

OREGON PEBB BOARD MEETING

LONG TERM STRATEGY: MESSAGING FRAMEWORK

AUGUST 20, 2019



AGENDA

01

LONG TERM STRATEGY MESSAGING

02

ADDITIONAL LONG TERM STRATEGY INFORMATION

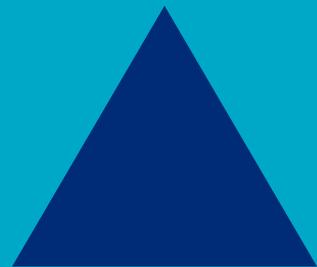
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UPDATES ON BRIDGE STRATEGIES

04

APPENDIX

LONG TERM STRATEGY MESSAGING



TRANSFORMING THE HEALTH PLAN

Triple Aim

Improve the quality of care

Improve the patient experience

Deliver care more efficiently



Improving Behavioral Health systems & increase value and pay for performance

Address social determinants of health and equity

Maintain a sustainable cost growth

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

Accessible and understandable information about costs, outcomes, and other health data that is available for informed decision-making

Appropriate provider, health plan and consumer incentives that encourage the right care at the right time and place

Benefits that are affordable to employers and employees

Health Plan Success Measure Areas

Patients



Delivery System



Plan Sponsor and Administrator



PROBLEM WITH TODAY'S HEALTH CARE SYSTEM

Without change, health care costs are on the rise and expected to outpace the state's budget and wages

For all that we spend, we don't often get the quality or value that we should. Expensive care is not always the best care



We know there are opportunities to have higher quality and higher value from Health Care Systems that is financially sustainable



PEBB has a mandate to redesign the health care system to drive better value for members and help control cost



Legislative mandate to control benefit spending to no more than 3.4% per year

OHA'S GUIDING PRINCIPLES FOR VALUE BASED CARE

Costs

- Leverage the state's purchasing power to receive better value and drive transformative change
- Move from a fee-for-service system that rewards volume and price increases to a payment system that rewards value, quality, and financial sustainability
- Create benefits that are affordable to employers and employees
- Obtain cost reductions from improved efficiency and effective care delivery, not from cost shifting to members

Care Transformation

- Leverage data across state programs to address outlier costs, waste, and inefficiency in the system
- Engage with innovative delivery systems in communities statewide that use evidence-based medicine to maximize health and use dollars wisely
- Focus on improving quality and outcomes, not just providing health care
- Create appropriate provider, health plan, and consumer incentives that encourage the right care at the right time for the right person at the right setting of care

Member Experience

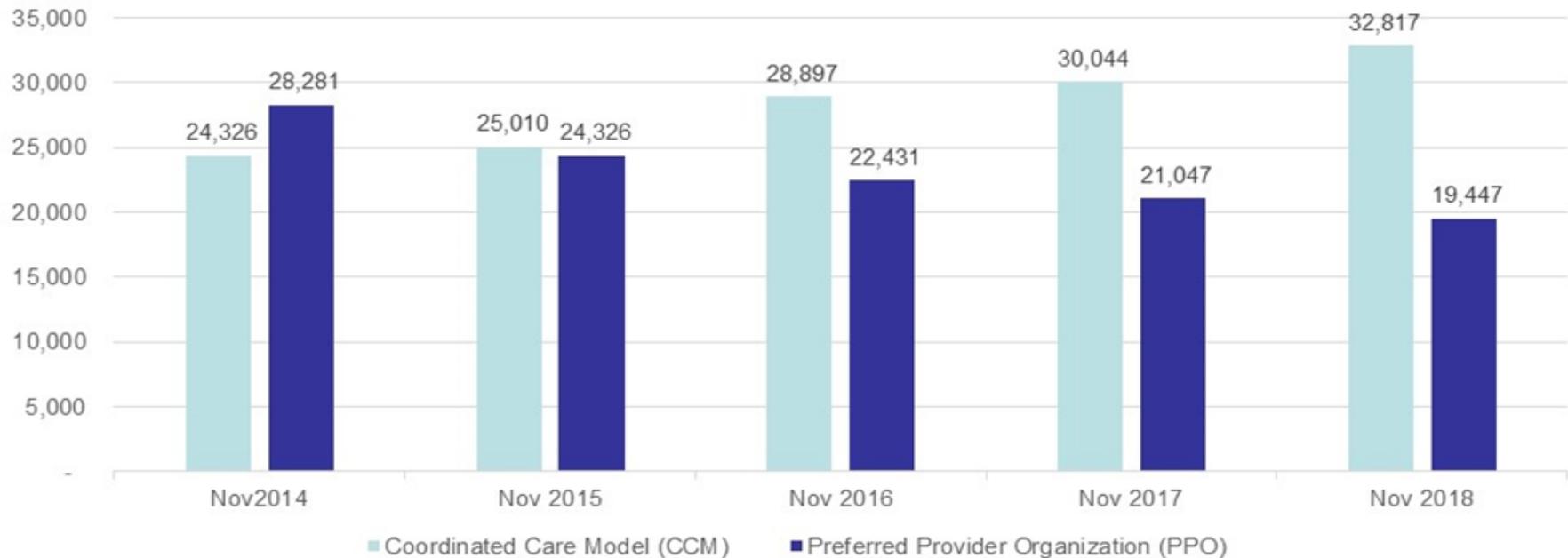
- Improve health equity by recognizing PEBB members are diverse and originate from racially, ethnically, culturally, gender- and ability- diverse communities throughout the state.
- Promote health and wellness through consumer education, healthy behaviors, and informed choices
- Provide accessible, understandable, and actionable information about costs, outcomes, and other health data to members, providers, and other stakeholders for informed decision-making

VISION

A LOOK AT THE NEW HEALTH PLAN

Oregon's coordinated care model has resulted in improved quality and reduced costs. PEBB will continue to evolve the coordinated care model building off the success to date while further advancing the model to improve health and healthcare, enhance the member experience, and lower costs.

Member Migration Between Plan Types 2014-2018



ALIGNMENT WITH OHA'S KEY ELEMENTS OF COORDINATED CARE MODEL



How the Oregon PEBB Health Plan will align with OHA's CCMs:

Providing equitable, patient centered care

The Health Plan will be expected to provide care based on the member's needs and preferences

Transparency in price and quality

The Health Plan will offer tools and resources for the member about the costs and quality of care within its provider network while supporting the member's decision making about healthcare choices

Partnering with communities to support health and health equity

The Health Plan will coordinate with community resources and services to meet the member's medical and human service needs throughout the healthcare system

Measuring performance and efficiency

The Health Plan will report on key measures of health compared to targets, including member experience, care from physicians and behavioral health specialists, hospitalizations, and other quality metrics

Financial stability and strategic investment

The Health Plan will keep its annual medical trend rate at or below 3.4% with a directional decrease over time

Paying for outcomes and health

The Health Plan will incent providers to deliver care that achieves the best outcomes for the member with financial impacts based on outcomes

HOW WILL PEBB DO THIS

Over the next year, PEBB will establish clear requirements for future health plans that can commit to advancing the coordinated care model by improving quality, reducing costs, and improving the member experience while seeking innovative health delivery system designs and delivery models.

Value-Based Payments

Advanced value-based payment arrangements that incent the health care system to reduce unnecessary services and unnecessary costs while improving care, including alignment with CCO 2.0 expectations that 70% of payments be in an advanced value-based payment category by 2024

Quality Metrics

Set quality and performance expectations and increase the amount of payments to plans based on whether the health systems meet those expectations, including physical health and behavioral health metrics

Enhanced Patient Experience

Establish metrics to measure and improve patient experience, including health equity, social determinants of health, patient reported outcomes, and patient empowerment metrics

WHAT DOES THIS MEAN FOR MEMBERS

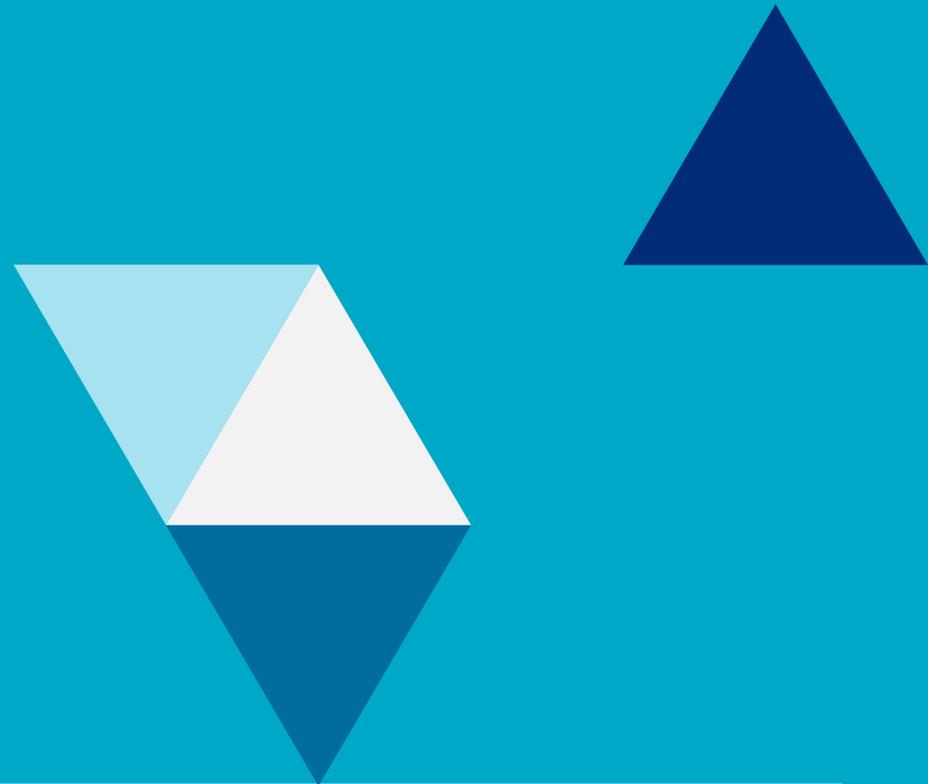
PEBB IS STILL IN THE DESIGN PHASE OF CREATING THE FUTURE VISION OF COORDINATED CARE MODEL PLANS

MEMBERS WILL RETAIN THE OPPORTUNITY TO CHOOSE WHICH PLAN THEY ENROLL IN

THE NEW HEALTH PLAN WILL OFFER THE OPPORTUNITY TO ENROLL IN HIGHER VALUE, LOWER COST PLANS FOR MEMBERS

THE NEW HEALTH PLAN WILL ALIGN AND FURTHER EVOLVE TO MEET THE GOALS OF THE TRIPLE AIM, THE GOVERNOR'S HEALTHCARE PRIORITIES, OHA'S GUIDING PRINCIPLES, AND PEBB'S VISION

ADDITIONAL LONG TERM STRATEGY INFORMATION



KEY TRENDS AND HEADLINES

- **North Carolina state employee benefit plan:** Hospitals refuse to join a network where the fee schedule was going to be based on a percent of Medicare
- **Surprise medical billing and balance billing:** Challenges and legislation to contain surprise billing
- **Medicare for All:** Range of plans from Democratic presidential candidate on reforming healthcare
- **Social determinants of health:** Health plan and provider initiatives to address transportation, housing, food, and other social issues
- **Behavioral health:** Strategies and care models for integration of primary care and behavioral health
- **Health Information Technology Grant:** OCHIN working to increase digital connections with primary care providers in 14 states
- **Public Option Plans:** State-chartered health plans on state exchanges using Medicare benchmark rates for providers
- **Price and Quality Transparency:** Tools for consumers as well as regulations requiring price transparency from hospitals

CHALLENGES WITH TODAY'S HEALTH CARE SYSTEM

The Commonwealth Fund's 2019 Scorecard on State Health System Performance assessed all 50 States on 47 measures of healthcare, quality of care, service use and costs of care, health outcomes, and income-based healthcare disparities revealing the following for Oregon:

Overall Ranking: 17; moved up 6 since 2018

- Top Ranked Indicators
 - Medicare spending per beneficiary
 - Children who are overweight or obese
 - Preventable hospitalizations age 18-64
- Most Improved Indicators
 - Home health patients without improved mobility
 - Uninsured adults
 - High out-of-pocket medical spending
- Bottom Ranked Indicators
 - Hospital 30-day mortality
 - Adults with inappropriate lower back imaging
 - Children without all recommended vaccines
- Indicators that Worsened the Most
 - Hospital 30-day mortality
 - Children without all recommended vaccines
 - Preventable hospitalizations age 18-64

OTHER IMPORTANT CONSIDERATIONS

Benefit plan design

Members are strongly encouraged 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 Health Plan network with no referral

If members go outside the Health Plan network, benefits have higher member cost share or may be not covered

Usual benefit prior authorizations, such as hospitalizations, are required

Premium cost share

Typically, the premium cost share is significantly lower than a PPO plan

The comparison of member cost shares to HMO plans varies by plan

Financial reimbursement model

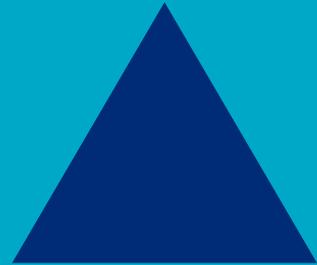
Depending on the maturity of the Health Plan model, the financial reimbursement typically sits on a “fee for service chassis” and then financial incentives and penalties are assessed based on quality metrics

Some highly mature Health Plans are fully at risk with some exceptions such as high cost claimants and specialty pharmaceuticals

Info sharing, coordination, and integration with benefits

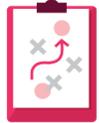
Health Plans share information and provide care coordination through various means, including shared electronic health record (EHR), data intermediary, and other technologies

UPDATES ON BRIDGE STRATEGIES



BRIDGE STRATEGIES PLAN OF ACTION

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

Incorporate questions
into renewal letters

Receive responses

PEBB decides if responses are
adequate, and if the carriers are not
able to do it, is the idea important
enough to go out to procurement

Procurement process on
ideas carriers cannot administer

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>
\$7 M	\$11 M	\$16 M	\$17 M

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

CONCIERGE AND ADVOCACY SERVICES (CAS) REQUEST FOR INFORMATION (RFI) CONTENT AND RECIPIENTS

RFI Content

- **CAS questions** – These questions were drafted by Mercer with input from OHA
- **OHA and CAS Background** – This was developed by both Mercer and OHA
- **Attachments** sent alongside the RFI

RFI Questions

- **Structure:** Questions regarding the organization, staffing model, scope of services, etc.
- **Process – Organization:** Questions regarding internal processes and member experience
- **Process – Administration (Non-Clinical):** Questions regarding how the concierge and advocacy service representatives assist members with claims, provider selection, benefit plan navigation, and other non-clinical services.
- **Process – Clinical:** Questions regarding the scope and range of clinical management programs, such as utilization management, case management, disease management, etc.
- **Integration:** Questions regarding their ability to share information and coordinate with other benefit providers.

Attachments

- **RFI Background** – The background information indicates PEBB's background and identifies the appropriate context of the RFI.
- **Summary Plan Design** – Member handbook as well as a summary of plan description for the Providence Statewide Plan.
- **Experience Report** - Prior claims history for the Providence Statewide plan with de-identified data.
- **Governor's Healthcare Strategy** - Governor Brown's vision is for all Oregonians to have quality, affordable health care, regardless of who they are or where they live.

The RFI is NOT a procurement, so no contract award will be made. The RFI was sent to a select number of organizations and is open to any responders to provide a market update on capabilities to OHA and PEBB.

CONCIERGE AND ADVOCACY SERVICES (CAS) REQUEST FOR INFORMATION (RFI) TIMELINE

1

- RFI released to vendors through ProposalTech – 8/5
- Questions due to Mercer – 8/12
- Mercer responds to the questions with help from OHA (no additional follow up questions) – 8/19
- Responses are due back to Mercer – 9/9

2

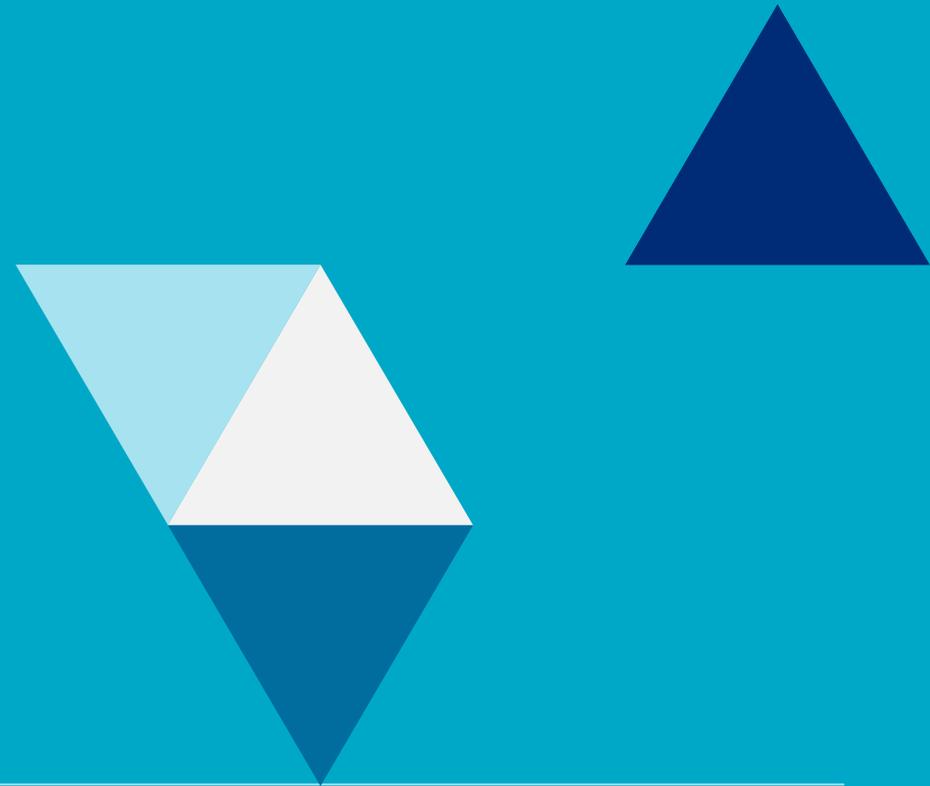
- Mercer conducts questions and interviews for respondents – 9/23 – 9/27
- Mercer compiles responses while reviewing responses with OHA staff – 9/9 – 9/27
- Mercer & OHA potential interviews with selected responders – 9/30 – 10/11

3

- Mercer summarizing findings – 10/11 – 10/25
- Mercer works with OHA staff to update and finalize the findings – 10/28 – 11/1
- Mercer presents the report and findings to the PEBB Board – 11/12

Mercer works with OHA staff to determine next steps, if any, regarding CAS services

APPENDIX



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



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

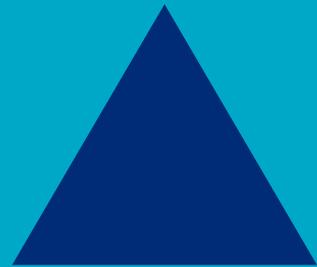
Enhance care coordination

Engage stakeholders and community partners

Measure progress

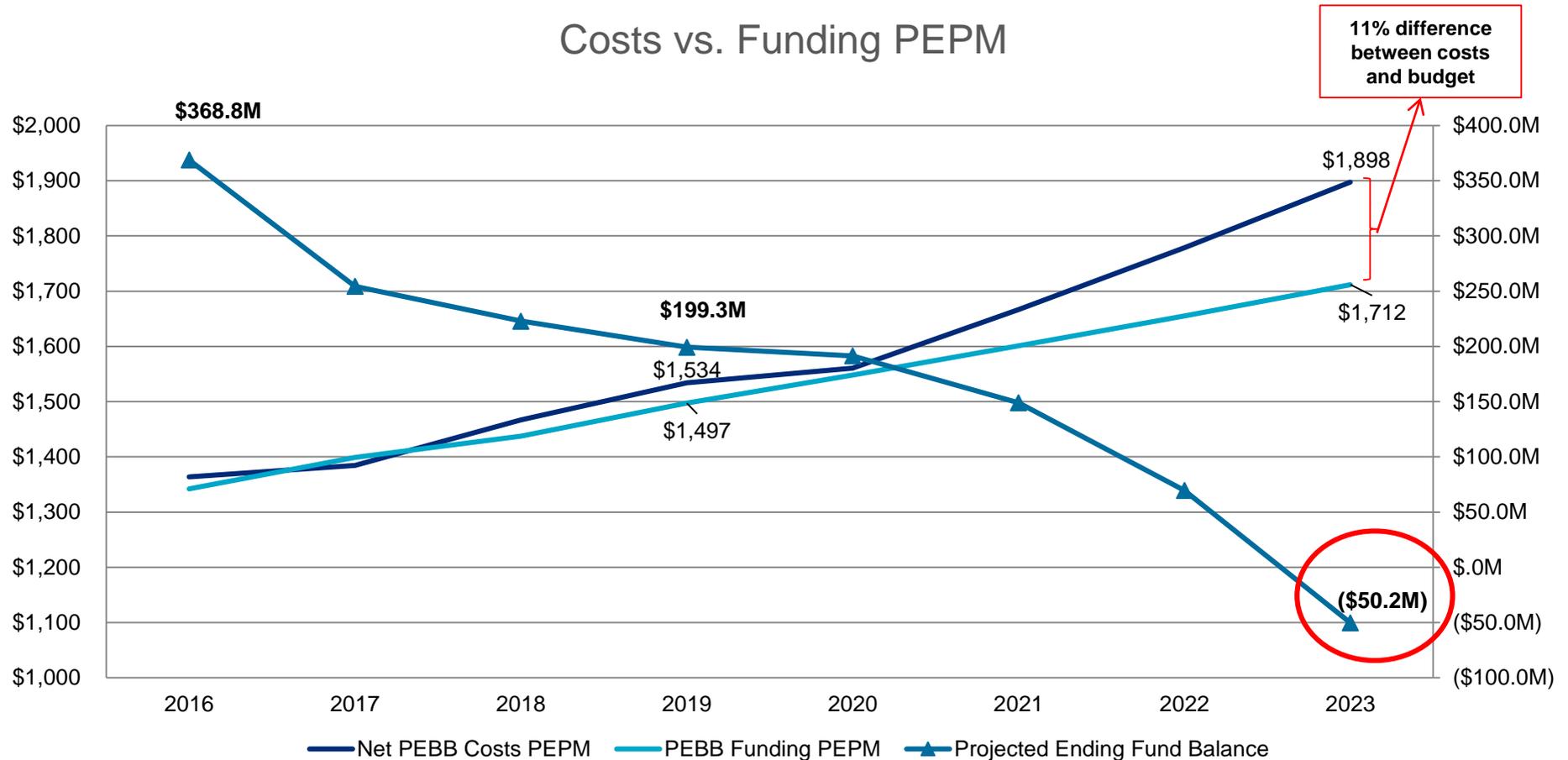
APPENDIX

PEBB'S CURRENT STATE



THE 3.4% FUNDING CAP FUND BALANCE TURNS NEGATIVE BY 2023

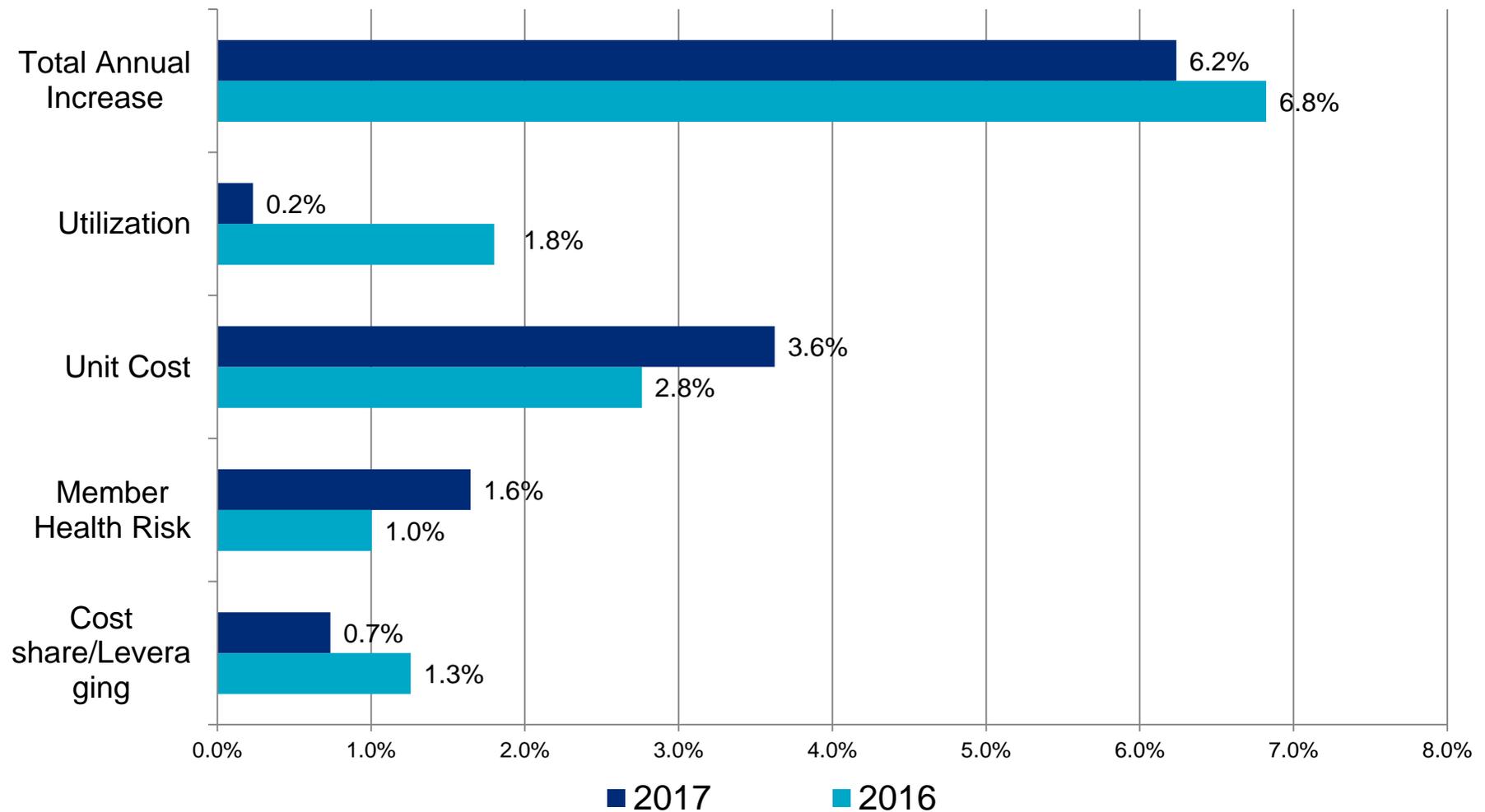
Costs vs. Funding PEPM



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			
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%			

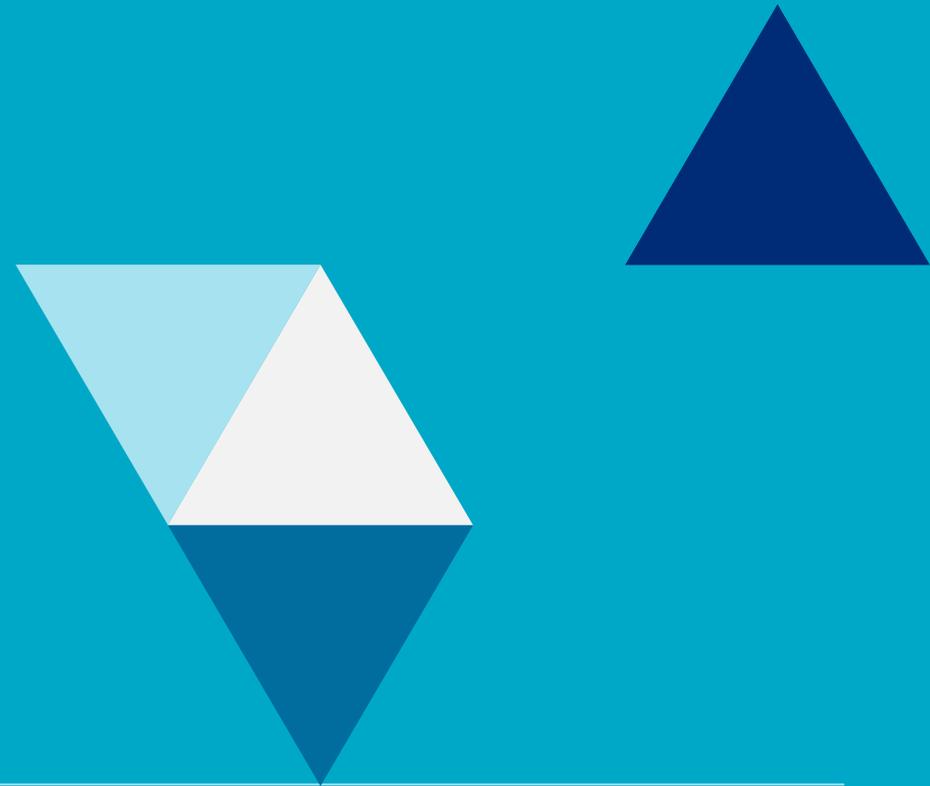
■ Previous ■ Current ■ Benchmark²

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



APPENDIX

POTENTIAL STRATEGIES AND ESTIMATED COST SAVINGS



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 a Health Plan
- 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

STRATEGY

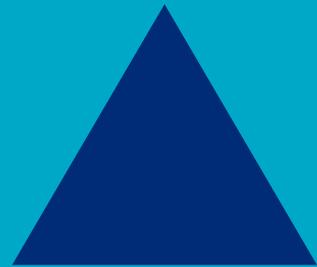
ILLUSTRATIVE SAVINGS

	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

APPENDIX

THE NEW HEALTH PLAN



TRANSFORMING THE CCM INTO THE NEW HEALTH PLAN

CRITICAL ELEMENTS

Element	Questions to Consider
Articulate the goals	<ul style="list-style-type: none"> • What are we trying to achieve through The Health Plan? • How do we define success? • How will we measure success?
Conduct gap analysis and identify opportunities	<ul style="list-style-type: none"> • 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 Health Plans medical Management Capabilities	<p>For organizations that want to partner and become a high functioning Health Plan, 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.</p> <ul style="list-style-type: none"> • How do we know that the delivery system can perform as a Health Plan 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 Health Plan? • Where there are gaps, what action plans are in place to eliminate those gaps?
Establish the Financial Reconciliation Methodology	<ul style="list-style-type: none"> • 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	<p>The Health Plan model needs to be patient-centered with tailored and customized communications in order to support patient enrollment and engagement</p> <ul style="list-style-type: none"> • 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 Health Plan • Document action steps to address gaps • Create metrics for success and methodology for calculating those metrics
Benefit Plan Design	<p>The benefit design needs demonstrate the value to the patient in enrolling in The Health Plan</p> <ul style="list-style-type: none"> • Is The Health Plan 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/Health Plan • Create process for obtaining a waiver to go outside The Health Plan • Will a primary care physician (PCP) designation be required?
Quality Management & Improvement	<p>The Health Plan 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</p> <ul style="list-style-type: none"> • 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	<p>The Health Plan needs timely, accurate, meaningful, standardized, and actionable information and data in order to support proactive population health management.</p> <ul style="list-style-type: none"> • 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	<p>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 The Health Plan is launched.</p> <ul style="list-style-type: none"> • How will the suppliers interact and collaborate in order to support a highly functional, integrated system?
Attribution	<ul style="list-style-type: none"> • 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?

EVOLVING THE CCM INTO THE NEW HEALTH PLAN

SAMPLE SUCCESS MEASURES

PATIENTS



- Plan design that demonstrates value and facilitates enrollment into The Health Plan
- 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)

PLAN SPONSOR



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 Health Plan design
- Reinforces the communication regarding The Health Plan 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

OPTIONS FOR ACHIEVING THE NEW HEALTH PLAN



1. Piggyback on existing OHA CCO arrangements

2. PEBB executes direct contracts with health systems for graduated risk-bearing entities

- 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 entities

- PEBB provides contractual requirements for Health Plan arrangements, carriers will need to customize any existing arrangements

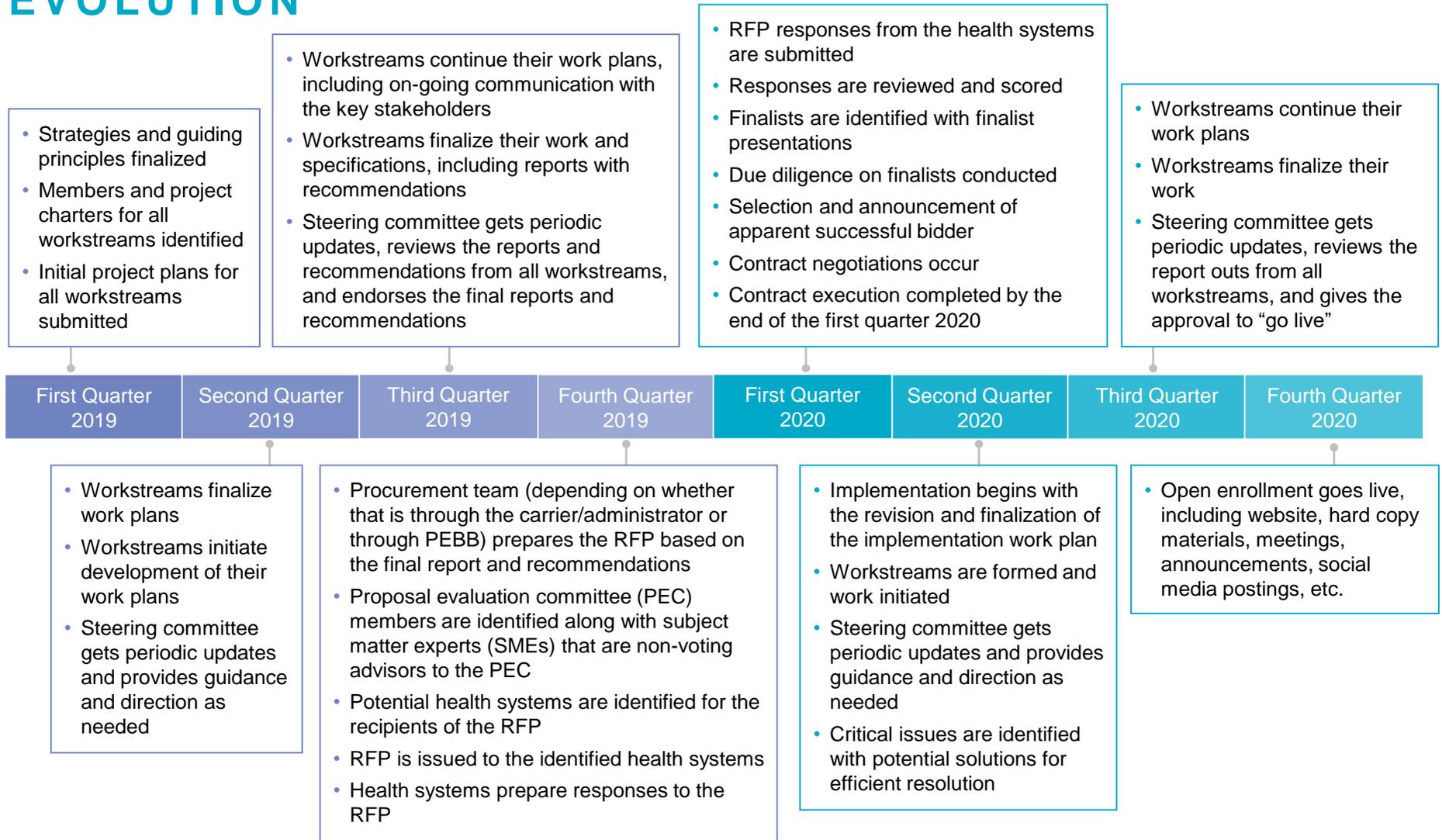
Example: Microsoft

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

SUGGESTED STRUCTURE FOR THE HEALTH PLAN'S EVOLUTION

<p>Steering Committee</p>	<ul style="list-style-type: none"> • Provides leadership guidance for the developers of The Health Plan • Includes Board members, PEBB staff members, carrier/administrator, consultants, and other stakeholder leaders 	
<p>Member Experience</p>	<p>Clinical, Quality, and Care Transformation</p>	<p>Integration, Data, and Operations</p>
<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Develops the requirements for the clinical, care transformation, and quality measurements for The Health Plan • Includes PEBB staff members, carrier/administrator, medical leaders, quality directors, consultants, and other stakeholders as necessary 	<ul style="list-style-type: none"> • Develops the protocols for integrating benefit vendors with The Health Plan, designs information sharing arrangements, and other operational aspects • Includes PEBB staff members, carrier/administrator, information technology experts, consultants, and other stakeholders as necessary

ILLUSTRATIVE TIMELINE FOR THE HEALTH PLAN'S EVOLUTION



SAMPLE GAP ANALYSIS AND ACTION PLAN BASED ON HEALTH PLAN EVOLUTION

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 The Health Plan
Quality	Siloed quality efforts	Coordinated quality efforts	Continuous quality improvement
Care Coordination	Through The Health Plan	Shifting the Health Plan	Health Plan-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			
The Health Plan 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 The Health Plan panel	Increased incentive, expanded The Health panel, introduce downside risk	Compensation with incentives tied to performance

HEALTH PLAN BOARD INPUT MEMBER SUCCESS MEASURES

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

THE HEALTH PLAN BOARD INPUT

PEBB'S SUCCESS MEASURES FOR A HEALTH PLAN

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 Health Plan	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 Health Plan to all stakeholders resulting in achieving the desired enrollment	3.00
Other:	

HEALTH PLAN BOARD INPUT

HEALTHCARE DELIVERY SYSTEM SUCCESS MEASURES FOR A HEALTH PLAN

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

HEALTH PLAN BOARD INPUT

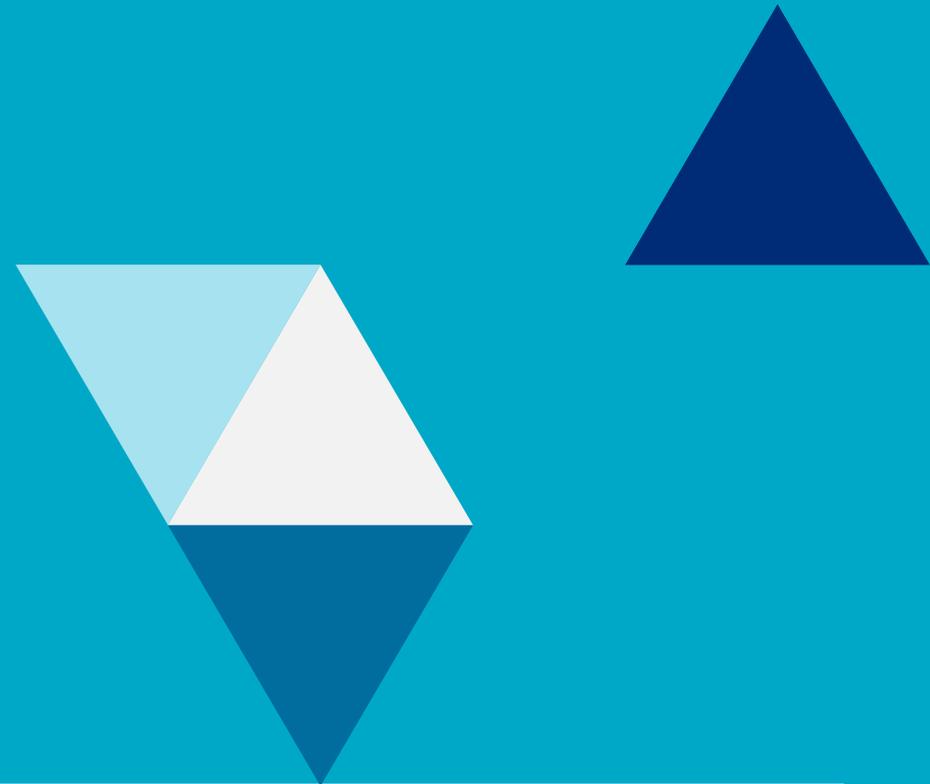
CARRIER/ADMINISTRATOR SUCCESS MEASURES

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

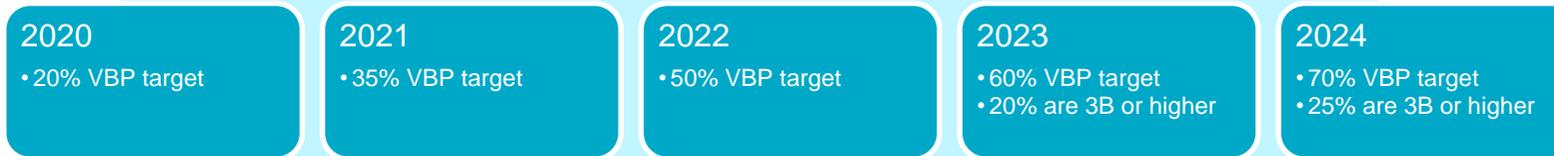
	POINTS
Able to meet or exceed all performance guarantees	4.83
Provides accurate, timely, and meaningful data with The Health Plan and all benefit vendors	4.40
Able to administer accurate, efficient, and timely value-based payments	4.25
Able to coordinate and integrate with The Health Plan for optimal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

APPENDIX

ROADMAP FOR PEBB'S VALUE- BASED-PAYMENT STRATEGY

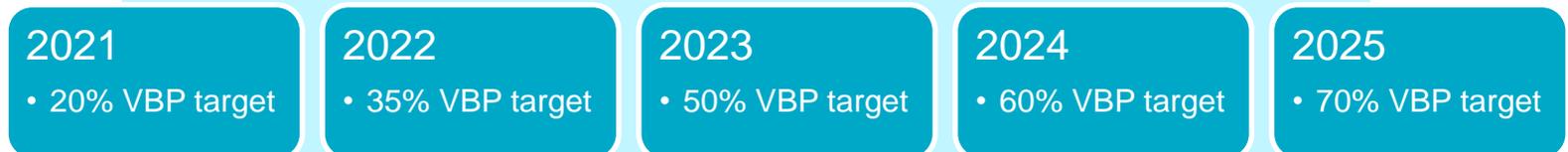


PEBB'S ROADMAP VS. OHA'S CCO 2.0 OHA ROADMAP



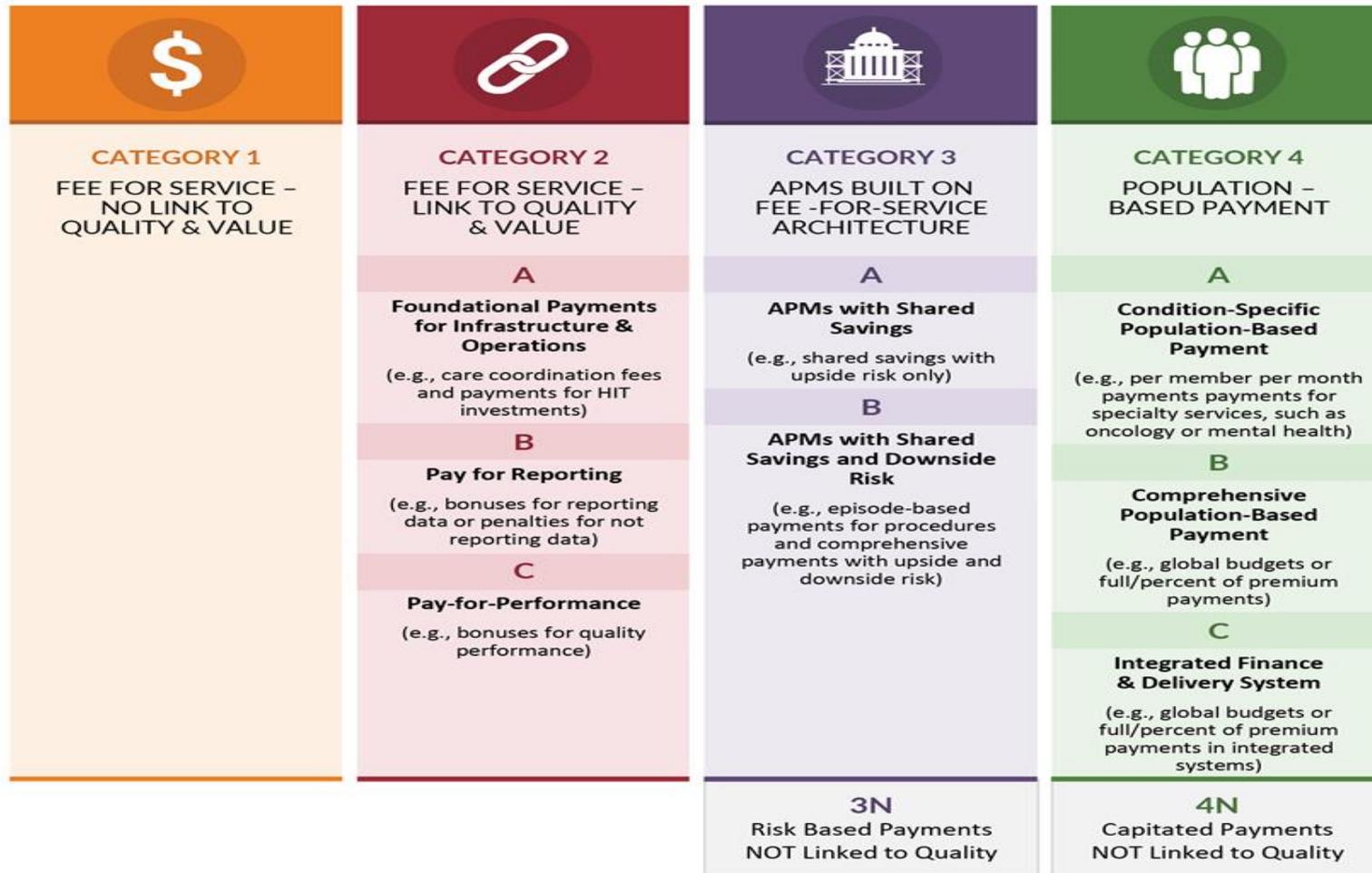
- OHA's CCO payments to providers must be in the form of a Value-Based-Payment (VBP) and fall within LAN Category 2C (Pay for Performance) or higher

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)
 - The Health Plan will be required to have a minimum Category 4 payment model as soon as possible

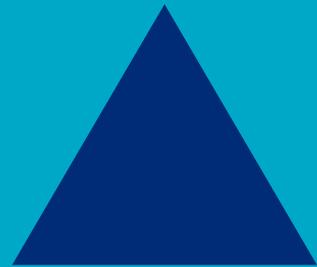
PEBB'S ROADMAP VS. OHA'S CCO 2.0 FINANCIAL ROADMAP



Source: APM Framework, HCP-LAN,2017

APPENDIX

EXAMPLES OF ACO NETWORKS



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/>

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

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

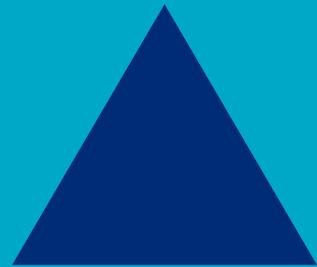
- **Advantages:**

- 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>

APPENDIX

EXAMPLES OF OTHER STATE INITIATIVES



STRATEGY FOR ACTION

WHAT IS WASHINGTON DOING?

THE HEALTH PLAN AND BUNDLED PAYMENTS

The Health Plan	Targets / Enhances <ul style="list-style-type: none">• Shared Risk Model• Member experience• Care transformation• Timely data• Incentives with benefit designs	Demonstrating Value <ul style="list-style-type: none">• 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	Targets / Enhances <ul style="list-style-type: none">• Concierge experience for members with total joint replacements• Virginia Mason designated COE through competitive procurement• Based on Bree Collaborative recommendations	Demonstrating Value <ul style="list-style-type: none">• 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

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

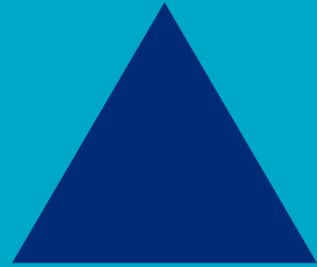
- Prospectively sets global budget for participating rural hospitals, based on historical revenue
- Rural hospitals will redesign delivery of care to improve quality and meet health needs of local communities

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

APPENDIX

OTHER BRIDGE STRATEGIES



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: 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 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

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



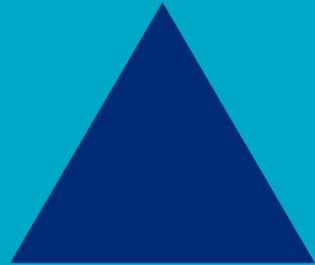
COMMUNICATION
DIRECTED AND
CONTINUOUS



IMPLEMENTATION
MEDIUM

APPENDIX

GLOSSARY OF TERMS



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+.

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 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.

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 from 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).



MERCER

MAKE TOMORROW, TODAY