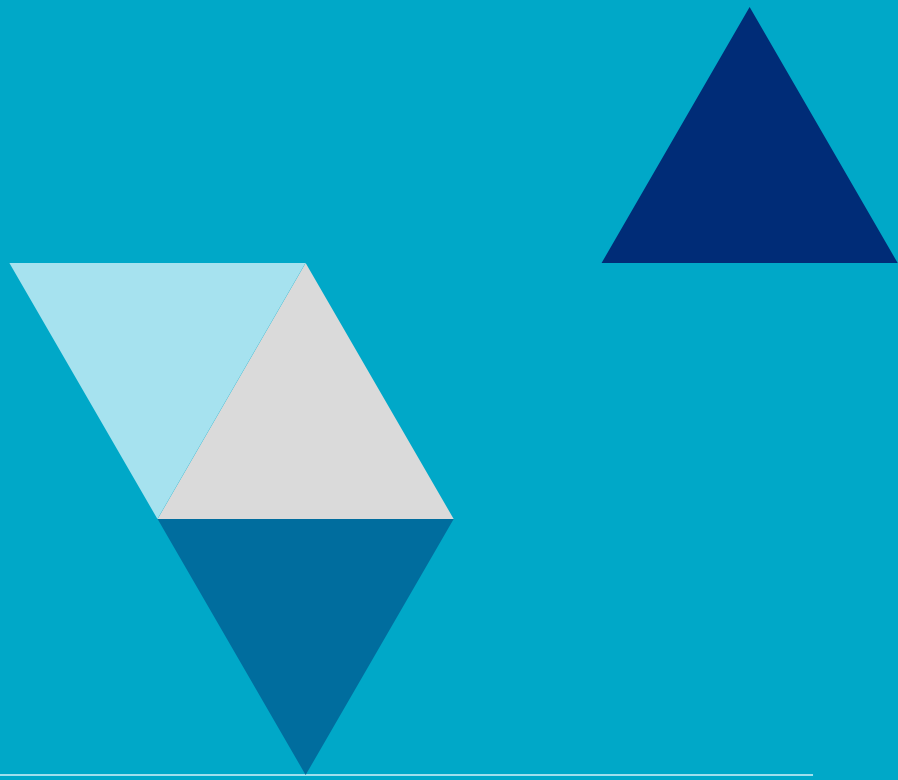
	POINTS
Demonstrated improvements in the clinical, financial, and member/patient experience outcomes	5.50
Able to meet or exceed all quality metrics and other targets while receiving the maximum financial rewards for performance	4.17
Incorporates systematic shared decision making (including patient decision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

ACO BOARD INPUT
CARRIER/ADMINISTRATOR SUCCESS MEASURES

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

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

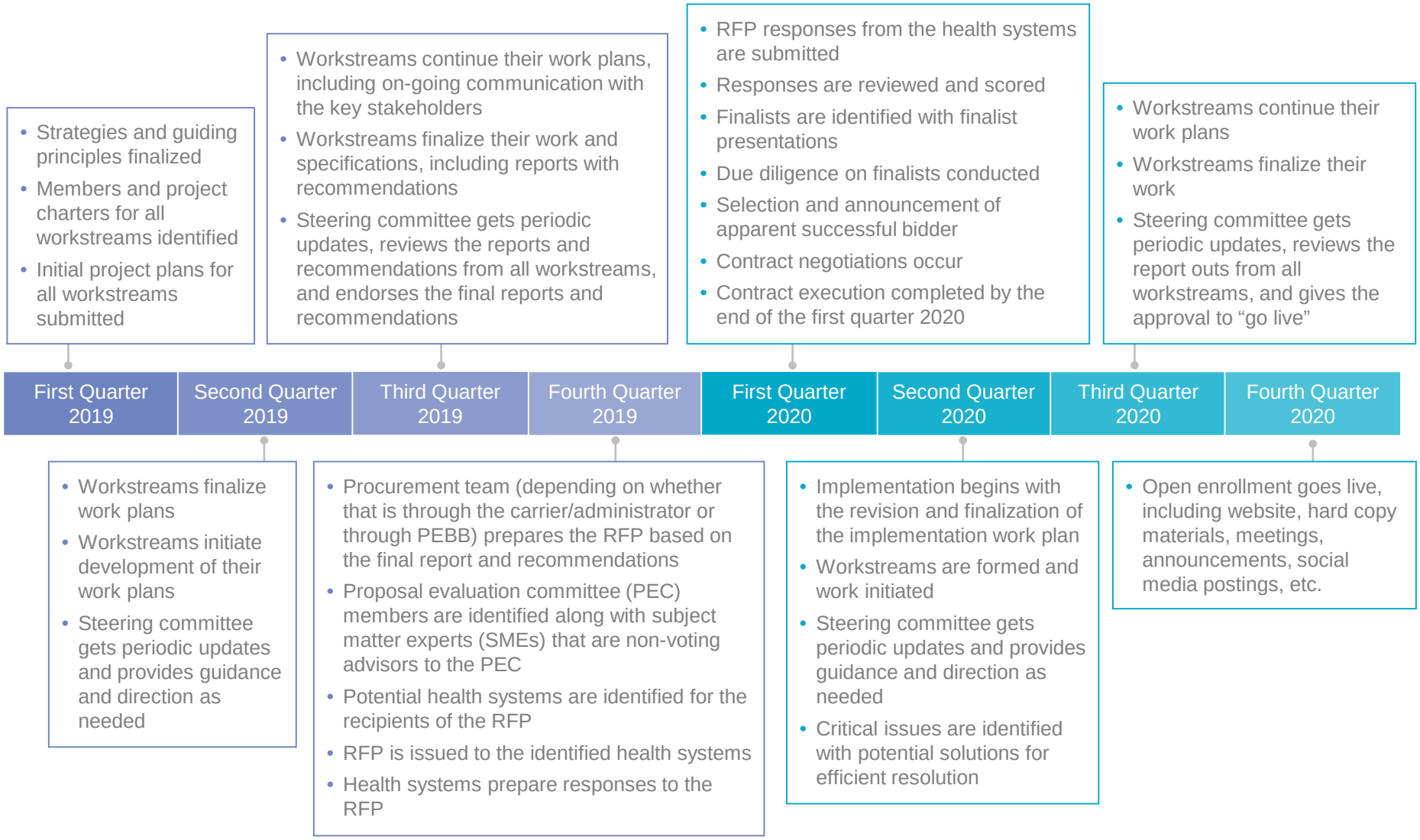
NEXT STEPS



SUMMARY AND NEXT STEPS

- **Summary:**
  - What is the summary of the Board's shared description and goals of this approach?
  - What is the Board's shared vision of the number, location, and structure for the ACO (e.g., direct contracting, customizing the carrier/administrator ACO, etc.)?
  - What are the Board's success measures (including clinical, financial, and member experience metrics) for the ACO?
  - What are the Board's commitment of resources from itself and from staff for the ACO?
- **Next Steps:**
  - Discuss with the carrier/administrator their capabilities in developing the ACO
  - Identify the Board, staff, consultants, carrier/administrator, and stakeholders for all of the ACO workgroups
  - Determine any coordination or information sharing with other entities
  - Develop a work plan for all workgroups
  - Identify the communication format and reporting cadence for ACO project updates

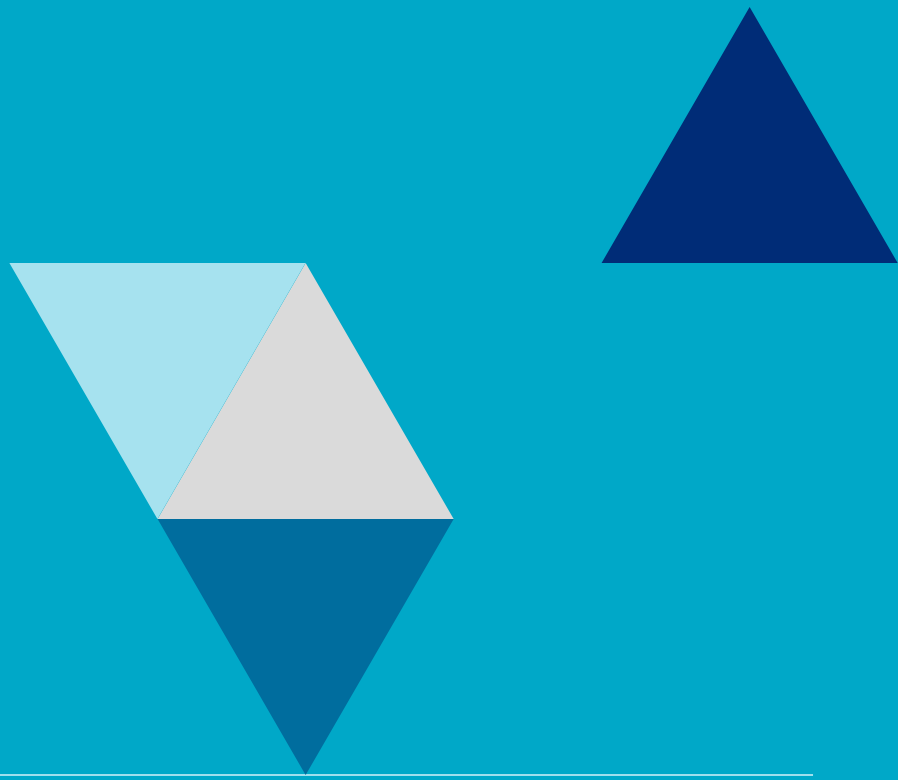
ILLUSTRATIVE TIMELINE FOR ACO DEVELOPMENT



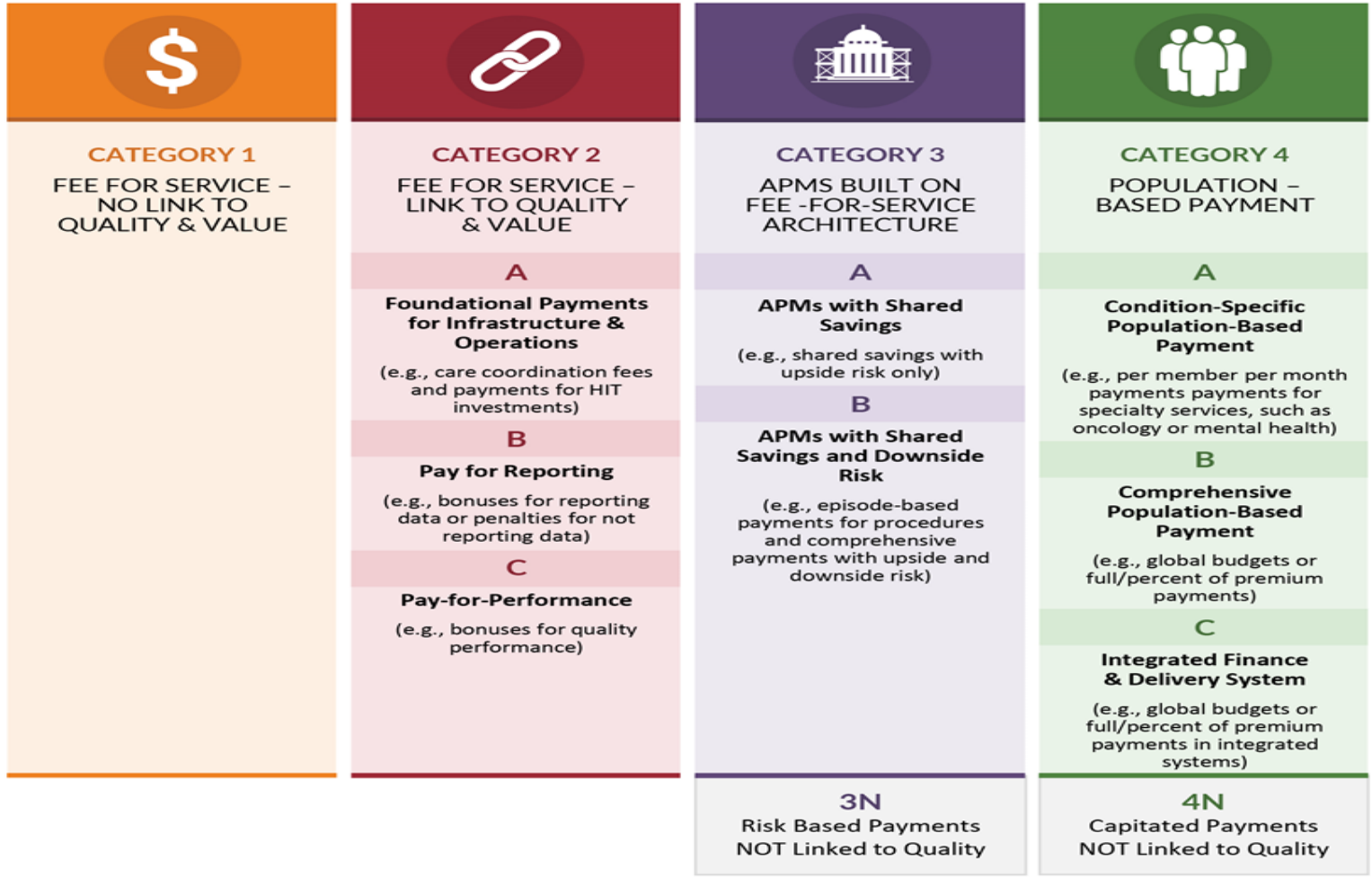
2020 RENEWAL OVERVIEW AND TIMELINE

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

APPENDIX



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



Source: APM Framework, HCP-LAN,2017

TRANSFORMING THE CCM INTO AN ACO
CRITICAL ELEMENTS

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

SAMPLE GAP ANALYSIS AND ACTION PLAN
BASED ON TYPICAL ACO TIMELINE

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