HEALTH WEALTH CAREER

Attachment 4

OREGON PEBB BOARD MEETING

STRATEGY DISCUSSION GUIDE

MARCH 19, 2019

TODAY'S AGENDA

01 WHERE WE LEFT OFF

02 EXECUTIVE SUMMARY UPDATES

03 SUPPORTING INFORMATION

04 NEXT STEPS

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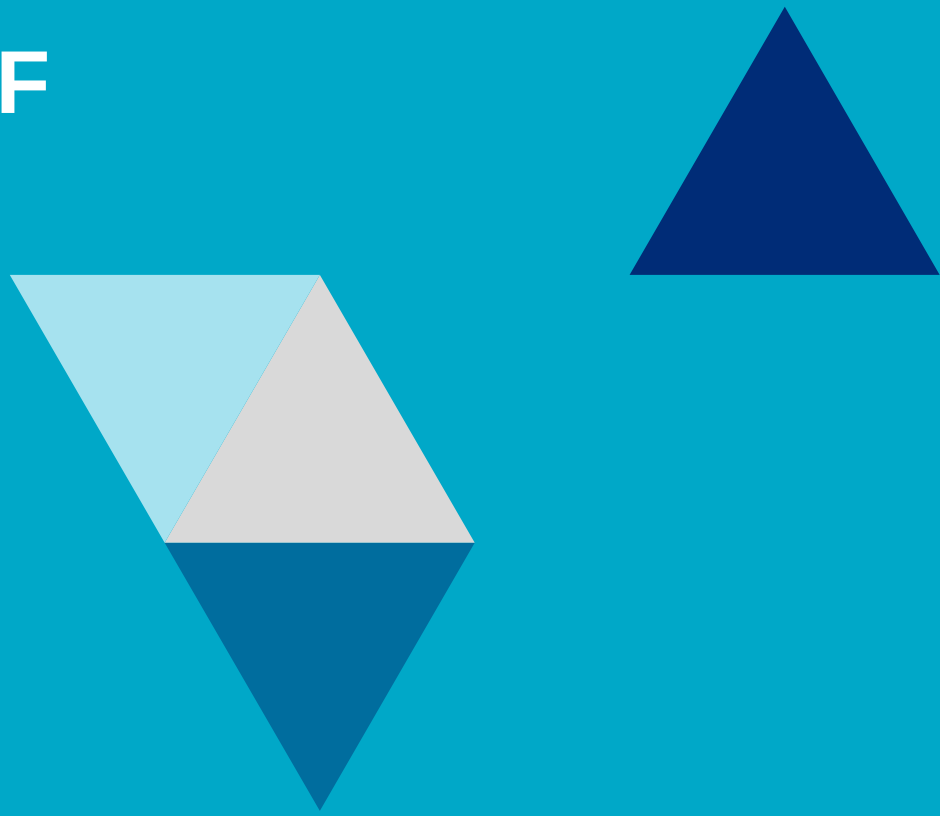
WHERE WE LEFT OFF



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TRANSFORMING INTO AN ACO/CCM+: RATIONALE

Triple Aim	**Improve the quality of care**		**Improve the patient experience**		**Deliver care more efficiently**	
OHA Guiding Principles	**Access**	**Innovation with accountability**	**Patient-centered**	**Health equity**	**Collaborative partnerships**	**Social determinants of health**
PEBB Vision	An innovative delivery system in communities statewide that uses evidence-based medicine to maximize health and use dollars wisely	A focus on improving quality and outcomes, not just providing health care	Promotion of health and wellness through consumer education, healthy behaviors, and informed choices	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

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HOW IT TIES TOGETHER
DRAFT STRATEGIC PLACEMAT

ENVIRONMENT

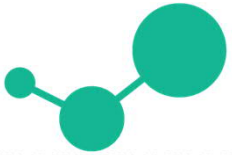
- Labor-management board who contracts and administers benefits for eligible state employees
- 136,000 covered participants
- Individuals live and work in every county in Oregon
- Mix of self-funded and fully-insured benefit plans
- Remain within 3.4% annual cost growth cap

GUIDING PRINCIPLES

- 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

STRATEGY

- Offer competitive plan design and employee contributions as appropriate
- Increase focus on value-based payment approaches rather than fee-for-service arrangements
- Encourage members to participate in wellness programs through incentives to help reduce overall medical cost trends
- Monitor and evaluate innovative solutions and “add-on” health plan services that help members effectively use their benefits and optimize their and PEBB’s healthcare investment
- Utilize vendor tools to educate and engage members
- Stay abreast of compliance requirements

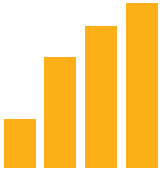


ACTIONS

- Collaborate with vendors to offer best-in-class products, tools and services to PEBB and its members
- Monitor vendors’ capabilities and evaluate innovations (e.g., ACO) for PEBB’s consideration
- Encourage employees’ use of vendor tools to select quality providers, learn about the true cost of specific procedures and better manage their overall health
- Educate employees on high performing providers to steer usage
- Look for programs and incentives to have the highest impact on overall health risks
- Develop data collection and dashboard tools for ongoing program measurement

BARRIERS

- Tight labor market
- Carrier capabilities
- Developing wellness program
- Decentralized workforce
- Staffing, growth and leadership retirements
- Employees unaware of available programs and their value
- Geographic health habits and influences
- Procurement rules
- Administrative time and cost impact
- Data integration from multiple carriers



SUCCESS MEASURES

- Year-over-year health care cost increase below trend
- Annual movement in value based payments to LAN Categories 3 and 4
- High levels of program participation and engagement
- Employees value their benefits and understand the underlying costs
- Increased consumerism behavior (e.g., generic Rx utilization, urgent care vs. ER)
- Health improvements (e.g., preventive screenings, disease management participation)

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PEBB-IDENTIFIED STRATEGES
LONG TERM STRATEGY AND BRIDGE STRATEGIES

LONG TERM STRATEGY

- Accountable Care Organization (ACO)
  - Need to develop a strategic framework and desirable metrics for PEBB's ACO model

BRIDGE STRATEGIES

- Bridge strategy for Concierge and Advocacy Services (CAS):
  - May go through request for information (RFI) process for "fact finding" on capabilities and return on investment
- Bridge strategies enhanced through carriers/administrators:
  - Center of excellence (COE) / Bundled Payments
  - Digital Health Solutions
  - Expert Medical Opinions (EMOs)

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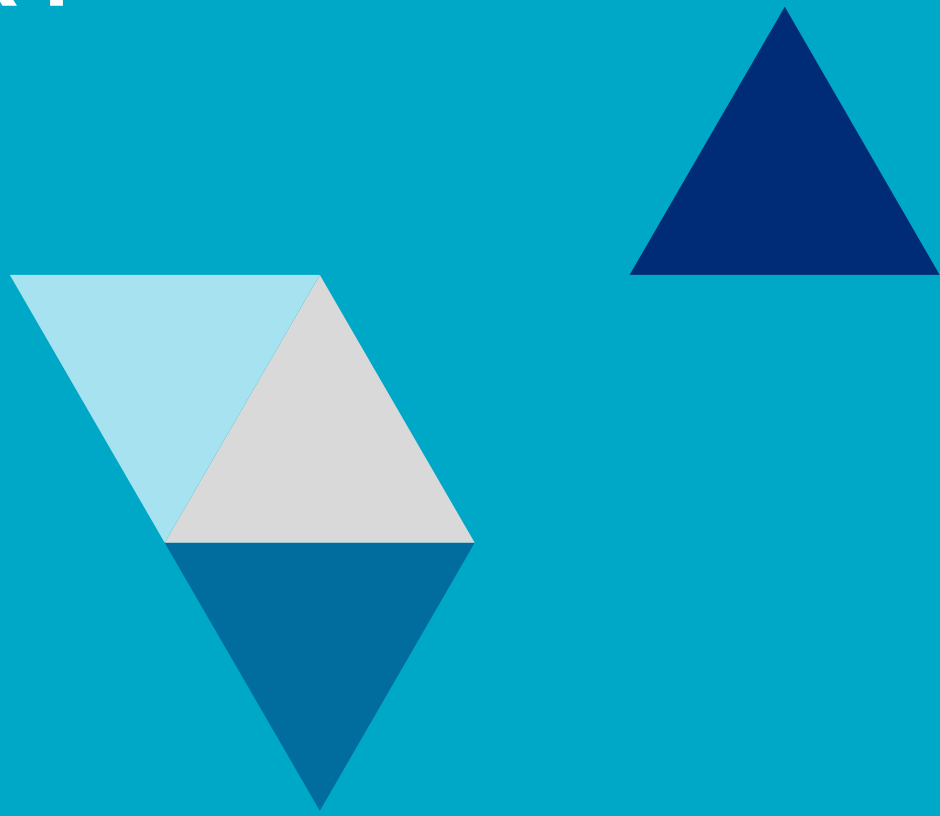
EXECUTIVE SUMMARY UPDATES



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UPDATES: LONG TERM STRATEGY AND BRIDGE STRATEGIES

Long Term: ACO

- Board has formed a small committee to work on developing a framework and guiding principles for the vision for an ACO specifically for PEBB
- With the strategic framework, there is more work to build out the full ACO model
- Board will decide on how to proceed with contracting

Bridge: Concierge and Advocacy Services

- Appropriate review is taking place to determine the advisable next steps based on procurement regulations
- Based on review, we will proceed to a request for information (RFI) as a “fact finding” process
- RFI would identify range of capabilities of vendors and their potential return on investment through analysis of de-identified claims data from PEBB

Bridge: Enhanced Carrier Services

- Data analytics are being performed to determine the health conditions for focus that will have the optimal impact on the PEBB population
- Carriers will be asked to describe how they can expand their existing programs to address significant opportunity areas based on the data analysis

Centers of Excellence/ Bundled Payments, Digital Health Solutions, Expert Medical Opinion

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MEDICAL
LONG TERM STRATEGY
ACO

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OVERALL COMPARISON BETWEEN CURRENT CCM AND ACO

	Healthcare Focus	Description	Financial Arrangement
Coordinated Care Model	Primary Care, some models include specialty care but others primarily focused on primary care	Care is coordinated and managed by primary care teams via patient-centered primary care homes	Variable financial risk arrangements depending on the provider, ranging from total cost of care to no financial risk
Accountable Care Organization (ACO)	Entire healthcare continuum of services	Primary care serves as the central coordinating focal (like current CCMs), and then also coordinates, information shares, and collaborates with other providers: • Specialists • Acute care • Long term care • Behavioral health • Ancillary services	• Fees at risk for the total cost of care • Graduated risk sharing over time • Exceptions may include high cost claimants, specialty pharmacy, etc.

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TRANSFORMING THE CCM 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

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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

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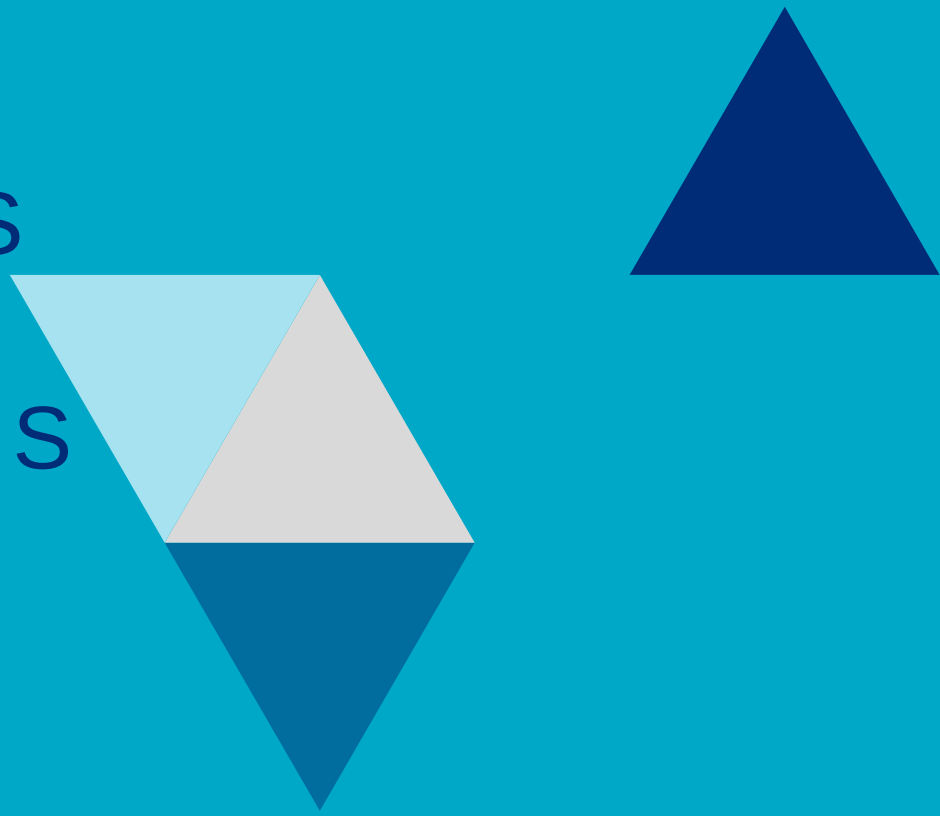
MEDICAL

BRIDGE STRATEGIES CONCIERGE AND ADVOCACY SERVICES



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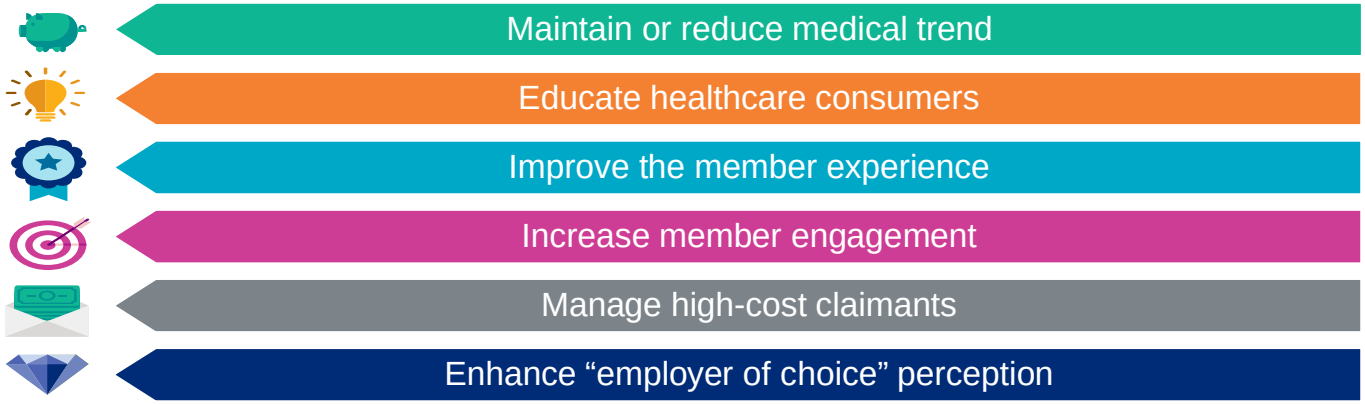
CONCIERGE / ADVOCACY
OVERVIEW AND PROBLEMS ADDRESSED

- **Enhanced customer service** staffed by highly qualified associates who seek to connect the dots between the caller's question and the underlying root-cause in an effort to **simplify the member's healthcare journey**
- Advocacy solutions have the potential to impact the following strategic goals:



- **The paradigm shift:**

Transactional, volume-driven service

- Customer service functions measured on call volume, call times – the shorter the better
- Clinical support teams viewed as a cost-center; emphasis on "making do" with resources at hand, without needing to invest more
- Limited integration between functions

Traditional carrier-led model

Transformative, outcome-focused service

- Customer service measured on referrals to relevant services/programs, identifying and resolving members' underlying questions
- Clinical teams seen as key in achieving proactive population health management
- Enhanced integration between functions; single point of contact where possible

Began as the carve-out niche, but carriers are adapting

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CONCIERGE / ADVOCACY
OVERVIEW AND PROBLEMS ADDRESSED

Problems being solved:

- Medical trend growth?
- Improved customer service?
- Enhanced clinical programs?
  - Targeting chronic conditions?
  - Targeting high-cost claimants?
- Engagement in healthcare and benefit programs?
- Return on program investment?
- Drive to quality in-network providers?
- Reduce administrative burden (for organization and/or member)?
- Provide assistance with navigating benefits and health system?

"Front door" for the member

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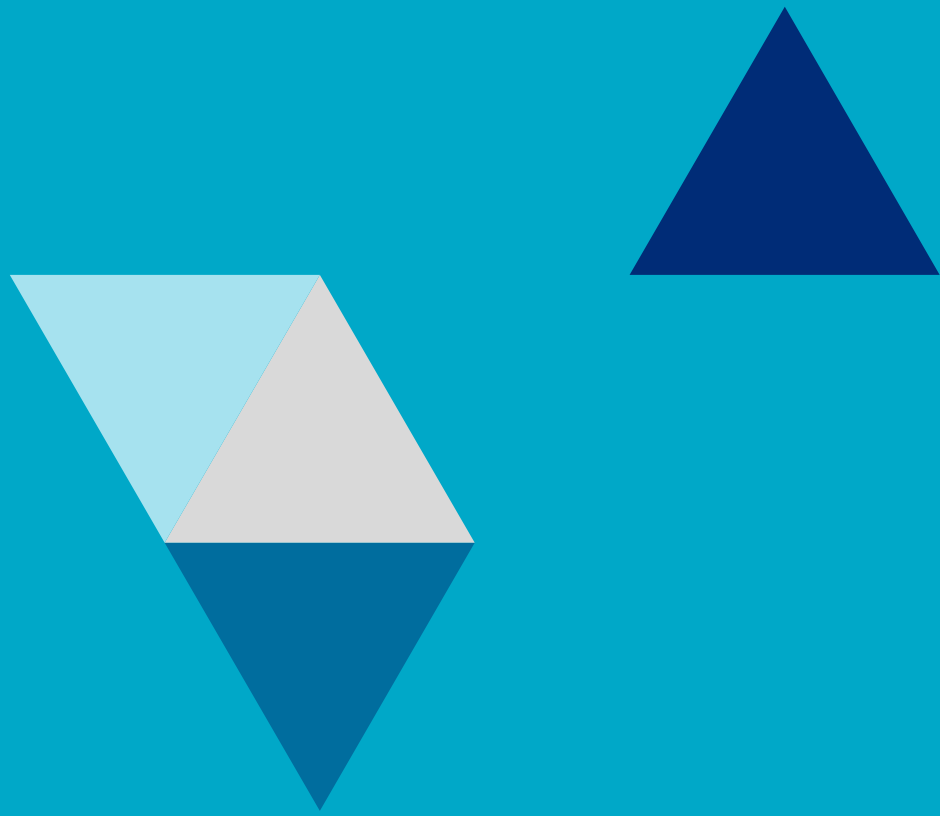
MEDICAL

OTHER BRIDGE STRATEGIES



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CENTERS OF EXCELLENCE
OVERVIEW AND PROBLEMS ADDRESSED

What is the problem?

- Lack of transparency with cost of major surgeries
- Extreme variation in cost and quality across the US and within markets
- Lack of consumer awareness about their options

What is a COE?

- A concentration of expertise and resources in a specific medical area
- Delivered in a comprehensive, interdisciplinary fashion
- Yielding an exceptionally high level of care

A bundled episode of care and payment

- A set of services to treat a condition or perform a procedure
- Expected total costs for a clinically defined episode of services
- Discourages unnecessary care
- Encourages coordination across providers
- Potentially improves quality and outcomes

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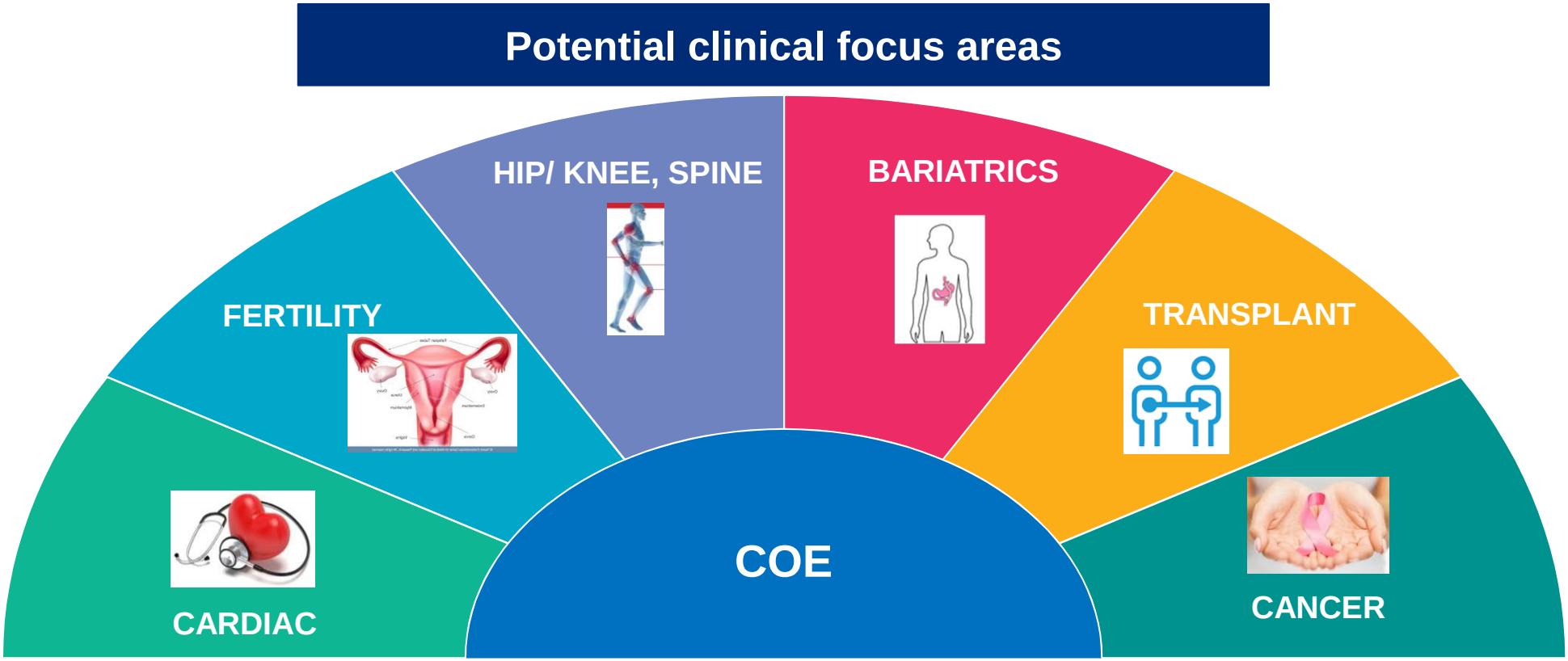
CENTERS OF EXCELLENCE
OVERVIEW AND PROBLEMS ADDRESSED



Integrated, whole-person health

Clinical standards of care

Engaged patients

Measurable health outcomes

Financial accountability

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DIGITAL HEALTH POINT SOLUTIONS
OVERVIEW AND PROBLEMS ADDRESSED

- Condition/risk-specific programs to improve the health outcomes of impacted individuals, including condition-specific apps and health coaching

Emerging point solutions are being developed across the healthcare continuum:

ACROSS CONDITIONS:

Behavioral Health	Sleep	Pregnancy
Cancer	Musculoskeletal	Cardiovascular
Diabetes	Senior Care	Provider quality
Financial wellness	Pharmacy	Chronic Disease and Asthma

ACROSS GENERATIONS:

- Millennials
- Generation X
- Baby Boomers
- Traditionalists

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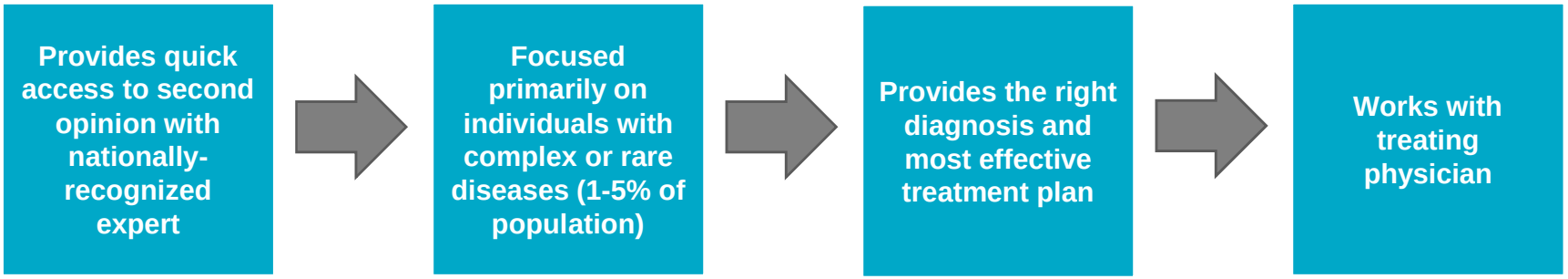
EXPERT MEDICAL OPINION (EMO)
OVERVIEW AND PROBLEMS ADDRESSED

- **What is the problem?**
  - Expert Medical Opinion (EMO) vendor data suggests over 30% of diagnoses and over 60% of treatment plans are incorrect
  - Employers and members may pay more than needed for excess and inappropriate testing and care, often with less than optimal outcomes
  - Patients and families feel overwhelmed by a diagnosis of a serious or rare medical condition
  - Health plan support is limited to in-network “experts” and health plans are cautious about the appearance of favoritism in selecting a limited group of experts
- **What is the solution?**



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EXPERT MEDICAL OPINION
OVERVIEW AND PROBLEMS ADDRESSED

- **Why should Expert Medical Opinion be considered?**

Better outcomes	Value to employees	Value to PEBB
• **Prevent unnecessary** testing and procedures • Reduce medical errors and optimize **quality of care** • Provides **more intensive** care management for high cost claimants	• Direct **access to top experts** without travel or out-of-pocket expenses • **Empowers** patient to make **informed** decisions • **Peace of mind** that diagnosis and treatment plan are correct	• **Potential to lower** health care costs and reduce absenteeism • **Enhances** benefit offering and integration with case management and other health management programs • **Global** Solution (limited to certain vendors)

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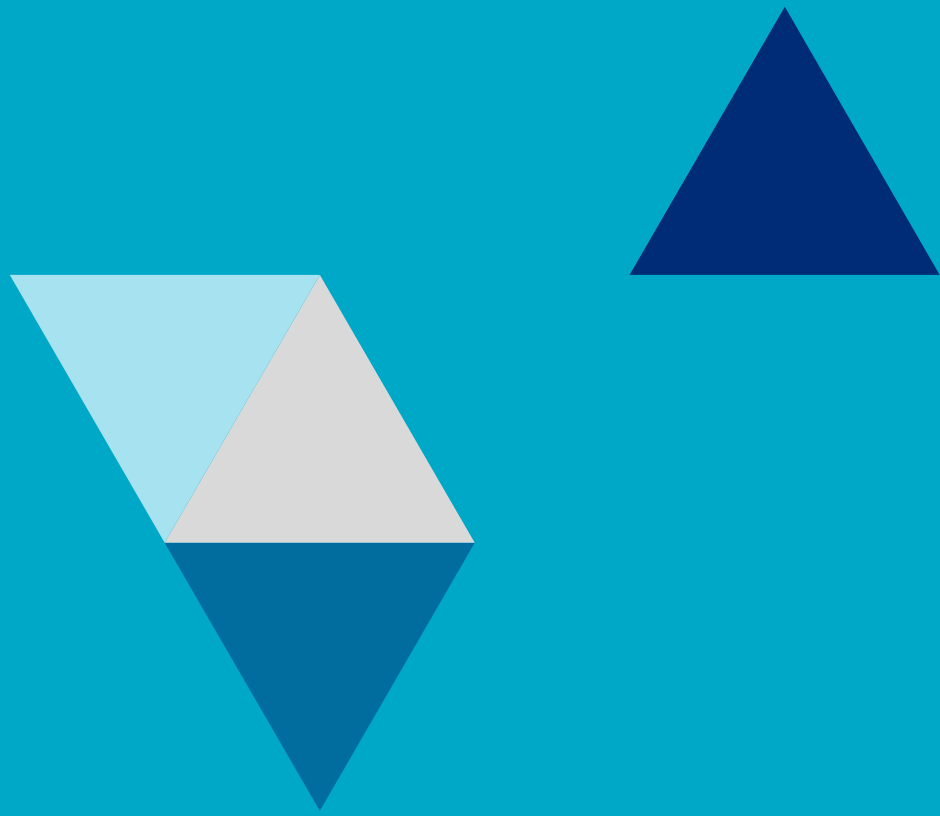
NEXT STEPS



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SUMMARY AND NEXT STEPS

ACO Development

Summary:

- ACO workgroup of the board provides a strategic framework and guiding principles
- The full Board reviews, refines, and finalizes its ACO strategic framework and guiding principles, such as the Board's shared vision of the number, location, and structure for the ACO (e.g., direct contracting, customizing the administrator's ACO, etc.)?
- Identify the Board's success measures (including clinical, financial, and member experience metrics) for the ACO
- Board's commitment to the necessary resources from itself and from staff for the ACO

Next Steps:

- Clarify procedures regarding applicable procurement regulations regarding an ACO initiative
- Discuss with the carrier/administrator their capabilities in developing the ACO - potentially
- Identify the Board, staff, consultants, administrator, and stakeholders for key workgroups to build out an ACO model
- Determine any coordination with other stakeholders
- Develop a work plan for all workgroups
- Identify the communication format and reporting cadence for ACO project updates to the Board

Bridge Strategies

Concierge and Advocacy Services (CAS):

- Review is being conducted regarding recommendations on how to proceed within applicable regulations
- Depending on the outcome of this review, potential request for information (RFI) fact finding process may occur

Other Bridge Strategies:
Center of Excellence (COEs)/ Bundled Payments, Digital Health Solutions, and Expert Medical Opinions (EMOs)

- Conduct data analysis to identify the high priority and high impact health conditions for the PEBB population
- If no additional information is needed and carrier responses meet Board expectations, explore enhancing the administrator's current programs based on the data analysis
- If the Board feels the carriers are not capable of administering a solution, PEBB Staff and Mercer may potentially work together to develop a formal RFI for the solution to source from a third party vendor

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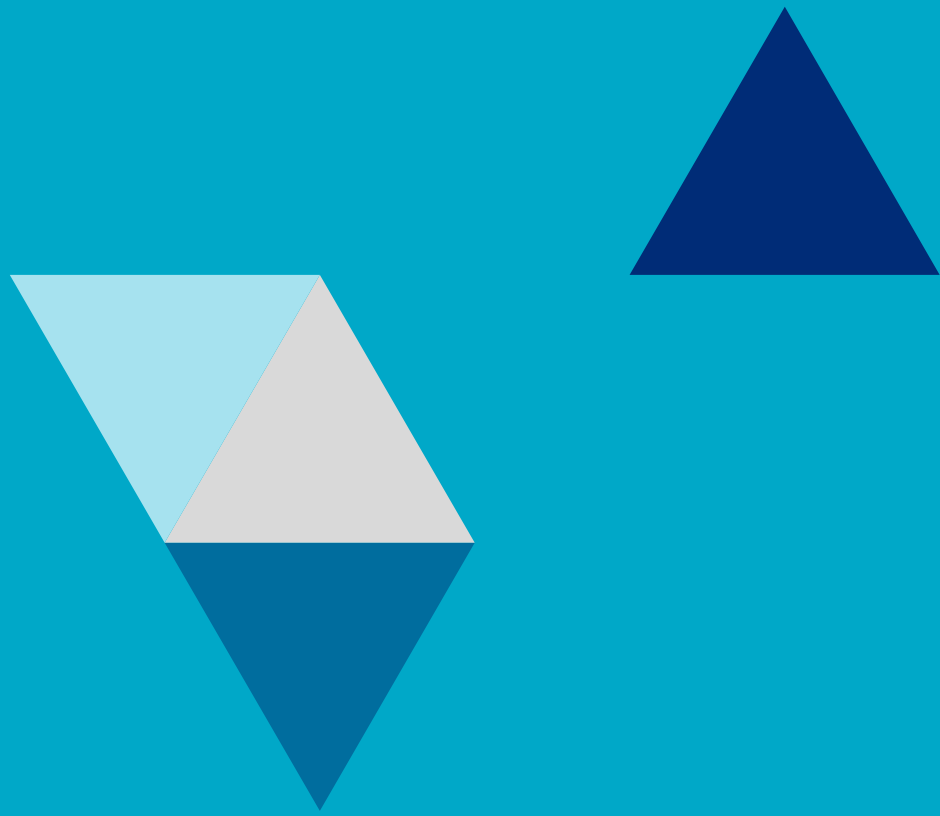
APPENDIX



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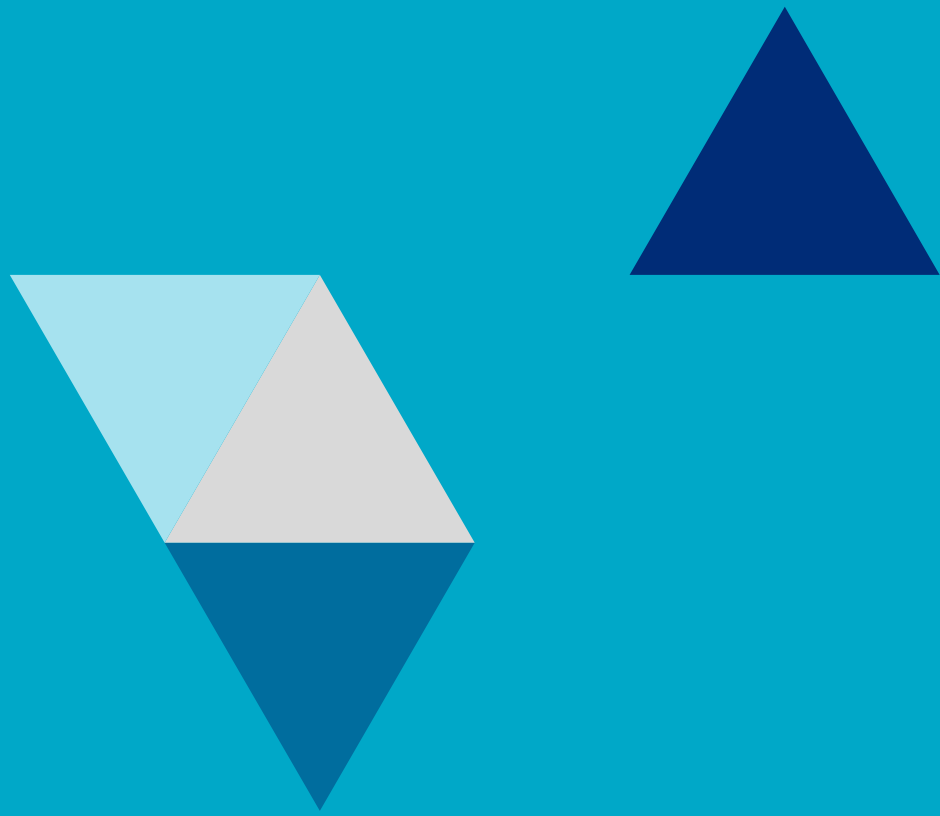
APPENDIX

ALIGNING WITH OREGON HEALTHCARE STRATEGIES



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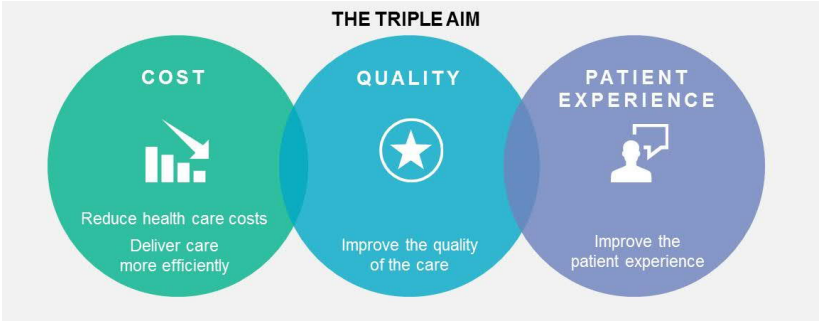
OREGON PEBB VISION

- 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



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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

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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

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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

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APPENDIX

PEBB'S CURRENT STATE

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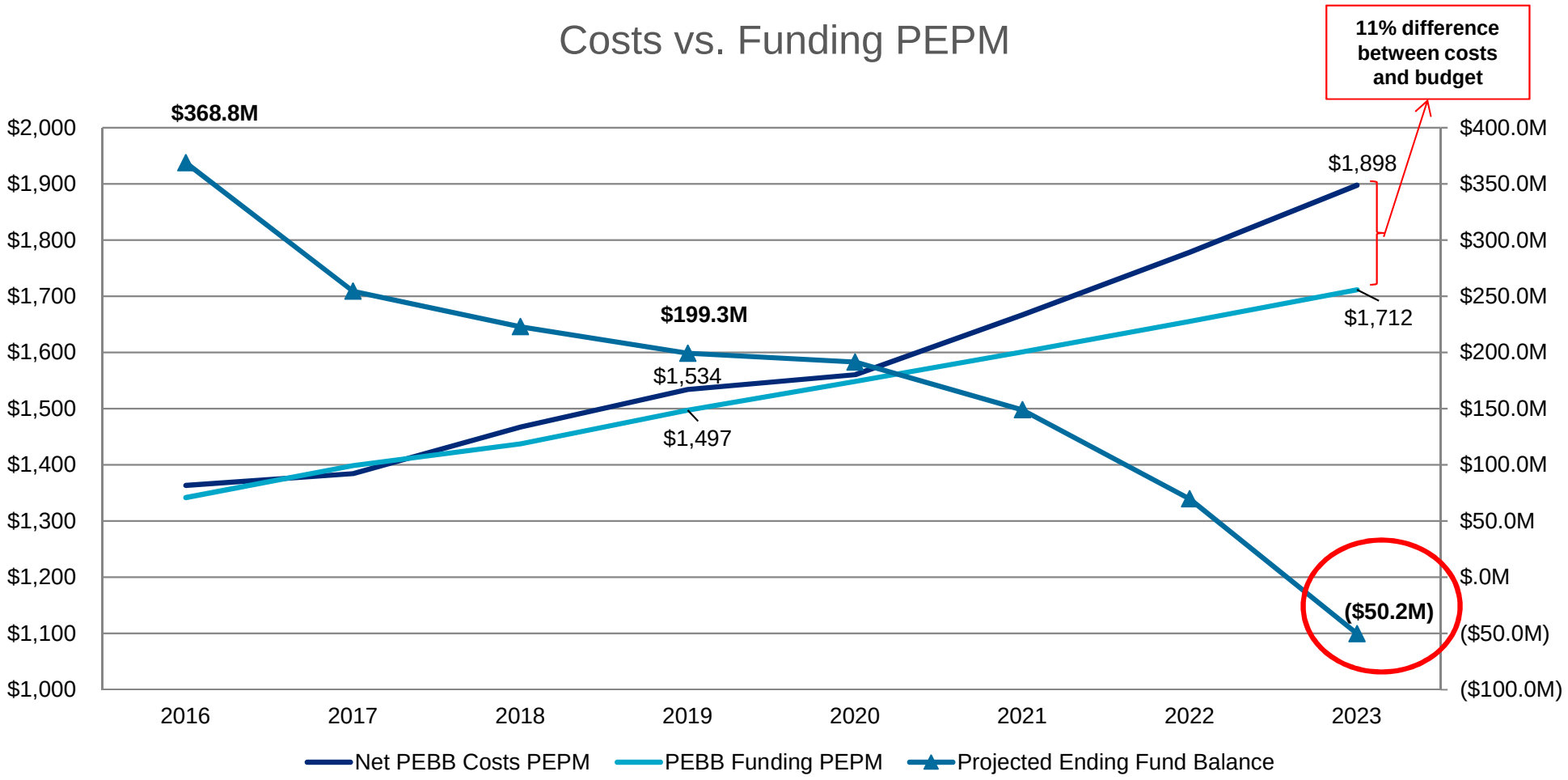
THE 3.4% FUNDING CAP
FUND BALANCE TURNS NEGATIVE BY 2023



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

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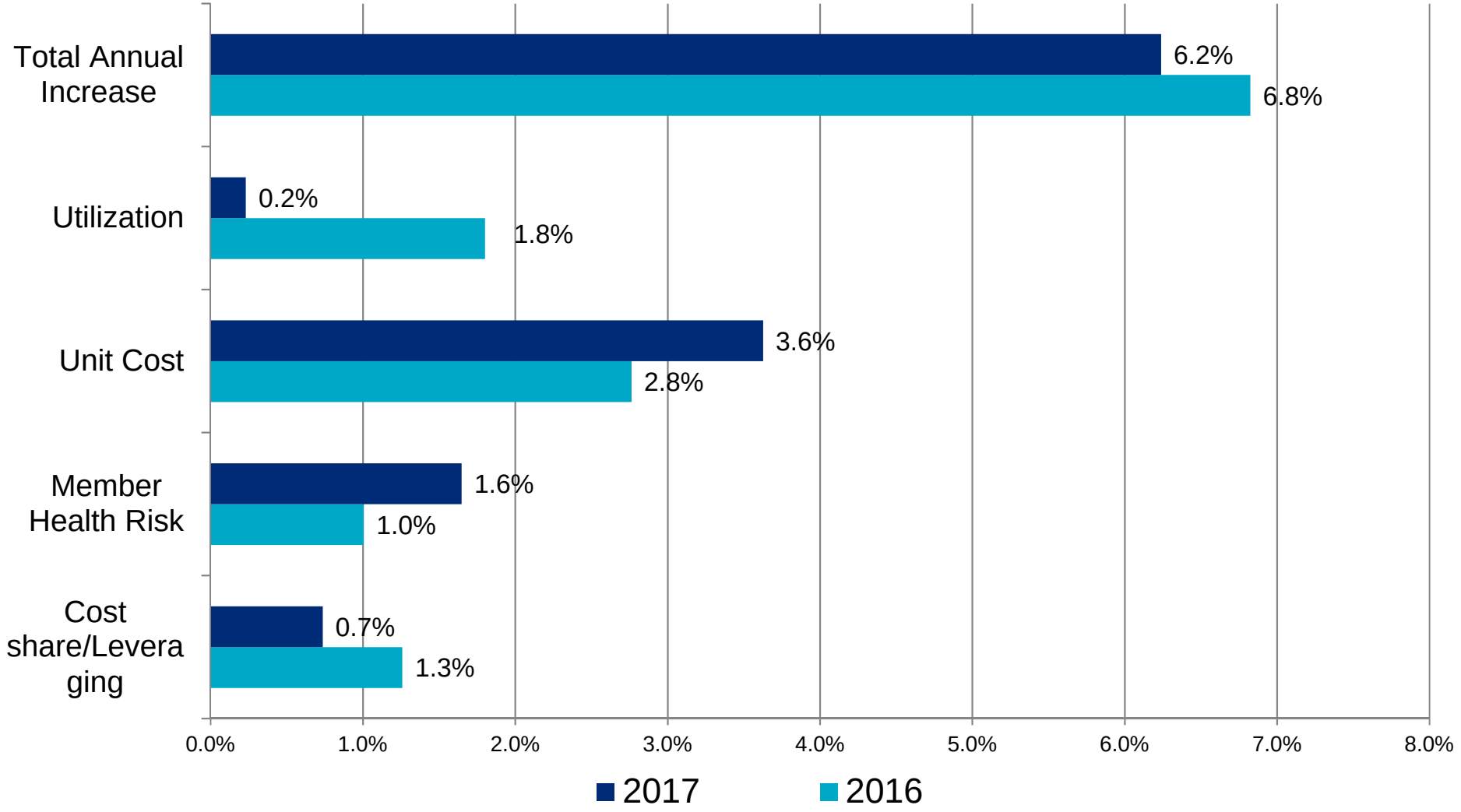
CHALLENGES OF 3.4% FUNDING CAP
HISTORICAL TRENDS REMAIN HIGH



Unit cost increases include impact of technology and service mix

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PEBB CHRONIC CONDITIONS

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

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

Previous Current Benchmark [3]

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

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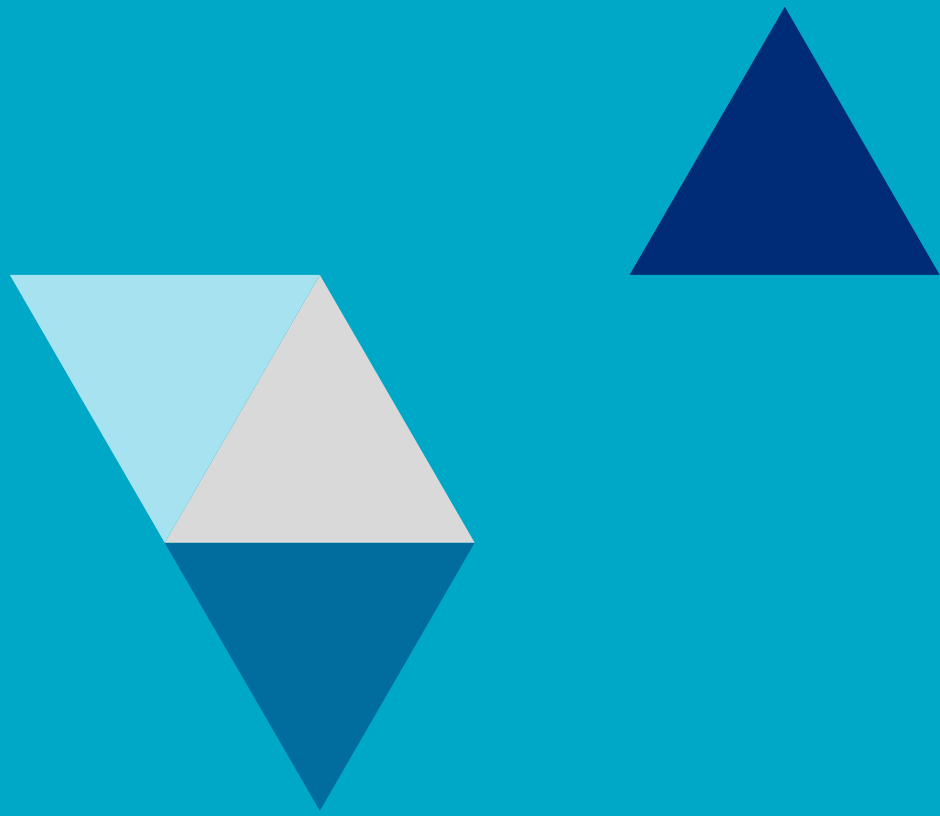
APPENDIX

POTENTIAL STRATEGIES AND ESTIMATED COST SAVINGS



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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

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BRIDGE STRATEGIES
ALIGNMENT WITH OHA'S COORDINATED CARE MODEL KEY ELEMENTS

	CONCIERGE AND ADVOCACY SERVICES	BUNDLED PAYMENTS AND CENTERS OF EXCELLENCE	DIGITAL HEALTH POINT SOLUTIONS	EXPERT MEDICAL OPINION (EMO)
Best practices to manage and coordinate care	Provides navigation to clinical services and benefit programs based on the identified needs of the members	COE contracts typically require vetted clinical teams and use of evidence-based clinical guidelines	Provides digital navigation, education, and support for members with clinical conditions	Incorporates evidence-based clinical guidelines in evaluating treatment options
Transparency in price and quality	May provide navigation to price and quality data if the plan includes that as a benefit program	May include information about the qualifications of the clinical teams, and the bundled payment amount is transparent	May incorporate data on cost and quality depending on the solution	May include information regarding quality providers
Shared responsibility for health	Should be included as a part of the requirements for this service, so that patients are given information about treatment options	Should be included as a part of the service, since the health system should be screening for the appropriateness of the proposed procedure	These solutions are aimed at providing education and support for patients with chronic conditions to accelerate self-care	Should be a part of this service, so that when the proposed procedure is being evaluated, the patients are also given information about treatment options
Measuring performance	Primary measure is active and sustainable engagement with the service	COE contracts typically include quality metrics, including performance guarantees, such as warranties and screening out members who are not appropriate for services	Primary measure is sustainable engagement with the digital health solution	Primary measure is based on avoidance of unnecessary services
Paying for outcomes and health	Potential array of performance guarantees related to member experience and engagement, referrals to clinical services, and improved health outcomes	Potential performance guarantees based on clinical outcomes, return to function, and member experience	Potential performance guarantees related to percent of members engaged with the digital health solution	Potential performance guarantees related to member experience, timeliness, and case outcomes
Sustainable rate of growth	Some vendors are willing to tie fees to overall trend growth depending on the overall structure of the program	Not directly tied to total cost of care but should result in reductions in unnecessary healthcare services	Not directly tied to total cost of care but could contribute to reduce costs with better managed conditions	Not directly tied to total cost of care but could result in avoidance of unnecessary services

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BRIDGE STRATEGIES
PLAN OF ACTION — FINALIZED IN DECEMBER

Strategies

Expert Medical Opinion

Concierge for Statewide

Bundled Payments with COE

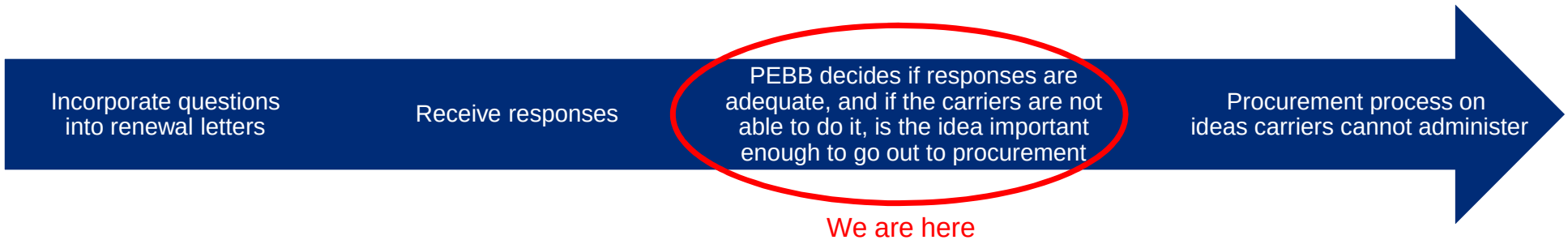
Point Solutions

Approach

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

#2
PEBB procures

Process



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CONCIERGE / ADVOCACY
FROM BOARD RETREAT

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

Projected Potential Savings

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

How this stacks up with key criteria

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

How this could make people happy

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

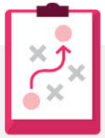
How this could frustrate people

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

TIMING
MEDIUM

CARRIER/VENDOR
NEW

COMMUNICATION
CONTINUOUS



IMPLEMENTATION
HIGH

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CONCIERGE / ADVOCACY SERVICES (CAS)
PROVIDENCE RESPONSE

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

Providence Proposal:

- Providence is willing to redesign the features of their existing customer service to identify member needs and provide an enhanced, personalized service experience
- **Service Delivery:**
  - Team-based structure by geography which will include clinical support, member support, whole person care management professionals, and ancillary Providence experts.
  - The team will manage all member inquiries, including claims/eligibility, coordination of care, provider access, and care plan coordination
  - Providence will also establish onsite resources at key locations throughout Oregon on a monthly or quarterly basis for face-to-face interactions
- **Experience / Training:** CAS teams will be selected from existing service and clinical caregivers
- **Quality / Metrics**:
  - Providence expects decreased utilization, decrease in avoidable costs, increase in number of members engaged in care management, decrease in complaints, and an increase in PCP / Express Care
  - Out of network costs will likely decrease
- **Marketing / Member Communication**:
  - Marketing campaigns throughout 2019 leading to full implementation in 2020
  - Existing PEBB microsite will be enhanced to direct Statewide members to the CAS program for navigation assistance
  - myProvidence portal will display geographically-based messaging to push relevant information, including direct contact information for the CAS team serving the member's location
  - Real-time web chat and email
- **Pricing**: Providence's goal is to have final pricing in alignment with the best-in-class concierge vendor

Questions / Concerns

- Providence is keenly interested in providing this service model for PEBB, however, it is completely new and many of the details are still in development
- The best-in-class vendors do not typically hire people with call center backgrounds, as the "retraining" is extremely challenging. The Providence CAS teams will be selected from the most seasoned among their existing customer service teams
- Providence will charge market rates for the service, but will not be placing fees at risk or proposing trend guarantees
  - According to Providence, the trend / PGs would not align with PEBB's goals of accelerating value based payment methodologies
- Procurement issues with going to an outside vendor, or even building it within Providence if the service deviates too far from original RFP

CAS = Concierge/Advocacy Services

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STRATEGY: BUNDLED PAYMENT WITH COES

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

Projected Potential Savings

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

How this stacks up with key criteria

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

How this could make people happy

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

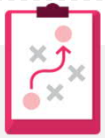
How this could frustrate people

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

TIMING
MEDIUM

CARRIER/VENDOR
CURRENT/NEW

COMMUNICATION
HIGH



IMPLEMENTATION
MEDIUM

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BUNDLED PAYMENTS / CENTERS OF EXCELLENCE (COE)

Existing Bundles and Savings

Providence

- **Total Joint Replacement (TJR)**
  - Two options: Providence Portland Medical Center or Providence St. Vincent Medical Center
  - Many patients receive the TJR surgery in the outpatient setting
  - Better experience for member, return to normal quicker
  - In 2017, 5% of the PEBB claims for major hip and knee joint replacement were included in the Joint Bundle program

Moda

- COE providers are available for the following:
  - Adult and pediatric transplants
  - Specialized cancer care
  - Congenital heart disease
  - Neonatal intensive care unit
  - Bariatric surgery
  - Ventricular assist device
- Partnership with OHSU – OHSU's advanced certification for stroke care, palliative care, heart failure, and ventricular assist devices

Kaiser

- COEs are part of Kaiser's integrated network
- For members requiring specialized care, Kaiser offers internal COEs regionally and external COEs perform transplants and other specialized procedures
- Services include: cancer treatment, cardiac, spinal, transplants, bariatric, joint, hemophilia, rheumatoid arthritis, HIV, MS, and transgender services
- Kaiser is willing to discuss performance guarantees associated with their COE services

On the roadmap

Providence

- Expansion of the Total Joint Replacement in an outpatient setting model that will further reduce costs and increase patient satisfaction

Moda

- Joint replacement
- Hemophilia
- Expansion of cancer care program options with the Knight Cancer Center, the only National Cancer Institute Designated Cancer Center in Oregon
- Certain pharmaceuticals, such as gene therapy

Kaiser

- Future COEs are determined by examining community needs, clinical research, and leveraging the knowledge collected by their electronic health record

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POINT SOLUTIONS
OVERVIEW AND PROBLEMS ADDRESSED

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

Projected Potential Savings

2020	2021	2022	2023
TBD	TBD	TBD	TBD

How this stacks up with key criteria

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

How this could make people happy

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

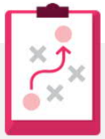
How this could frustrate people

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

TIMING
SHORT

CARRIER/VENDOR
NEW

COMMUNICATION
DIRECTED AND
CONTINUOUS



IMPLEMENTATION
MEDIUM

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POINT SOLUTIONS

Note: each of the carriers' responses were geared towards their care management or disease management programs; there were only a few instances Mercer found where the carriers used app-based digital technology platform

Overview

PROVIDENCE

- **Providence Ventures**
  - Investment arm of Providence has invested in a number of health innovation companies
- Many of the digital technology investments are tailored to hospitals / providers, but a few are member facing:
  - **Lyra Health –** Transformative Technologies in Behavioral Health
  - **Omada Health –** Digital Therapeutics for Chronic Disease Prevention
  - **SQORD –** Children's Wearable and Activity Platform
  - **Wildflower –** Mobile Family Health Platform
- Providence is working on a pilot partnership with **98.6**, which is on-demand primary care using a text-based mobile platform

MODA

- **eDoc** – Provides members with professional clinical online advice with timely personal responses, typically arriving in less than two hours. eDoc helps members understand their symptoms and make informed health decisions. It also encourages PCP follow-up as needed
- **Health Shelf** – Includes articles, mini-quizzes, self-checks, how-to-guides, worksheets, and recipes for healthy meals
  Moda is able to offer other programs such as VLM through **Canary**
  - Moda offers Canary for another large Statewide public group
- **Health & Wellness** –
  - Online health assessment (HA) tool where members receive a wellness score on a scale from 1 to 100.
  - Once the HA is completed, members can visit the Health Shelf, an online toolkit of health and wellness information

KAISER

- One of Kaiser's core strategies is the increased use of telehealth solutions, in all formats. Kaiser is making investments to ensure more members are steered towards these telehealth opportunities
- Kaiser's integrated system and electronic medical record (EMR) helps to identify at-risk members early through screenings, disease registries, hospital and outpatient visits, pharmacy records, and laboratory results
- Live coaching is available in several formats – in group settings, one-on-one sessions, online, or by phone
- Monthly, high-priority measures and other HEDIS measures are reported to all KP providers and staff. Kaiser can also capture long-term (up to 6 years) performance trends in most clinical areas
- Clinical data, engagement data, overview reports, and various utilization reports can be requested regarding all of Kaiser's disease management efforts

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STRATEGY: EXPERT MEDICAL OPINION

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

Projected Potential Savings

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

How this stacks up with key criteria

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

How this could make people happy

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

How this could frustrate people

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

TIMING
SHORT

CARRIER/VENDOR
NEW

COMMUNICATION
HIGH FOR
UTILIZATION

IMPLEMENTATION
MEDIUM

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EXPERT MEDICAL OPINION (EMO)

Overview

PROVIDENCE

- Providence Care Management Nurses assist members in starting a second opinion process
- Third opinions are available if the opinions of the first and second differ
- Utilization Management - Licensed clinical staff includes nurses, registered dietitians, and pharmacists responsible for clinical review in prior authorization, concurrent review, and discharge planning, etc.
- Providence has a number of Health System programs:
  - AskProv – connects providers with specialists, who can provide advice in near real-time
  - Spine Care Continuum (SCC) – supports managing patients with back and neck pain by reviewing MRI and clinical history
- Providence is willing to expand on their existing second opinion for PEBB
  - Phone # would be set up for members to call
  - Service could be used for various institutes – cardiology cancer, etc.
  - Willing to discuss reporting and data
  - Condition specific pricing may be paid on a case rate for EMO services

MODA

- Moda has a partnership with Magellan Rx Management for consultations on complex medication requests.
  - Particularly beneficial for rare and orphan diseases where there are a limited number of providers in the country
- Key Opinion Leaders provide second-opinion services during the prior authorization process and are also available for peer-to-peer conversations with treating providers
  - Reviews are initiated at the request of the provider or member, or a Moda clinical reviewer

KAISER

- Members may received a second medical opinion upon request, via in-person, telephone, or KP.org
- Physicians may also refer members to physicians outside KP for a 2nd opinion when medical expertise relevant to a condition isn't available within Kaiser
- Kaiser's Care Management Institute (CMI) develops and refines approaches to providing better health care and clinical performance
- All medical specialties are represented in Kaiser's EMO network
- Kaiser monitors compliance with clinical practice guidelines and clinical protocols, conducting quality assurance audits at least quarterly to measure variations in care
  - Deviations from guidelines are addressed at the system level and at the individual clinician level
- Behavioral health and chemical dependency are included
- Kaiser is open to discussing performance guarantees associated with reporting

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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

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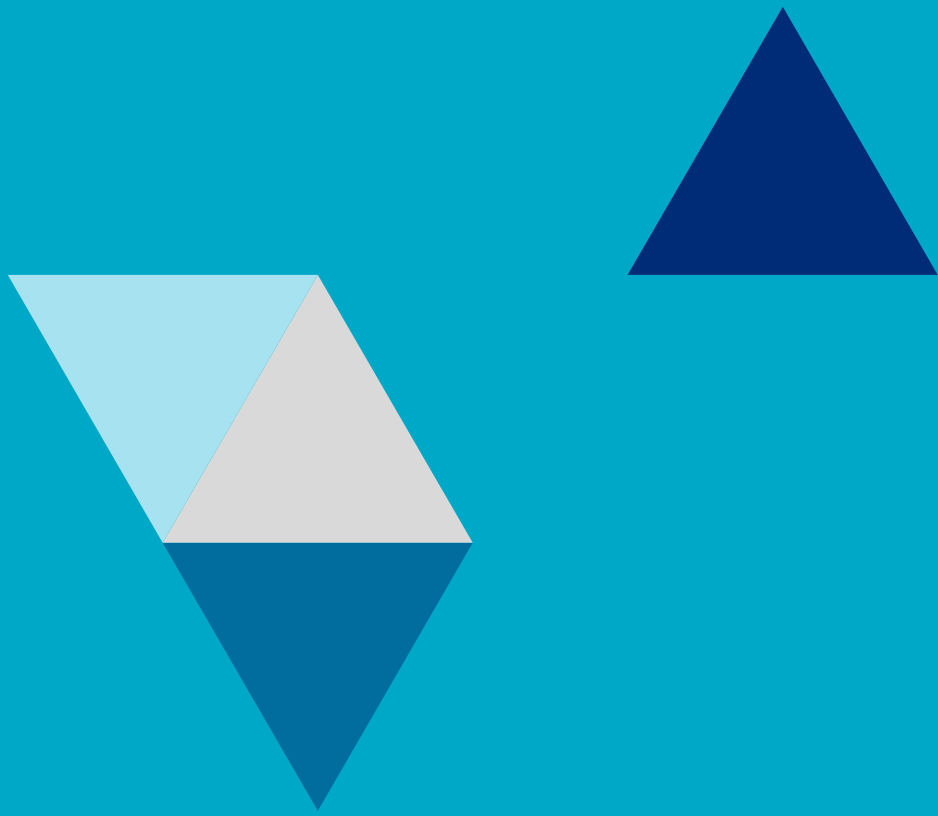
APPENDIX

ACO / CCO DEVELOPMENT



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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?

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OHSU STUDY
MCO, ACO, AND CCO COMPARISON

MCOs (Managed Care Organizations)	• MCOs receive capitated payments from a state Medicaid program to manage benefits for Medicaid members • Typically contract with and manage a network of health care providers • As in Oregon before 2012, separate MCOs typically manage physical, behavioral, and oral health benefits • MCOs may work with providers in their networks to improve care coordination, implement APMs, and improve other aspects of health care delivery and payment systems, although they usually lack an explicit directive to transform health care broadly
ACOs (Accountable Care Organizations)	• ACOs are groups of providers that assume responsibility for health care access and quality among a defined population of members • At minimum, they consist of a group of doctors and a hospital • ACOs typically receive financial incentives if they meet quality goals • The federal Medicare program recognizes multiple kinds of ACOs, and states are beginning to experiment with Medicaid ACOs
CCOs (Coordinated Care Organizations)	• CCOs shared aspects of MCOs and ACOs but resemble MCOs more closely • Like MCOs, CCOs contracted with and managed networks of providers, although some CCOs were organized as partnerships between MCOs and providers • Like ACOs, CCOs were accountable for the health care of a defined population and could receive financial incentives for performance • Unlike MCOs and ACOs, CCOs integrated funding and payment for behavioral and oral health care, and were directed to transform health care delivery and payment more broadly

Source: “Evaluation of Oregon’s 2012-2017 Medicaid Waiver” – OHSU Center for Healthy System Effectiveness

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KEY ELEMENTS OF VALUE-BASED CARE
ALIGNMENT WITH OHA'S KEY ELEMENTS OF COORDINATED CARE MODEL

OREGON COORDINATED CARE MODEL KEY ELEMENTS

Least Managed → Most Managed

	Statewide PPO	Coordinated Care Model (CCM)	Accountable Care Organization (ACO)	Kaiser HMO
Best practices to manage and coordinate care	Although there are reported quality measures, systematic implementation of evidence-based clinical guidelines across the entire PPO network is not required	The CCM model incorporates the primary care team as the focal for care coordination and referrals to specialists The financial arrangement depends on the provider – from no financial risk to total cost of care risk	ACOs have expectations for incorporating evidence-based clinical guidelines across the entire healthcare continuum	Evidence-based clinical guidelines are embedded into the electronic health record (EHR) for all providers
Transparency in price and quality	Limited implementation of a transparency tool by vendor	Some providers have vendor transparency tools include a healthcare cost estimator web tool for members to evaluate price Members can access information regarding the patient-centered primary care home (PCPCH) certification status	There is variability in ACOs providing cost and transparency tools to members ACOs are required to provide quality management of their in-network ACO providers Some ACOs are required to obtain and maintain primary care or patient centered medical home certification	Kaiser has an app that members can use in identifying providers within the Kaiser network Uncertain on the level of price and quality information in the Kaiser app Kaiser is an accredited health plan, so they publish their HEDIS scores which include quality metrics that are publicly available at the plan level, not the provider level
Shared responsibility for health	Not currently a requirement	Incorporated as one of the underlying principles for this model but unknown extent of dissemination Moda's programs for member engagement include the disease management programs as well as the C3 program and promote shared responsibility	Could be included as a requirement, including reporting out on the dissemination and outcomes (e.g., avoided procedures)	Typically included as a part of the Kaiser model, but not certain about reporting on the extent of the application

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KEY ELEMENTS OF VALUE-BASED CARE
ALIGNMENT WITH OHA KEY ELEMENTS

OREGON COORDINATED CARE MODEL KEY ELEMENTS

Least Managed → Most Managed

	Statewide PPO	Coordinated Care Model (CCM)	Accountable Care Organization (ACO)	Kaiser HMO
Measuring performance	Some quality measures are required to be reported with financial impact for meeting or not meeting the target	Quality metrics for primary care performance are part of the contractual requirement with financial penalties and incentives Coordinated Care Governance model includes requirements for provider participation including regular review of financial reports, quality & costs measures, network changes/updates, etc.	Quality and outcome measures are a key component for the ACO, including primary care, specialty care, hospitalizations, member experience, etc.	Kaiser reports out its quality metrics for PEBB as well as for plan accreditation with their HEDIS scores for the overall plan, not for individual providers
Paying for outcomes and health	Payment is based on a traditional fee-for-service (FFS) model	Primary care quality is incorporated into those providers who have a total cost of care reimbursement model based on the identified quality metrics for primary care Outcomes from specialty care and acute care are not part of the proposed payment model for CCMs but vendor may incorporate in future years	Depending on the extent of the financial risk, ACOs are incented to proactively manage care across the continuum of care with financial consequences when outcomes are achieved or not achieved	Kaiser is under a total cost of care, complete at risk contract, so there is an inherent incentive to obtain healthy outcomes with the lowest costs
Sustainable rate of growth	Over the last three years, the claims growth rate has been 7%, annualized	Over the last three years, the claims growth rate has been 6%, annualized (Includes Choice and Moda)	The medical trend rate is typically outlined over the course of several years with increasing limits to the trend rate over time	Over the last three years, the claims growth rate has been 5%, annualized (Includes Deductible and HMO plans)

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KEY ELEMENTS OF VALUE-BASED CARE
OTHER IMPORTANT CONSIDERATIONS

ADDITIONAL KEY COMPONENTS	Statewide PPO	Coordinated Care Model (CCM)	Accountable Care Organization (ACO)	Kaiser HMO
Benefit plan design	Members can access primary care or specialty care at will with no referrals required Prior authorizations are required for certain services such as hospitalizations	To receive In-Medical Home benefits, members must choose a medical home in the plan, notify the plan of their choice, and receive care through providers from that medical home or from providers referred by their medical home Otherwise, benefits typically have higher costs or may not be covered Usual benefit prior authorizations, e.g. hospitalizations, are required	Members are strongly encourage to select a primary care physician, and to allow the PCP to coordinate care and specialty referrals However, members can receive care from any provider within the ACO network with no referral If members go outside the ACO network, benefits have higher member cost share or may be not covered Usual benefit prior authorizations, e.g. hospitalizations, are required	Members must select a PCP who serves as the coordinator of care, including specialty care referrals required for certain services Co-pays and deductibles are lower than the statewide PPO when care is received from Kaiser providers and when referrals are obtained when required Except for emergency care, there is no coverage when seeking care outside the Kaiser network unless Kaiser has prior authorized the out of network services
Premium cost share	Highest premium cost share to the member	Lower than both Kaiser HMO plans and statewide PPO	Typically, the premium cost share is significantly lower than a PPO plan The comparison to HMO plans varies by plan	Traditional Kaiser plan is lower than the statewide PPO but higher than all of the other plans Kaiser deductible plan is lower than the traditional Kaiser plan and the statewide PPO plan
Financial reimbursement model	Traditional fee-for-service (FFS) reimbursement model	Primary care practices in the medical home network are reimbursed on FFS basis and with financial impact based on quality measures Limited capitated and foundational payments	Depending on the maturity of the ACO model, the financial reimbursement typically sits on a “FFS chassis” and then financial incentives and penalties are assessed based on quality metrics Some highly mature ACOs are fully at risk with some exceptions such as high cost claimants and specialty pharmaceuticals	Risk bearing, integrated delivery system combing coverage and cost of care Limited fee for service payments to contracted network hospitals
Information sharing, coordination, and integration with all benefit programs	No infrastructure or requirement for information sharing or care coordination	Primary care practices within the medical home network share information, and PCPs can make specialty referrals when the member seeks the coordination Uncertain if there is systematic information sharing between specialty practices and primary care practices	ACOs share information and provide care coordination through various means, including shared electronic health record (EHR), data intermediary, and other technologies	Kaiser providers share an integrated electronic health record (EHR), so that all providers (including primary care, specialty care, acute care, etc.) have access to all clinical information

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OPTIONS FOR ACHIEVING CCO / ACO

1. Piggyback on existing OHA CCO arrangements

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

Examples: Boeing, Washington HCA

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

Example: Microsoft

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

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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

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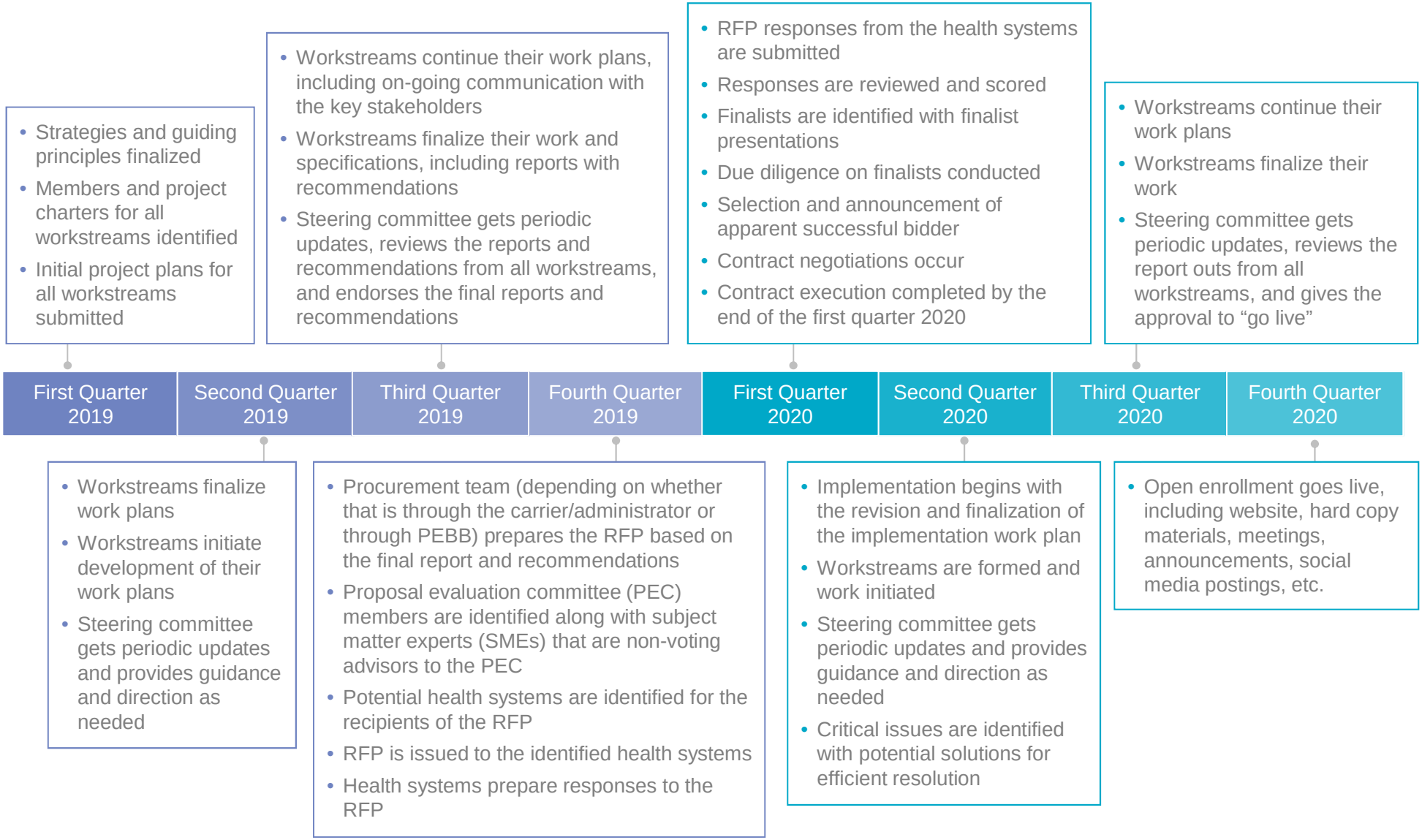
ILLUSTRATIVE TIMELINE FOR ACO DEVELOPMENT



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ACO BOARD INPUT
MEMBER SUCCESS MEASURES FOR AN ACO

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

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

*One abstention

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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:	

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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

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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

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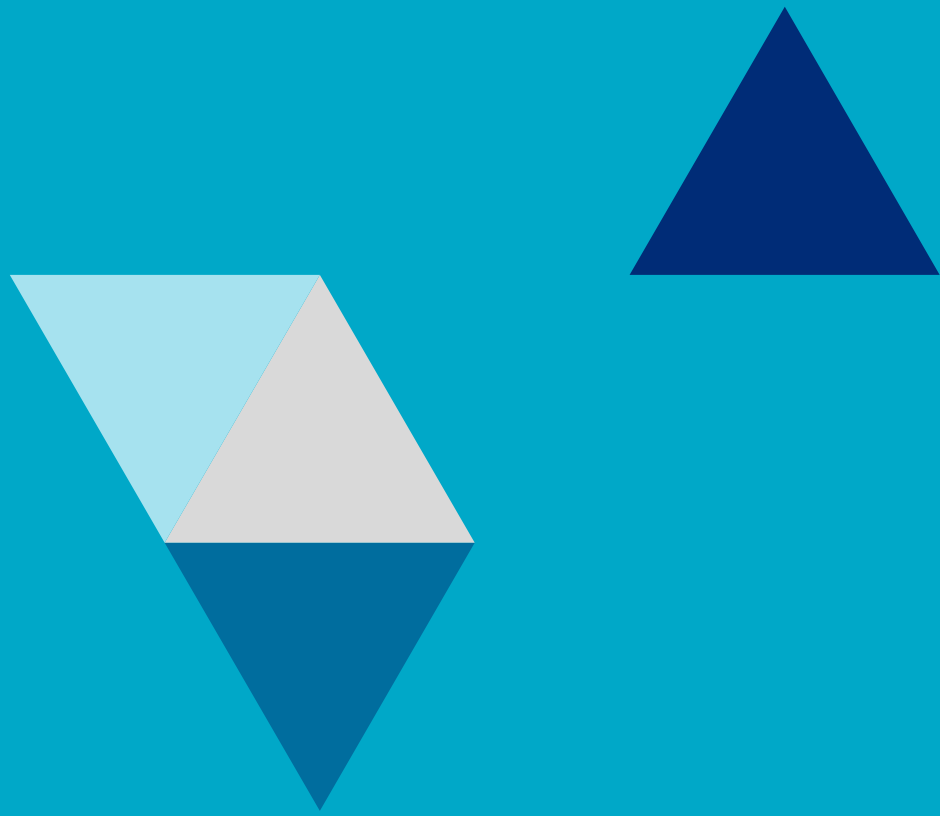
APPENDIX

ROADMAP FOR PEBB'S VALUE-BASED-PAYMENT STRATEGY



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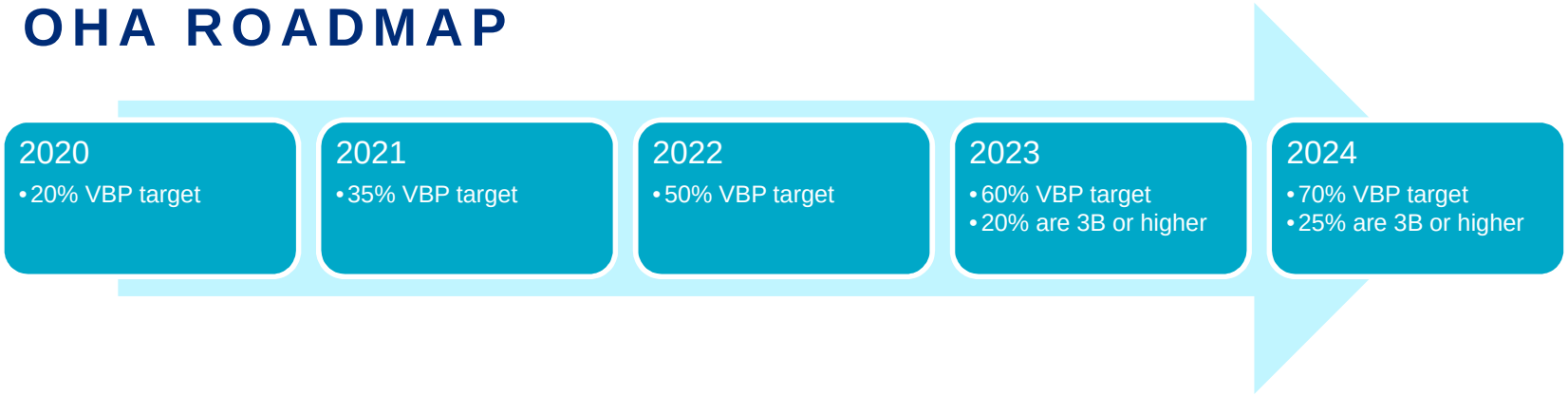
PEBB'S ROADMAP VS. OHA'S CCO 2.0

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

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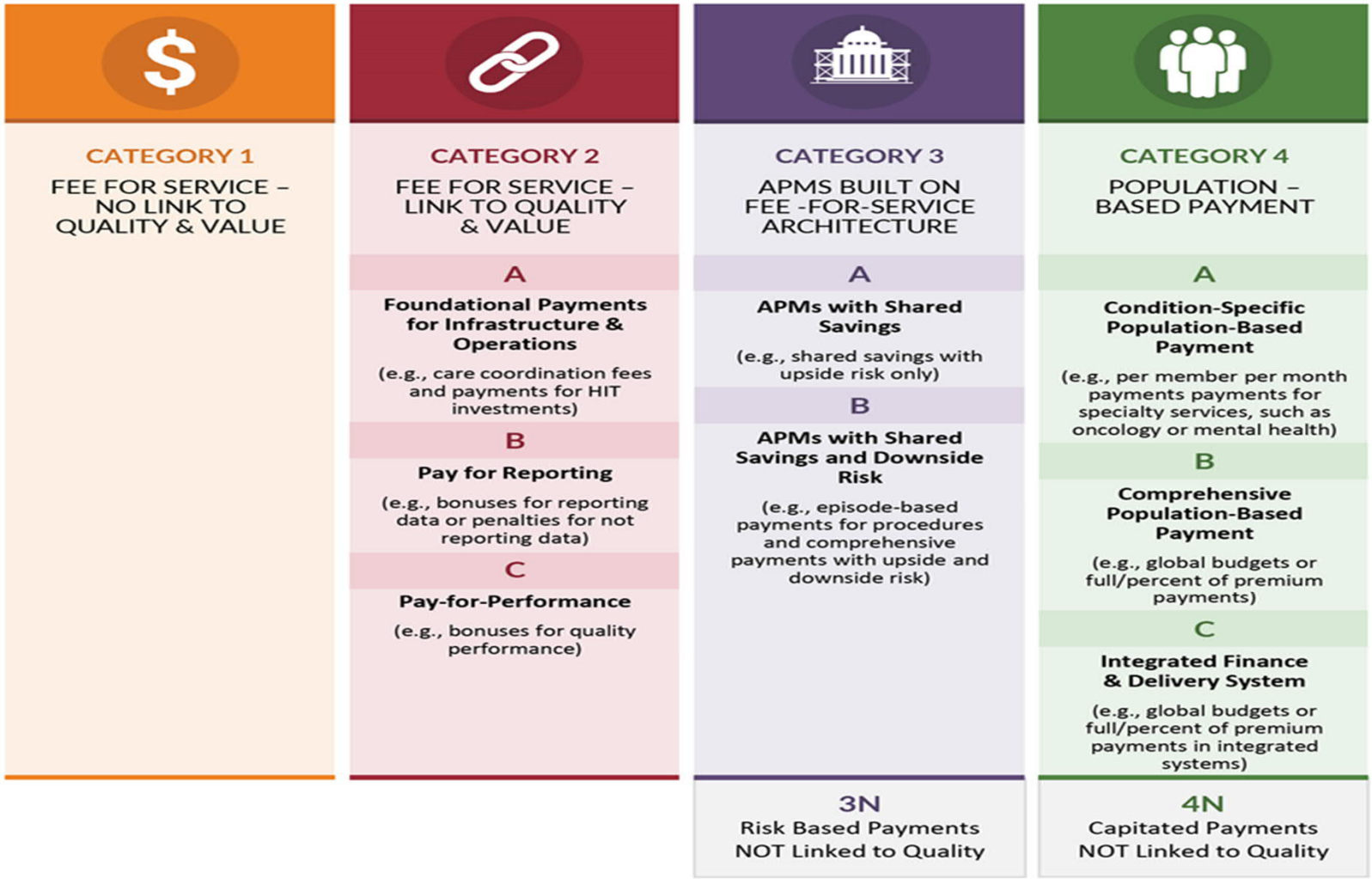
PEBB'S ROADMAP VS. OHA'S CCO 2.0
FINANCIAL ROADMAP



Source: APM Framework, HCP-LAN,2017

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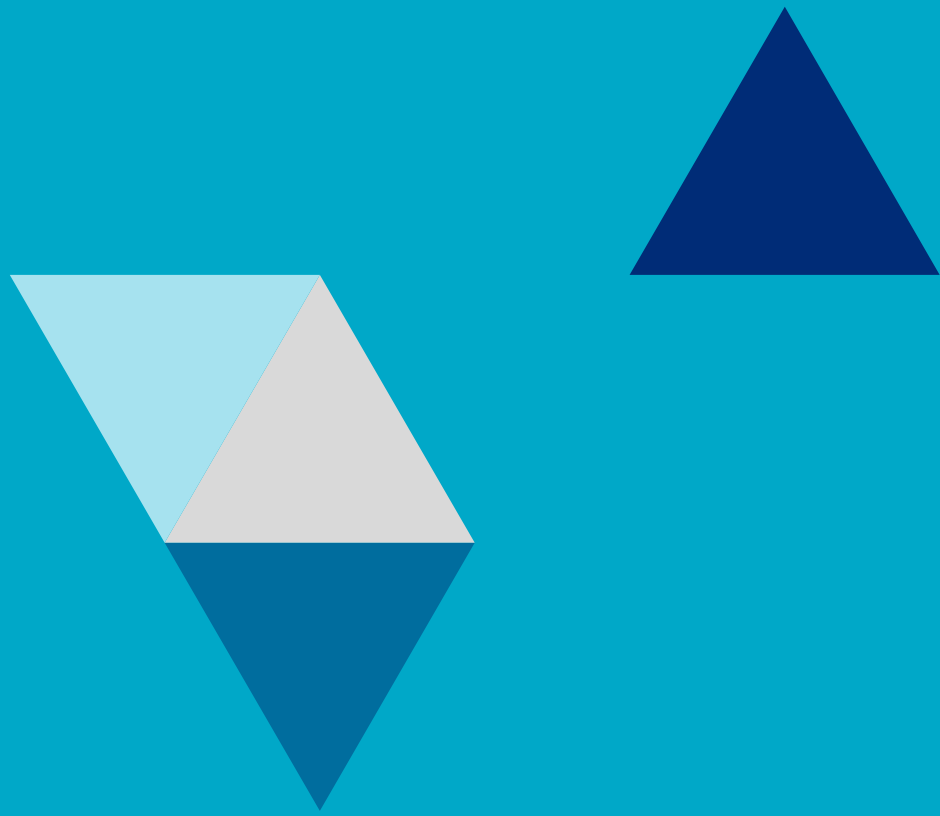
APPENDIX

EXAMPLES OF ACO NETWORKS



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MICROSOFT
THE HEALTH CONNECT PLAN

From Microsoft media release and employee newsletter:

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

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

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BOEING
PREFERRED PARTNERSHIP

For eligible employees in the Puget Sound region

From Boeing's Preferred Partnership website for employees:

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

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

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WASHINGTON HEALTHCARE AUTHORITY
UNIFORM MEDICAL PLAN (UMP)

From WA State HCA website

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

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

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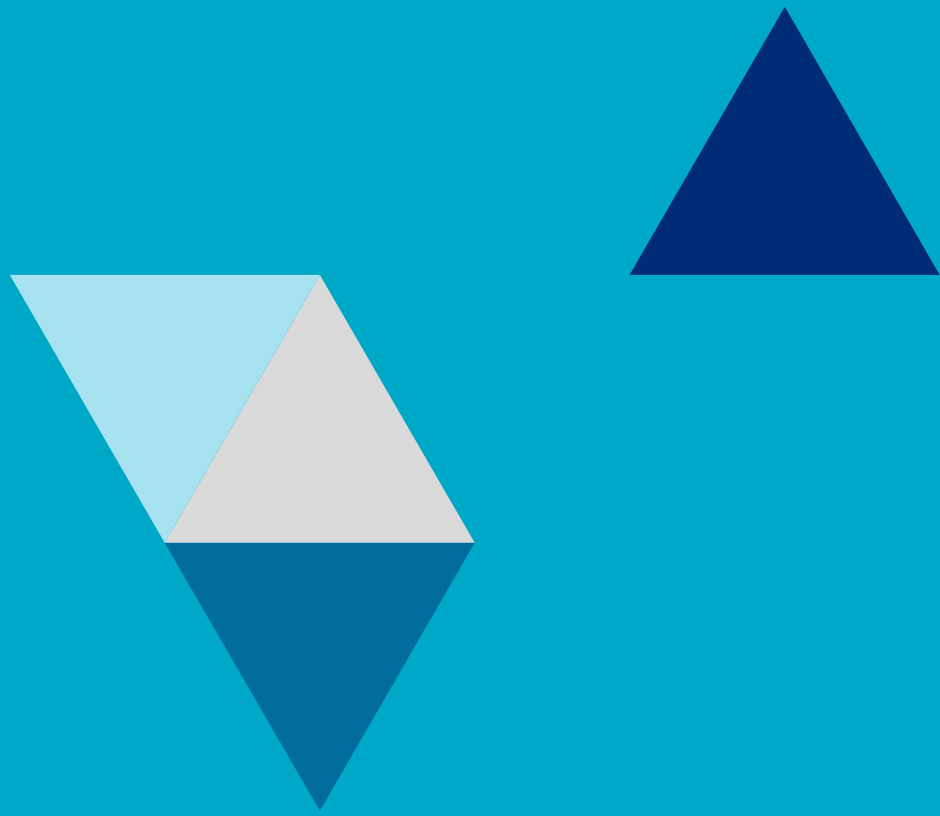
APPENDIX

EXAMPLES OF OTHER STATE INITIATIVES



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STRATEGY FOR ACTION
WHAT IS WASHINGTON DOING?
ACO AND BUNDLED PAYMENTS

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

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STRATEGY FOR ACTION
RURAL PAYMENT STRATEGY

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

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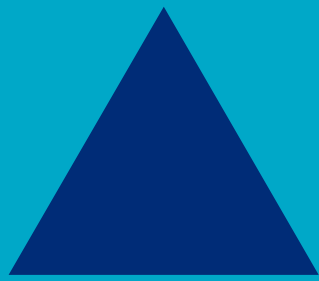
APPENDIX

GLOSSARY OF TERMS



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GLOSSARY OF TERMS

- **Accountable Care Organization (ACO):** This is a group of health care providers, potentially including doctors, hospitals, health plans and other health care constituents, who voluntarily come together to provide coordinated high-quality care to populations of patients. The goal of coordinated care provided by an ACO is to ensure that patients and populations — especially the chronically ill — get the right care, at the right time and without harm, while avoiding care that has no proven benefit or represents an unnecessary duplication of services.
- **Alternative Payment Model (APM):** This is a payment approach that gives added incentive payment to provide high-quality and cost effective care. APMs can apply to a specific clinical condition, a care episode, or a population. The APM framework began as a payment model classification system originally presented by the Centers for Medicare & Medicaid Services (CMS) and later modified by the HCP LAN workgroup, and it tracks progress toward payment reform and provides a pathway for the delivery of person-centered care.
- **Bundled payment**: a model that pays multiple providers across multiple settings for healthcare services associated with a defined “episode of care” under a single payment rate. Bundled payment is sometimes called “episode-based payment.”
- **Care coordination:** This is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care.
- **Capitation:** The per capita (per patient or beneficiary) payment arrangement for providing a specific menu of health services to a defined population over a set period of time. The provider usually receives, in advance, a negotiated monthly payment from the payer. This payment is the same regardless of the amount of service rendered by the provider.
- **Case management (CM):** This is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual’s and family’s comprehensive health needs through communication and available resources to promote quality cost-effective outcomes.
- **Centers of excellence (COE):** These are specialized programs within healthcare institutions which supply exceptionally high concentrations of expertise and related resources centered on particular medical areas and delivered in a comprehensive, interdisciplinary fashion.
- **Clinically integrated network**: This is defined as a collection of health providers, such as physicians, hospitals, and post-acute specialists that join together to improve care and reduce costs. Such networks generally share record systems, track data, and rely on evidence-based guidelines to provide high-quality care across participating providers.
- **Comprehensive Primary Care Plus (CPC+):** This is program from the Centers for Medicare & Medicaid Services (CMS) this is a regionally based, multi-payer advanced medical home model offering an innovative payment structure to improve healthcare quality and delivery. It is a five year federal program beginning in January 2017. Over 150 practices in Oregon have been selected to participate in CPC+.

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GLOSSARY OF TERMS

- **Coordinated Care Organization (CCO)**: This is a network of all types of health care providers (physical health care, addictions and mental health care and dental care providers) who work together in their local communities to serve people who receive health care coverage under the Oregon Health Plan (Medicaid).
- **Fee-for-service**: a model in which providers are reimbursed by payers at negotiated rates for individual services delivered to patients without financial responsibility for the total cost for specified episodes of care or for a population of patients. This category also includes pay-for-performance incentives that accompany fee-for-service payments.
- **Full Continuum of Care**: All aspects of care delivery, spanning preventive to end-of-life services in all settings.
- **Global payment**: a model that establishes spending targets to cover all of the expected costs for healthcare services to be delivered to a specified population during a stated time period. Global payment is called by other names, including “total-cost-of-care payment” and “population-based payment.”
- **Health Care Payment Learning & Action Network (HCP LAN):** This is a public-private partnership established to accelerate transition in the healthcare system from a fee-for-service payment model to those that pay providers for quality care, improved health, and lower costs.
- **Narrow Networks:** A strategy employed by health insurance companies (payers) that limit the number and types of physicians that are included in their network. In return, those physicians “in the network” typically extend greater discounts to the payer and receive greater numbers of patients. This arrangement may be primarily be based on deep discounts and not necessarily on quality metrics.
- **Patient Attribution:** The method used to determine which provider group is responsible for a patient’s care and costs.
- **Patient-Centered Primary Care Home (PCPCH), also called Patient-Centered Medical Home (PCMH):** This is an approach to providing comprehensive primary care for children, youth, and adults. This is a health care setting that facilitates partnerships between individual patients, and their person physicians, and when appropriate, the patient’s family.
- **Pay for performance (PFP or P4P):** An incentive system offered by some payers to healthcare providers based on their quality practices and/or outcomes or other factors. P4P programs come in a variety of forms based on the payer. Examples include Medicare’s Quality Payment Program (QPP). Some other programs offer financial incentives to providers who can meet evidence-based standards of care for particular conditions, such as heart disease, asthma and breast cancer screening that may exist both in government and private health plans or programs.
- **Population-Based Payment Model (PBM):** A payment model in which a provider organization is given a population-based global budget or payment and accepts accountability for managing the total cost of care, quality, and outcomes for a defined patient population across the full continuum of care.
- **Population Health:** The health outcomes of a group of individuals, including the distribution of such outcomes within the group. It is an approach to health that aims to improve the health of an entire human population.

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GLOSSARY OF TERMS

- **Population health management:** An approach to health care delivery that aims to improve the overall health outcomes of a defined population of individuals, based on the preservation of health, prevention of disease, and management of acute and chronic disease among members of the group. It typically relies on the aggregation of patient data across multiple health information resources, and analysis of data and actions through which care providers can improve both clinical and financial outcomes.
- **Risk adjustment:** A statistical process that attempts to take into account the known and latent comorbid conditions of a patient cohort when comparing health care outcomes or health care costs.
- **Risk Scoring:** A numeric value assigned to a particular patient in a risk adjustment system that indicates the relative level of spending that is expected for that patient and/or the relative level of quality or outcomes that can be expected in the delivery of care to that patient relative to other patients.
- **Risk Stratification:** A process of identifying, predicting, and separating patient populations into high-risk, low-risk, and likely to be at high risk (or rising-risk group) to assist in population health management activities.
- **Shared risk**: a model that holds the provider financially responsible for a negotiated portion of costs that exceed a predetermined budget, in exchange for provider eligibility for a portion of any savings generated below the predetermined budget. Shared-risk arrangements can be applied to global or bundled payments.
- **Shared savings:** a model that allows the provider to share in a portion of any savings generated below a predetermined budget. Shared-savings arrangements can be applied to global or bundled payments.
- **Total Cost of Care (TCOC):** A broad indicator of spending for a given population (i.e., payment form payer to provider organizations). In the context of PBM models, in which provider accountability spans the full continuum of care, TCOC includes all spending associated with caring for a defined population, including provider and facility fees, inpatient, and ambulatory care, pharmacy, behavioral health, laboratory, imaging, and other ancillary services (e.g., home health, hospice, durable medical equipment, supplies, etc.)
- **Value-based Care**: This is about empowering and rewarding providers to provide the right care, at the right time, in the right setting.
- **Value-based insurance design (VBID):** This is an insurance benefit design strategy that encourages use of high-value clinical services by aligning consumer spending with high-quality and beneficial health services and medications.
- **Value-based Payment:** This is a new payment method for healthcare services to providers aimed at rewarding value (quality of care), not volume (fee-for-service), so that providers assume more accountability for the quality and cost of care, incentivizing higher-value care, by health plans or purchasers.
- **Value-based Purchasing:** Purchasers, plan sponsors, and employers use to incent higher value care (i.e., quality metrics in contracts, payment based on quality and outcomes).

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