

HEALTH WEALTH CAREER

OREGON PEBB BOARD RETREAT

STRATEGY FOR ACTION DISCUSSION GUIDE

NOVEMBER 15, 2018





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INTRODUCTIONS & OBJECTIVES





STRATEGY FOR ACTION

INTRODUCTION

- Mercer has met individually with PEBB's medical carriers
- We're working under the premise no carrier changes for 2020
- Therefore we will need to rely on leveraging strategies with your carriers in the short-term
- Strategies will vary in their impact, timing, and potential disruption
- We will share information with you today, but we're looking for your thoughts, impressions, reservations about them
- Let's make this interactive!



STRATEGY FOR ACTION

DISCUSSION OBJECTIVES

TODAY'S OBJECTIVES:

Revisit Your Current State

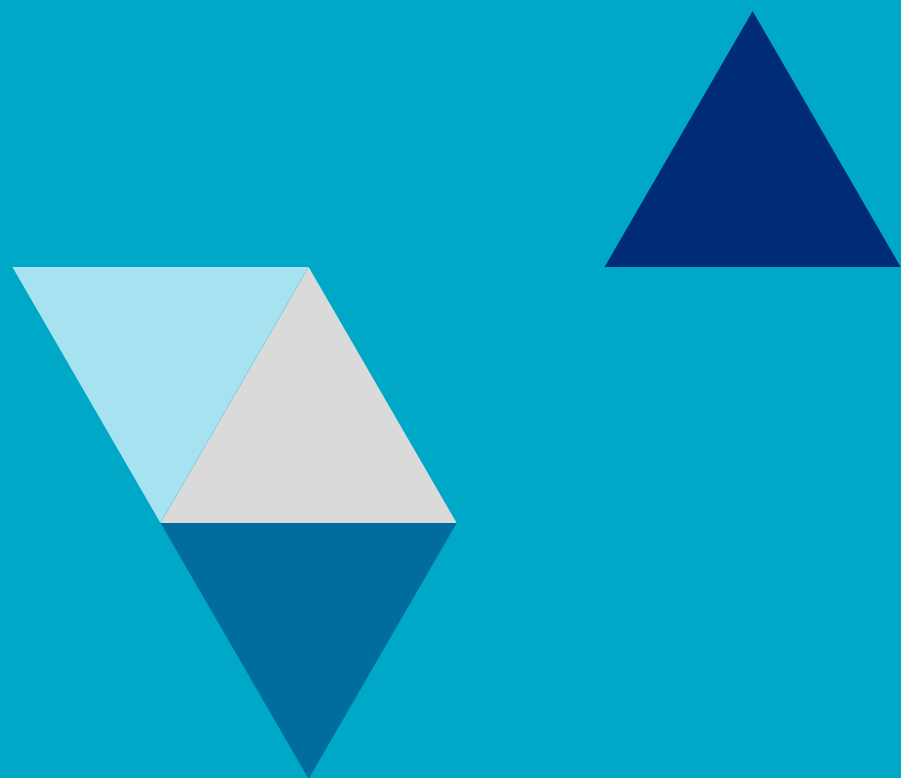
Determine PEBB's Priorities

Identify Your Opportunities and Possible Actions

Develop Your Plan For 2020+

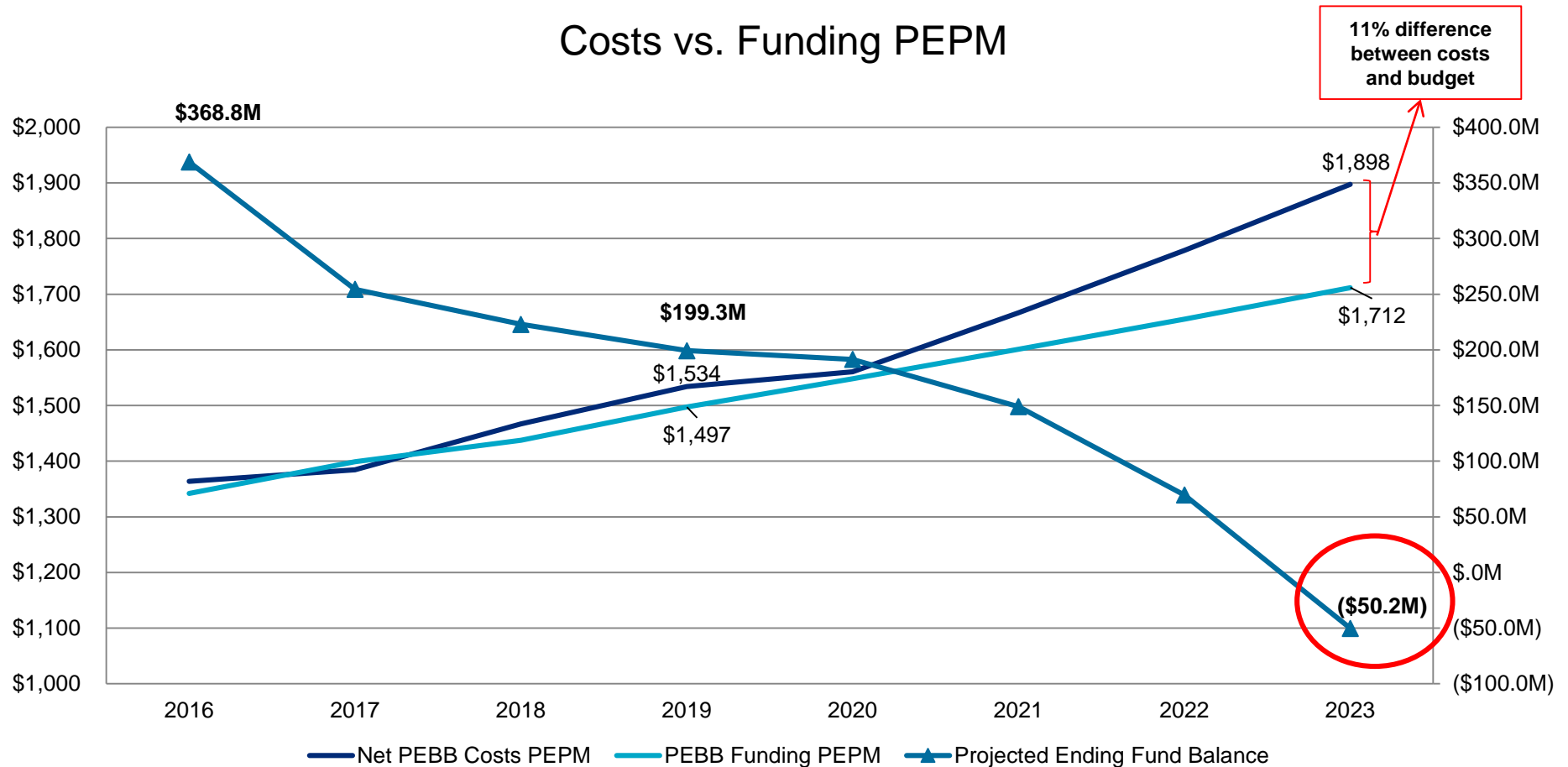
Agree On Timing And Next Steps

YOUR CURRENT STATE



THE 3.4% FUNDING CAP FUND BALANCE TURNS NEGATIVE BY 2023

Costs vs. Funding PEPM

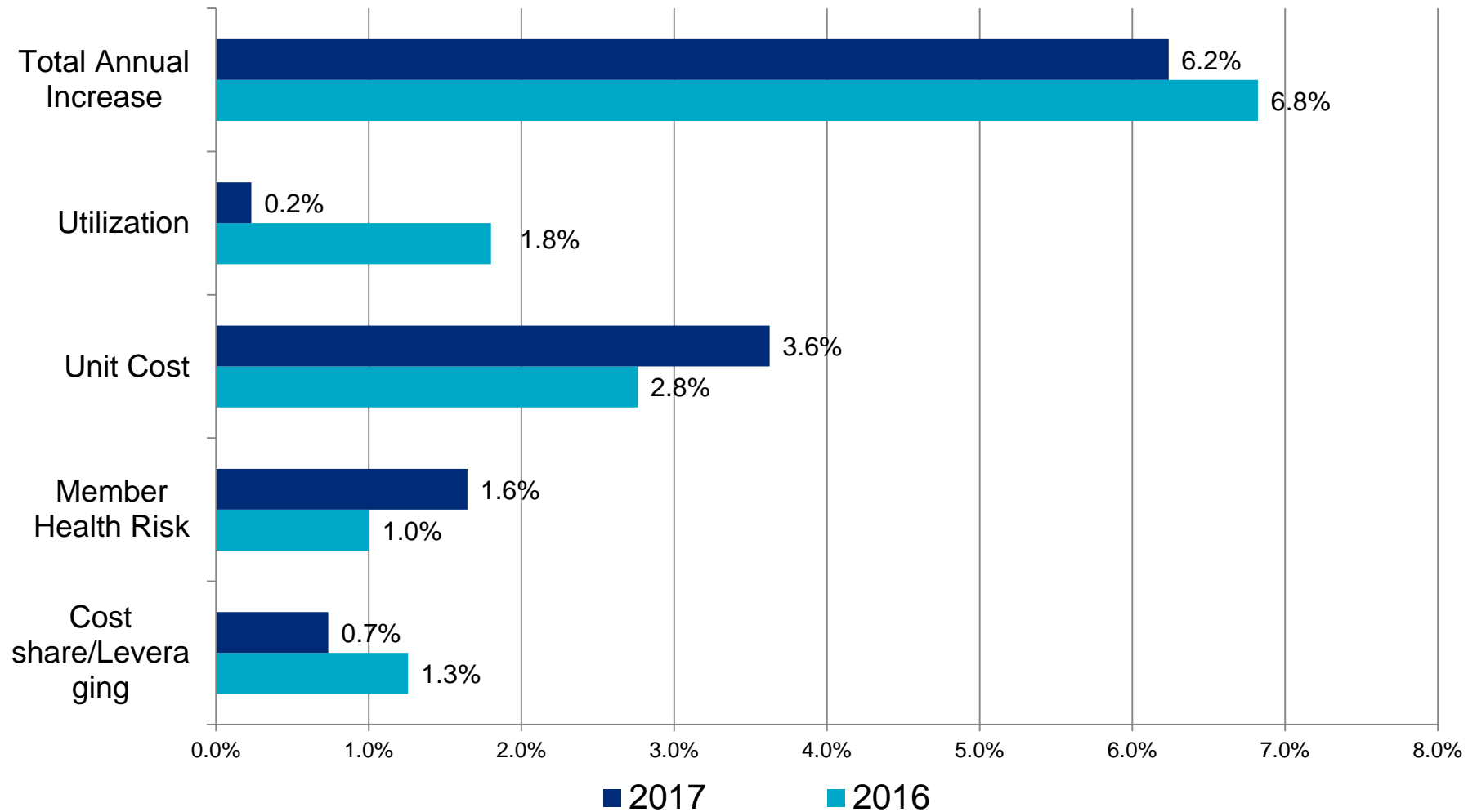


Affecting positive impacts on health status, behavior change and costs can take several years



CHALLENGES OF 3.4% FUNDING CAP

HISTORICAL TRENDS REMAIN HIGH



Unit cost increases include impact of technology and service mix

PEBB CHRONIC CONDITIONS

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

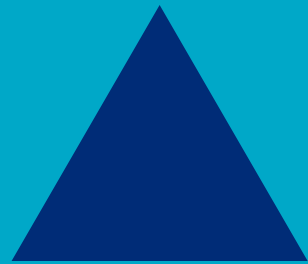
| | | | Allow Amt Med + Rx Cost Per Pat (Episode Based) | | | |
|---------------------|--|-------------------------|---|---------|---------|----------|
| | | Previous | Current | \$1,147 | \$1,164 | \$1,806 |
| Asthma | Prevalence per 1000 | | | | | |
| | Prevalence per 1000 Benchmark ⁴ | 25.4 | 27.7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

■ Previous ■ Current ■ Benchmark ³

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



ALIGNING WITH OREGON HEALTHCARE STRATEGIES



OREGON PEBB VISION

- Vision Statement
 - We seek optimal health for our members through a system of care that is patient-centered, focused on wellness, coordinated, efficient, effective, accessible, and affordable. The system emphasizes the relationship between patients, providers, and their community; is focused on primary care; and takes an integrated approach to health by treating the whole person.
- Key Components
 - 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





GOVERNOR BROWN'S AREAS FOR HEALTH CARE TRANSFORMATION

Addressing social determinants of health and equity

Increasing value and pay for performance

Improving the behavioral health system

Maintaining a sustainable cost growth



ALIGNING PEBB WITH CCO 2.0 GOALS

Increase Value Based Payments

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

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

Ensure health disparities & members with complex needs are considered

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

Reward CCO and provider performance



CCO 2.0 STRATEGIES FOR PAYING FOR VALUE

Pay for outcome and value

Shift focus upstream

Improve health equity

Increase access to healthcare

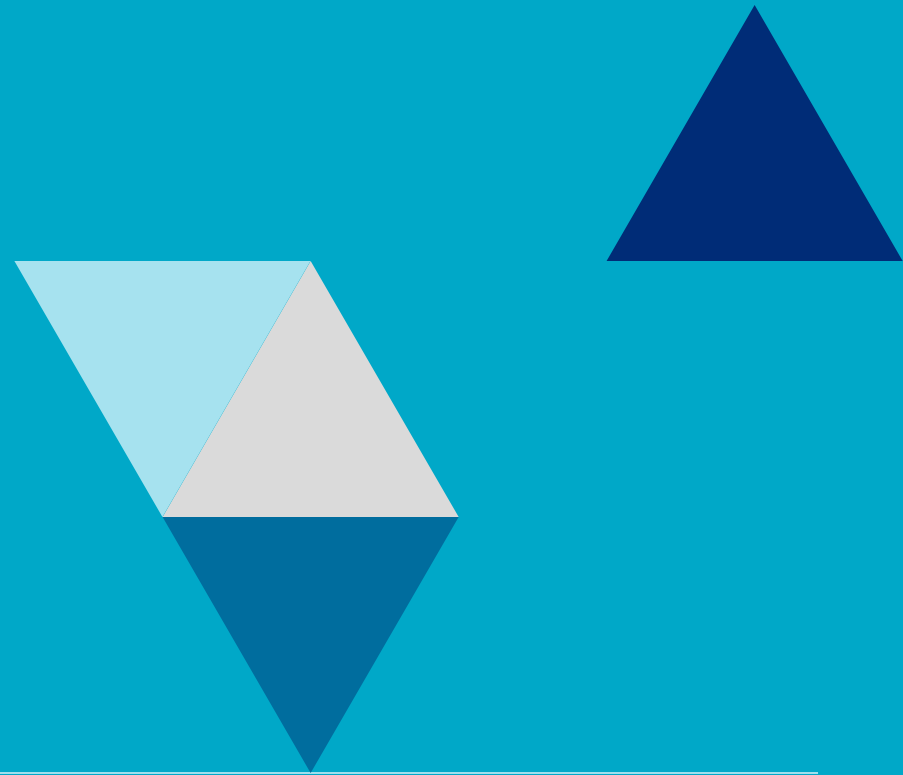
Enhance care coordination

Engage stakeholders and community partners

Measure progress



POTENTIAL STRATEGIES FOR ACTION





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

CONTINUUM OF STRATEGIES TO IMPACT COSTS

Unit Prices

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

Benefit Coverage

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

Delivery and Associated Payments

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

Payment Model with Risk Sharing

- Upside and downside risk
- Create ACO
- Changing in-network to only include risk bearing providers

Patient Behavior

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



NARROWING THE POSSIBILITIES FRAMEWORK FOR EVALUATION



CRITERIA

- Does it actually save money?
- How much savings?
- What is the expected timing for savings?
- How does it align with OHA?
- How disruptive is it?
- Can your current carriers administer it?
- How accessible is it (timing for implementation)?



CRITERIA DETERMINATION EXERCISE

RANK 1 TO 8

- Amount of savings
- Improved health outcomes
- Improved experience for members
- Timeframe for saving
- Alignment with OHA
- Limited disruption of members
- Limited disruption of vendors
- Ease of implementation

CRITERIA DETERMINATION RESULTS

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____



STRATEGY ILLUSTRATIVE SAVINGS

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

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

STRATEGY: CONCIERGE FOR STATEWIDE

Overlay digital navigation and advocacy services to the PPO plan and create steerage by offering the highest level of benefits when receiving care through a concierge care management vendor

Projected Potential Savings

| <u>2020</u> | <u>2021</u> | <u>2022</u> | <u>2023</u> |
|-------------|-------------|-------------|-------------|
| \$7M | \$11M | \$16M | \$17M |

How this stacks up with key criteria

- Demonstrated savings with guaranteed ROI from some vendors
- Some vendors provide reduced trend guarantees with first year savings if implemented on a total replacement basis
- Increased care coordination and improves the member experience at the expense of current plan administrators
- Maximum savings requires extreme disruption by outsourcing all customer service and care management to third party vendor

How this could make people happy

- High quality, high touch guidance through the health care system improves the experience
- Concierge service could help guide members and increase utilization of relevant point solutions

How this could frustrate people

- Change from current customer service and care management to a new administrator



TIMING
MEDIUM



CARRIER/VENDOR
NEW



COMMUNICATION
CONTINUOUS



IMPLEMENTATION
HIGH

STRATEGY: EXPERT MEDICAL OPINION

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

Projected Potential Savings

| <u>2020</u> | <u>2021</u> | <u>2022</u> | <u>2023</u> |
|-------------|-------------|-------------|-------------|
| \$1 M | \$1 M | \$1 M | \$1 M |

How this stacks up with key criteria

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

How this could make people happy

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

How this could frustrate people

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



TIMING
SHORT



CARRIER/VENDOR
NEW



COMMUNICATION
HIGH FOR
UTILIZATION



IMPLEMENTATION
MEDIUM

STRATEGY: DOUBLE SPOUSAL SURCHARGE

Increase monthly spousal surcharge from \$50 to \$100 for working spouses

Projected Potential Savings

| <u>2020</u> | <u>2021</u> | <u>2022</u> | <u>2023</u> |
|-------------|-------------|-------------|-------------|
| \$2.5 M | \$2.5 M | \$2.5 M | \$2.5 M |

How this stacks up with key criteria

- Saves PEBB money by partially recouping cost of spouses with coverage available at another employer
- 1st year savings estimated at \$3 million
- Savings is immediate on a per paycheck basis
- Does not align with OHA
- Disruptive by \$600/yr to impacted families
- No special administrative requirements other than employee communications
- No implementation concerns: available as early as Jan. 1, 2020

How this could make people happy

- Reduces inequity with how employees with coverage available via other employers are treated vis-à-vis state employees

How this could frustrate people

- Financial burden to impacted employees



TIMING
SHORT



CARRIER/VENDOR
N/A



COMMUNICATION
AT ANNUAL
ENROLLMENT



IMPLEMENTATION
EASY

STRATEGY: CCM IN EFFICIENT COUNTIES

Restrict the counties where CCM plans are offered to those with demonstrated efficiencies and improved outcomes

Projected Potential Savings

2020
N/A

2021
\$2M

2022
\$3M

2023
\$3M

How this stacks up with key criteria

- Reduces costs by eliminating less efficient plans
- Savings dependent on **how** restrictive the approach is
- Recommended that inefficient plans have a couple of years to improve or face elimination
- Action plan for inefficient plans to improve may result in closer alignment with CCO 2.0 principles
- Eliminating plans may be very disruptive

How this could make people happy

- Lower overall costs

How this could frustrate people

- Reduces choice of health plans
- Will force some employees to switch plans



TIMING
MEDIUM



CARRIER/VENDOR
CURRENT



COMMUNICATION
AT ANNUAL
ENROLLMENT



IMPLEMENTATION
EASY

STRATEGY: BUNDLED PAYMENT WITH COES

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

Projected Potential Savings

| <u>2020</u> | <u>2021</u> | <u>2022</u> | <u>2023</u> |
|-------------|-------------|-------------|-------------|
| \$2M | \$2M | \$2M | \$2M |

How this stacks up with key criteria

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

How this could make people happy

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

How this could frustrate people

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



TIMING
MEDIUM



CARRIER/VENDOR
CURRENT/NEW



COMMUNICATION
HIGH



IMPLEMENTATION
MEDIUM

STRATEGY: POINT SOLUTIONS

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

Projected Potential Savings

2020
TBD

2021
TBD

2022
TBD

2023
TBD

How this stacks up with key criteria

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

How this could make people happy

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

How this could frustrate people

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



TIMING
SHORT



CARRIER/VENDOR
NEW



COMMUNICATION
DIRECTED AND
CONTINUOUS



IMPLEMENTATION
MEDIUM

STRATEGY: ACCOUNTABLE CARE ORGANIZATION

Work with provider groups and hospital organizations to create a closed network of coordinated providers with lower reimbursement, risk sharing, and performance guarantees based on quality metrics and trend guarantees

Projected Potential Savings

| 2020 | 2021 | 2022 | 2023 |
|------|------|------|------|
| N/A | \$2M | \$4M | \$7M |

How this stacks up with key criteria

- Potential for large savings if trend guarantees and negotiated discounts are contracted
- The Triple Aim is the paradigm for ACOs
- Development and implementation of ACOs may take multiple years with true care coordination realistically achieved over a long time frame
- Aligns directly with CCO 2.0
- Disruption is dependent on which provider systems are willing to form an ACO

How this could make people happy

- Better care and better health outcomes along with lower cost
- Typically members are incented to join ACOs via reduced cost sharing

How this could frustrate people

- Provider network could be greatly reduced in size depending on the provider systems willing to form the financial and clinical ties
- Financial and clinical improvements may take years to achieve



TIMING
LONG



CARRIER/VENDOR
NEW



COMMUNICATION
HIGH



IMPLEMENTATION
VERY DIFFICULT



STRATEGY PRIORITIZATION EXERCISE

RANK 1 TO 7

- Concierge for Statewide
- Expert Medical Opinion
- Increase Spousal Surcharge
- CCMs in Efficient Counties
- Bundled Payments with COEs
- Point Solutions
- Accountable Care Organizations

STRATEGY PRIORITIZATION RESULTS

1. _____

2. _____

3. _____

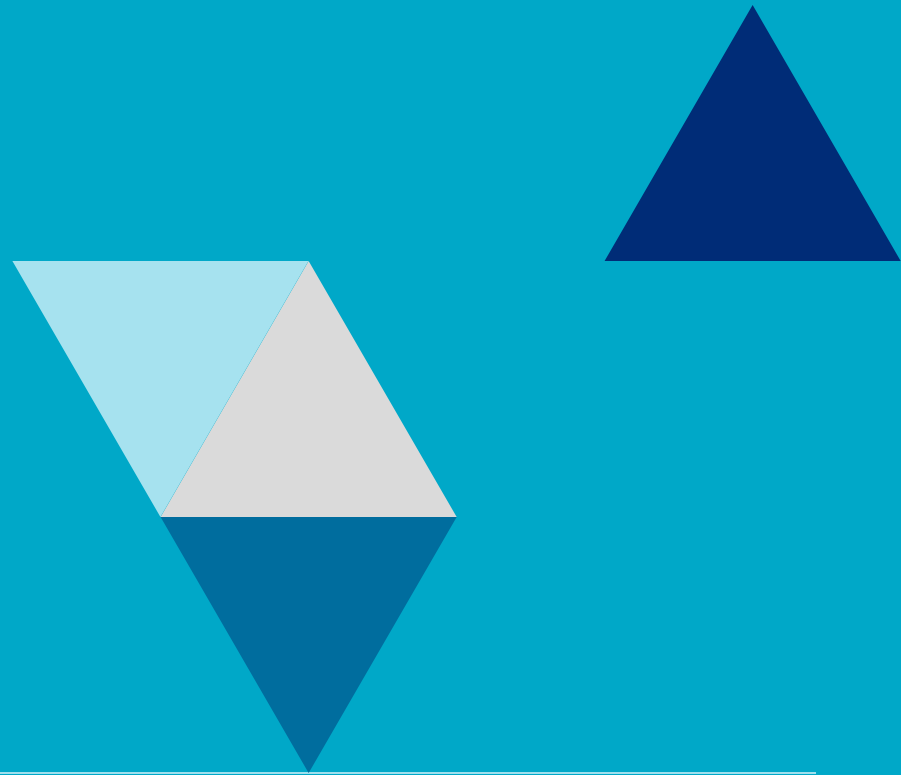
4. _____

5. _____

6. _____

7. _____

NEXT STEPS





NEXT STEPS

CALL TO ACTION

- 1 Document PEBB's strategic path forward

- 2 Determine venues for strategic initiatives

- 3 Assign resources to drive forward PEBB's strategies

- 4 Create action plan for investigating and vetting solutions

- 5 Communicate with impacted vendors requests and expectations

- 6 Implement strategies



MERCER

MAKE TOMORROW, TODAY



PEBB CARRIER SUMMARY

PROVIDENCE

| Unit Prices | Benefit Coverage | Delivery and Associated Payments | Payment Model with Risk Sharing | Patient Behavior |
|--|---|---|---|--|
| <ul style="list-style-type: none"> •Fractured ASO plans minimizes ability to drive down costs in contracting •Reference pricing for inpatient services has limited benefit •Reference pricing for outpatient services has more opportunity •ICER evaluation for Rx high cost claims •Use specialty team to coordinate with DM and care providers, since this is more effective than Rx PA •Mitigate costs of infusibles & injectables via ASP if available, or WAC or AWP market rates | <ul style="list-style-type: none"> •Suggest consolidation of plan administrators •MSK issues are the biggest challenge •Consider caps on PT/OT/ST & Chiro •Enhanced DM: incentive for chronic conditions, engagement is key •Suggest waiving co-pays for medications and supplies for chronic conditions | <ul style="list-style-type: none"> •Leveraging virtual care for key chronic conditions: hypertension and depression •Medications and supplies are the cost drivers for diabetes •Need to address ER use for asthma •Salem Community Collaborative: increased caps, les FFS, tied to 3.4%. Would like to expand, but providers need to be motivated •Minimal impact for RBP •Care managers in the community is currently being tested in pilot | <ul style="list-style-type: none"> •Open to ACO, but unclear how to implement outside of Portland metro area | <ul style="list-style-type: none"> •Consider mandatory shared decision making before surgery; has decision support with Intel •Consider an opt-out strategy for health risk assessment •Choosing Wisely—implementing based on WA criteria (e.g., pap/mammography) •Not clear the strategies to address social determinants of health |



PEBB CARRIER SUMMARY

KAISER PERMANENTE

| Unit Prices | Benefit Coverage | Delivery and Associated Payments | Payment Model with Risk Sharing | Patient Behavior |
|--|---|--|---|---|
| <ul style="list-style-type: none"> •Goal is to provide 10% price advantage over PPO plans •Drive down patient day rates; better leverage ambulatory care and virtual care visits •Leverage mid-levels more (currently 50% of PC uses teams; used at “Care Essential” locations); model 2 years old •Facing administrative challenges with the 200% of Medicare reimbursement model | <ul style="list-style-type: none"> •Building out Lane County; expansion difficult due to monopolistic settings—focus on smaller practices, not hospitals | <ul style="list-style-type: none"> •Will NOT build hospitals, instead pay for virtual care, retail care, & hospital at home •New model of community health workers (CHWs) supporting multi-disciplinary care teams and social determinants •BH: not enough providers in Portland, use social workers in a broker model (not therapy), needs help integrating medical and BH (suggest “Healthier Washington”) •Have incorporated Choosing Wisely metrics to reduce waste •Leveraging “a doctor and a computer” in new geographic areas •Maintaining HMO model so new choice plans | <ul style="list-style-type: none"> •Currently in place | <ul style="list-style-type: none"> •Need to improve shared decision making, having end-of-life conversations •Patient experience via CAHPS & Press Ganey; familiar with Patient Activation Measure (PAM), however they are using other methods to measure engagement. •Navigators help with social determinants of health •Adjusting employee contributions – marginal difference doesn’t drive selection |



PEBB CARRIER SUMMARY

MODA

| Unit Prices | Benefit Coverage | Delivery and Associated Payments | Payment Model with Risk Sharing | Patient Behavior |
|--|---|---|--|--|
| <ul style="list-style-type: none"> •Most medical homes are Tier 3 to Tier 5: trend is 2.7% in 12-county area for Eastern Oregon CCO (EOCCO) | <ul style="list-style-type: none"> •PEBB uses PCPs and ER more, likely due to rich benefits •Plan design changes will need to be part of steerage in Synergy 2.0 •Suggest eliminating co-pays for BH services and BH medications •Focused on reducing opioid prescribing, including addressing dentists | <ul style="list-style-type: none"> •Building on CPC+; evolving towards total cost of care driven from primary care •95% in Central OR use PCPCH certified providers •Owns BH management/quality/in-house network; access to BH services does not seem to be an issue •Nurse case managers to coordinate with CHWs in community •Training CHW for Eastern OR •Willing to explore COEs, but needs Mercer guidance •Bundled payments for chronic conditions are on the table (align with CMS) •Using virtual care visits with OHSU, expanding from primary care to pediatrics, geriatrics, and specialists | <ul style="list-style-type: none"> •Goal is a mix of Alternative Payment Methodologies (APMs) •Want to expand the C3 program with financial incentives •Want to incorporate downside risk and performance guarantees (PGs) to providers •PCPCH providers perform better than non-PCPCH providers | <ul style="list-style-type: none"> •Shared decision making is required by APM Category 4 providers •Telehealth to cover primary-pediatrics-geriatrics-specialty •Satisfaction measured via PAM (3 years of data) •ICD10 coding to address social determinants of health, need to explore non-claims data sources •Not yet systematically monitoring shared decision making •Not yet incorporating Choosing Wisely guidelines |