

Oregon Health Fund Board Meeting

Wednesday, August 27, 2008
12:00 pm – 5:00 pm
Sheraton Portland Airport
Mt. St. Helens C&D Ballroom
8235 NE Airport Way
Portland, OR

AGENDA

Time (est)	Item	Lead	Action Items
12:00 – 12:30	Lunch, Call to Order	Bill Thorndike	X
12:30 – 1:00	Presentation of Work Plan by Health Leadership Taskforce	Panel	
1:00 – 2:30	Discussion of August 20 th Draft Action Plan	Barney Speight	X
2:30 – 2:45	Break		
2:45 – 4:15	Discussion of August 20 th Draft Action Plan	Barney Speight	X
4:30 – 5:00	Approval to Release Amended Draft Action Plan for Public Comment, September 3 rd – 30 th	Barney Speight	X
5:00	Adjourn	Bill Thordike	X

[Directions to Sheraton](#)

Next Meeting: Tuesday, September 30

Kaiser Permanente
Town Hall
3704 North Interstate Ave
Portland, OR

Oregon Health Fund Board



Building a Healthy Oregon

An Action Plan

DRAFT FOR BOARD REVIEW

August 20, 2008 Draft

[This page reserved for Letter of Transmittal to:

**Governor Ted Kulongoski
President of the Senate
Speaker of the House
Senate Majority Leader
Senate Republican Leader
House Majority Leader
House Republican Leader]**

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INTRODUCTION

Senate Bill 329 and the Establishment of the Oregon Health Fund Board

In June 2007, the Oregon Legislature passed the Healthy Oregon Act (Senate Bill 329, Chapter 697 Oregon Laws 2007). The Act called for the appointment of the seven-member Oregon Health Fund Board (“Board”) to develop a comprehensive plan to ensure access to health care for all Oregonians, contain health care costs, and address issues of quality in health care. The Board’s comprehensive action plan, titled “Building a Healthy Oregon,” reflects the work of scores of volunteer committee members, testimony and input from hundreds of Oregonians, the review of health services research and policy initiatives under consideration or adopted by other states, and advice from local and regional policy experts who assisted the Board and its committees.

The Board’s Goals for System Reform

The Board synthesized the twelve goals enumerated in SB 329 into the following four goals:

- Expand coverage to Oregon’s uninsured populations;
- Contain the annual increases in health costs in Oregon;
- Continuously improve quality, safety, efficiency and patient satisfaction in Oregon’s health care systems; and
- Improve the health of ALL Oregonians.

Strong Committee Work Paved the Way for the Board’s Action Plan

In addition to creating the Board, the Healthy Oregon Act also established committees to develop recommendations on specific aspects of the reform plan. These committees were comprised of Oregonians representing a wide range of expertise and perspectives and developed reform strategies addressing:

- Health benefit design;
- Delivery system reform;
- Insurance and premium assistance eligibility and program enrollment;
- Implications of federal law to state health reform and suggested changes;
- Strategies for financing the proposed reforms; and
- Strategies for promoting equitable health care for all individuals.

Working within the framework of the Board’s design principles and assumptions (see Appendix C), the committees developed recommendations that were submitted to the Board in Spring, 2008. After reviewing these recommendations, the Board has developed this draft Action Plan for public review and comment. Public responses will be received in September. After considering the public’s input and any final revisions, the Action Plan will be finalized in October, and sent to the Governor and legislative leadership in November.

**THE PLAN COMPLETED:
WHAT WILL OREGON LOOK LIKE WHEN WE'RE DONE?**

Every plan – whether it is to build a house, prepare for retirement, or take a vacation – contemplates an “end state”: What will be different when the plan is completed? This report contains detailed descriptions of strategies and actions that will contribute to achieving the goals outlined above. But first, imagine what a truly healthy Oregon can look like in a very few years.

The Board recommends a series of actions to be undertaken along two simultaneous, parallel tracks:

- Track 1: Expanding access to affordable coverage for all Oregonians; and
- Track 2: Transforming Oregon’s current health care system into a leading, 21st century model that provides every resident with safe, effective, patient-centered, timely, efficient and equitable health care – in a phrase, Quality Health Care.

Track 1: Affordable Coverage for all Oregonians

The work of the committees of the Board, supported by staff and consultants, lays out a path to affordable coverage for 96% to 97% of all Oregonians by 2015. Dramatically reducing the uninsured rate (currently 16%) to 3-4%, would make Oregon the national leader in access to affordable coverage.¹

Oregon can achieve this goal through five essential health care financing programs:

1. Employment-based coverage for employees (and their dependents) working for firms that offer group health insurance coverage.

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2. A revitalized Oregon Health Plan (OHP) for all individuals and families who meet the eligibility requirements approved by the federal government.

+

3. A new Oregon Health Insurance Exchange program (OHIE) for Oregonians working for employers that do not provide group health insurance coverage (“non-offering employers”). These residents would receive financial assistance for the cost of premiums through direct state contributions or state personal income tax credits.

+

4. A reformed individual health insurance market for those not eligible for any of the programs noted above, and who choose to obtain coverage through this market rather than the OHIE option.

+

5. Medicare coverage for Oregonians who qualify by age (65 and over) or disability.

¹ As of 2006, Minnesota had the lowest uninsured rate at 8.6%. Kaiser State Health Facts, <http://www.statehealthfacts.org>

The estimated new revenue required by state government to finance increased enrollment in OHP and the new OHIE program will range between \$1 billion to \$1.6 billion per year. To put this into context, it is estimated that health care expenditures in Oregon from all private and public sources are \$19 to \$20 billion per year.²

To attain and sustain the goal of affordable coverage for all Oregonians, certain policy, financial and market conditions are necessary:

- There must be a requirement for residents to have some form of minimal health insurance coverage through one of the five programs noted above.
- The state must provide financial contributions (“subsidies”) for low- and moderate-income individuals and families who participate in the OHP or the OHIE. These state contributions, based on household income, will defray premium costs, in whole or in part.
- Equitable and stable financing mechanisms must be enacted to pay the state’s share of the costs of OHP and OHIE. Total funding for the programs would be a combination of state funds, authorized federal matching funds, and individual/family premium contributions.
- The individual health insurance market must be reformed to operate on a guaranteed-issue and guaranteed-renewable basis.
- There must be an affordable, accessible and consumer-valued essential benefit plan.
- The state must create a trusted and efficient organization (i.e., an Oregon Health Insurance Exchange) through which:
 - Individuals and families can shop for coverage and choose their health plan from a range of options;
 - State contributions can be efficiently administered; and
 - Participating insurers compete based on administrative efficiency, provider networks, and other quality and service factors, not on the basis of enrolling lower risk members.

There are two remaining conditions necessary to fulfill the goal of affordable coverage for all Oregonians, both of which directly impact the sustainability of this action plan.

- The first condition is a strong, resilient, and robust Oregon economy. A vibrant and growing economy sets the stage for stabilizing and expanding employment-based coverage and provides the state with the financial capacity to meet the needs of Oregonians, not only in health care, but in education, transportation, public safety, and social services.
- The second condition is lowering the annual increase in health care costs. When health care costs rise at two, three, or even four times the Consumer Price Index (CPI), families, businesses and government confront a true crisis of sustainability. This latter condition leads directly to the Board’s proposed second, parallel track of action:

² Oregon Health Policy Commission. *Road Map for Health Care Reform*. July 2007.

Track 2: Transforming Oregon's Health Care System

The Board's Action Plan aims to contain the ever-rising cost of health care by fundamentally transforming our current health care system. The burden of disease and the costs associated with it are primarily associated with chronic conditions. Oregon's health care system must be transformed from its almost singular emphasis on treating diseases in the acute stage to one that includes: a community framework for wellness and disease prevention; early interventions; and comprehensive, evidence-based, outpatient management of chronic disease. This vision calls for both new models of care and better integration of care across community systems of care (wellness, public health, ambulatory or outpatient services and acute, hospital-based care).

The recommendations that follow align closely with the findings of the Institute of Medicine's Committee on Quality of Health Care in America:³

- *The American health care delivery system is in need of fundamental change.*
- *[H]igher level of quality cannot be achieved by further stressing current systems of care. The current care system cannot do the job. Trying harder will not work. Changing systems of care will.*
- *[I]ncreased value will not be derived by...asking people to work harder, faster, and longer...Rather, increased value will result from systematically developed strategies that focus on the aims of health care...safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity – and reduce all forms of waste by eliminating activities or resources that do not add value.*

Strategic Domains of Change

In addition to providing affordable coverage for all Oregonians, the Board has identified seven (7) additional “strategic domains of change” to bring about transformation of Oregon's health care system:

1. Set high standards and measure and report on the performance of Oregon's health care system using recognized quality, clinical, and financial indicators.
2. Stimulate system innovation through:
 - a. new models or systems of care that include modifying current reimbursement methods to incentivize and reward health care providers and community systems of care for quality outcomes;
 - b. wide use of health information technology;
 - c. new public health programs to improve the health of communities;
 - d. support of community-based efforts at innovation; and
 - e. programs to eliminate health disparities based on gender, ethnicity, geographic location, and socioeconomic status.

³ Institute of Medicine Committee on Quality of Health Care in America, *Crossing the Quality Chasm: A New Health System for the 21st Century*, National Academy Press, Washington, DC, 2001

3. Unify purchasing strategies among public purchasers (Oregon Health Plan, Public Employees Benefit Board, Oregon Educators Benefit Board, local governments, etc.) with more coordinated contract standards; develop a first generation Oregon Health Insurance Exchange for the individual market; and possibly establish regulatory activities to control insurer premiums and provider prices.
4. Develop and implement a strategic plan to assure that Oregon has a 21st Century health care workforce that can meet the needs of our residents.
5. Encourage the deployment and interoperability of health information technologies.
6. Advocate for changes in federal policy to assist Oregon in these system transformation actions.
7. Create an Oregon Health Authority to be responsible for overseeing the implementation of these strategies for change and to act as the central entity in state government accountable for the cost, quality, access and performance of Oregon's health care system.

With commitment, collaboration, and resources, today's vision will be a reality in the 2009-2015 timeframe.

Perhaps the biggest disappointment on the part of the Board, and many who read this report, is the anticipated time it will take to achieve a truly Healthy Oregon. But lasting and sustainable change must occur within Oregon's complex systems of health care finance and delivery. This Action Plan calls for persistence, leavened by patience.

The Board hopes that Oregonians will share its vision and imagination, and that all of us will commit to building a truly Healthy Oregon!

NOTES TO READER:

The diagram on the next page summarizes the eight (8) Strategic Domains of Change and key strategies. It may be a useful reference tool as you review this report.

The reader will also note the reference to the "Authority" in the pages that follow. Detailed recommendations relating to the Oregon Health Authority begin on page 52.

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Oregon Health Fund Board Action Plan Eight Strategic Domains of Change

I. "BRING EVERYONE UNDER THE TENT"

The Vision

- Affordable Coverage For All Oregonians

Stage I: 2009 Expansion Objectives

- All Kids <200% FPL
- Adults <100% FPL

Stage I: 2009 Financing Plan

- Alternative Provider Taxes
- Increase Tobacco Taxes

Stage II: 2011 – 2015 Expansions

- Premium Assistance Plan: Linked to cost containment & available funding

II. SET HIGH STANDARDS – MEASURE & REPORT SUCCESS

Trusted Information

- Uniform, Statewide Data Quality, Clinical, Financial

Set High Standards

- Clinical Quality Measures
- Clinical Guidelines
- Population Health Targets
- Insurance Administration Practices

Performance Reporting

- Public Reporting to: Consumers, Providers, Purchasers, Insurers, Policy Makers

III. STIMULATE SYSTEM INNOVATION

New Care Models/Systems

- Integrated Health Homes
- Behavioral Health Integration
- Payment Reform

The Public's Health

- Community-Centered Health Promotion
- Local Public Health

Community-Based Initiatives

- Community Collaboratives
- Accountable Health Communities

Health Equities

- Outreach, Education, Translation
- Disease Management, Provider Training

IV. UNIFY PURCHASING POWER

Coordinated Purchasing

- State & Local Governments Common Contract Standards
- Patient Decision Aids
- Purchasing Cooperative
- Public & Private Purchasers

Oregon Health Insurance Exchange

- Begin with current Individual Market
- Stage II, Individual Market: Guaranteed Issue, Premium Assistance
- Ultimately include Small Group Market

Regulatory Options

- Review & Approve Insurer Administrative Expense Increases
- Set Ceilings on Provider Price Increases

V. HEALTH CARE WORKFORCE

- Reliable Data
- Long Term Needs
- Resources for Training
- Recruit, Retain
- Licensing
- New Models ("Top of License")

VI. INFORMATION TECHNOLOGY

- Widespread use of Health IT
- Include clinical decision support tools
- Plan for statewide health information exchange
- Provide for privacy & security of personal data

VII. FEDERAL ADVOCACY

- Federal Laws Committee Recommendations
- Seek Opportunities under Federal Reforms

VIII. OREGON HEALTH AUTHORITY

- Accountable for the Performance of Oregon's Health System

TRACK 1: AFFORDABLE COVERAGE FOR ALL

DOMAIN I: “BRING EVERYONE UNDER THE TENT”
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Objective: Make affordable coverage available for all Oregonians.

Strategy: Use existing systems to expand insurance access.

As described in the vision, Oregon must simultaneously ensure access to care for all Oregonians and transform the delivery system so that the expanded access is to higher quality, more affordable care.

Oregon will achieve affordable coverage for all Oregonians by expanding access to coverage and care between 2009 and 2015. This goal will be achieved by building on a 5-part system of health care financing. Coverage expansion efforts will utilize the systems through which many Oregonians already receive coverage:

- The Oregon Health Plan for those in and near poverty;
- A new Oregon Health Insurance Exchange (OHIE) for Oregonians working for employers that do not offer group health insurance and those receiving state financial assistance through premium contributions or tax credits;
- Employer-based group coverage for employees and their dependents working for employers offering group coverage;
- Medicare for Oregonians qualifying due to age or disability;⁴ and
- The individual health insurance market for those not eligible for any of the above.

Based upon econometric modeling done for the Board’s Finance Committee, the programs noted above would provide coverage to 96% to 97% of all Oregonians.

Strategy: Expand access now, beginning with children and low-income Oregonians.

Increasing access to health insurance positively impacts health and Oregon’s economy. Nationwide, the economic value of foregone health among the 40 million uninsured in is estimated to be between \$65 and \$130 billion that year.⁵ Applied to Oregon’s approximately 600,000 uninsured and adjusted to 2008 dollars—this would be between \$1.25 and \$2.5 billion lost in foregone health.⁶

Enrolling children and low income adults in health insurance will reduce the state’s uninsured population by at least one third, and restores coverage lost due to previous state budget cuts.

⁴ As Medicare eligibility and benefits are determined by the federal government, the Board’s plan assumes Medicare is an important coverage component but does not attempt to build a reform plan predicated on reforms to the program.

⁵ Institute of Medicine, “Hidden Costs, Value Lost,” (Washington: National Academy Press, 2003), p. 112.

⁶ 2000 dollars adjusted to 2008 dollars using the United States Department of Labor, Bureau of Labor Statistics Inflation Calculator found at: http://www.bls.gov/data/inflation_calculator.htm

Investing in public coverage is a first step toward achieving the state's goal of universal access. Therefore, the Board embraces Governor Kulongoski's vision for giving all uninsured Oregon children under age 19 an opportunity to enroll in comprehensive, affordable health insurance coverage. In addition, the state will open Oregon's Medicaid program, the Oregon Health Plan (OHP), to adult Oregonians with incomes at or below 100% of the Federal Poverty Level (FPL).⁷ Enrolling children and low income adults in health insurance will reduce the state's uninsured population by at least one third, and restores coverage lost due to previous state budget cuts.

In 2009-11, the state will expand coverage to all Oregon children. Children with family income under 300% of the Federal Poverty Level (FPL) will build on existing programs, using OHP and FHIAP to maximize federal matching dollars. Children with family income up to 185% FPL are already eligible for OHP and FHIAP. Eligibility for OHP and FHIAP will be expanded, allowing children with family income up to 200% FPL to enroll with no family premium sharing. Children with family income between 200-300% FPL can get a premium subsidy through expanded FHIAP eligibility for those with access to employer-sponsored coverage, or through a new program for families without such access. Families in this income range will contribute on a sliding scale to affordable premiums.

Families with income above 300% FPL and no access to employer-sponsored insurance for their children will also be able to purchase this affordable product for their children. These families will not utilize premium subsidies, and the state will not seek federal match for this population.

To help finance its program expansion, Oregon will seek federal waiver approval in order to receive federal financial participation for children between 185-300% FPL. Through these actions, Oregon will ensure that high quality, affordable coverage is available to all children in the state.

As of June 2008, the OHP Standard program covered 24,000 adults with incomes below 100% FPL. To improve coverage for low-income adults, the state will re-open the program to all adults up to 100% FPL. This will allow entry to approximately 100,000 new enrollees. Additionally, the OHP Standard benefit package is considered to be inadequate for those living below poverty, and it should be adjusted back up to the OHP Plus level of benefits this population received prior to 2003 reductions.

Strategy: Reduce barriers to enrollment and re-enrollment for children.

More than half of the 117,000 uninsured children in Oregon are eligible for but not enrolled in state-funded health coverage. To expand enrollment, Oregon will eliminate enrollment barriers by simplifying the application process, providing outreach with application assistance, increasing the number of school-based health centers, creating a 24-hour nurse advice line, establishing a disease-management program, and extending eligibility for coverage from six to 12 months.

Strategy: Standardize and rationalize benefits.

Current benefit designs that primarily consider ease of administration (e.g., 20% coinsurance for all services) serve to contribute to rising health care costs by providing equal coverage for both effective services and those of questionable value. Therefore, the Board believes that basing

⁷ In 2008, the Federal Poverty Level is \$21,200 for a family of four.

coverage decisions on available evidence and structuring cost sharing in a rational fashion will encourage more appropriate utilization. This alternative strategy will shift emphasis to services resulting in greater population health. This is a lesson Oregon can learn from other health care systems around the world that use fewer resources and have better outcomes.

The Legislature will establish, to the extent allowable by federal law, an essential benefit package (EBP) that all health insurance plans offered in the state must meet or exceed. It should be noted that, in the absence of cost-sharing, the EBP is equivalent to the OHP Plus benefit package. The OHP benefits should be offered to all pregnant women and children under 200% FPL and adults up to 100% who would qualify under the current OHP rules. The EBP, with affordable cost sharing included, will also apply to expansion populations at moderate income levels.

The EBP will include a defined set of health care services that is affordable and financially sustainable, using the priorities outlined in the Prioritized List of Health Services, which was developed and is maintained by the Health Services Commission (HSC). Furthermore, the HSC will be provided with the additional resources necessary to ensure that the Prioritized List reflects the most current evidence-based research available.

The EBP, which will be structured in the manner recommended by the Benefits Committee in its June 25, 2008 report to the Board, will include the following considerations:

- Protect enrollees from profound financial losses due to medical expenses, but still be affordable to the state and other payers through the use of cost-sharing mechanisms.
- Require little or no individual contribution for those living below the federal poverty level, with the contribution increasing on a sliding scale basis as a family's financial means rises.
- Do not discourage the private market from offering plans that are more comprehensive than the EBP, in order to provide greater consumer choice for those who can afford higher premiums.
- Promote the provision of services in an integrated health home in an effort to reduce unnecessary hospitalizations and emergency department visits.
- Require little or no cost sharing for evidence-based preventive care and other value-based services, such as those shown to keep individuals with chronic illnesses from experiencing preventable acute exacerbations of their disease.
- Reward patients for actively participating in their own care.
- Assign higher cost sharing on elective or discretionary services.

The Board believes that purchasers, insurers, and consumers will benefit from these principles through a healthier population at reduced cost.

Strategy: Finance coverage expansions with provider taxes.

The cost of expanding health insurance coverage to all Oregonians is not insignificant. See Table 1 for estimates of the cost of expanding coverage for Oregonians in 2009-11 and 2011-13. The coverage expansions outlined above will be financed through taxes on health care providers. Well-structured and efficiently-administered provider taxes will be used to leverage additional federal financial participation to expand coverage to over 175,000 uninsured residents.

**Table 1: Estimated State and Federal Funds
Needed to Support Coverage Expansions (2009 – 2013)**

\$ in millions	State Funds '09 – '11	Federal Funds	State Funds '11 – '13	Federal Funds
Coverage for Kids	\$ 62	\$ 120	\$ 79	\$ 150
OHP Standard	\$ 354	\$ 604	\$ 671	\$ 1,008
<i>Subtotal</i>	<i>\$ 416</i>	<i>\$ 724</i>	<i>\$ 750</i>	<i>\$ 1,158</i>
Improved Benefits	\$ 50	\$ 75	\$ 77	\$ 116
Increased Provider Rates	up to \$ 100	\$ 250	up to \$ 100	\$ 250
System Transformation (including public health)	up to \$ 50	\$ 0	up to \$ 50	\$ 0
Total	\$ 616	\$ 1,049	\$ 977	\$ 1,524

Source: Division of Medical Assistance Programs

To ensure that the taxes are equitable and sustainable, the Board believes that the mix of taxes and the specific tax rates must be determined collaboratively by the Governor, Legislature, and interested stakeholders.

The Board recognizes that provider taxes could have a negative impact on current individuals and group health insurance purchasers. A new provider tax program must be accompanied by rigorous oversight of both hospital and insurer financial performance to avoid adverse financial impact on current purchasers.

Strategy: Tie additional coverage expansions (2011-2015) to cost containment successes and available funding.

The first stage of state-sponsored coverage expansions targets all children and adults with income below 100% FPL. The Board recognizes that individuals above 100% often have difficulty affording health insurance. To ensure that coverage is affordable for all purchasers, whether or not they access state assistance, cost containment strategies must be implemented system-wide. Future expansions will be linked to cost containment success. While expanding OHP enrollment to children and low income adults, Oregon will simultaneously plan for a future market that includes:

- A requirement that all Oregonians get insurance;
- Reform of the individual insurance market rules;
- Subsidies for low and moderate income families;
- A “pay or play” payroll tax; and
- An insurance exchange for those receiving state contributions.

ACTION STEPS:

1. Expand coverage for children and low-income adults.

Starting in 2009, the Oregon Health Plan (OHP) and the Family Health Insurance Assistance Program (FHIAP) expand free coverage to all children up to 200% FPL. Children with family income between 200% and 300% FPL receive subsidized coverage through FHIAP and a new

program (Kid Connect) for children without access to a family member's employer-sponsored coverage. OHP expands coverage to adults up to 100% FPL.

To increase coverage for children with family income above 300%, relevant state agencies create a program – Kid Connect – through which families can purchase affordable, high-quality insurance for their children. Kid Connect will be either a new program or a modification to an existing one, offering access for children not eligible for state premium assistance or free coverage.

The Department of Human Services (DHS) currently has federal approval to enroll children up to 185% of FPL and adults to 100% FPL. To expand OHP beyond these levels, the state must seek federal approval to amend its Medicaid waiver authority. To allow the enrollment of children up to 300% of FPL in OHP and FHIAP, the 2009 Legislature authorizes DHS to apply for federal waiver authority.

In addition, the 2009 Legislature authorizes the Authority to develop and implement a program expansion or new program for children with family income above 300% FPL. This program, which could be built on OHP or may be a new program, will not include any state contributions to premiums.

Both the OHP Plus and Standard populations will receive the same benefit package, thereby raising benefit levels for OHP Standard enrollees to match those currently provided to OHP Plus members. Additionally, the Legislature directs the Authority to oversee the development of cost-sharing protections and requirements for program enrollees.

2. Legislative authorization of financing.

The Governor, Legislature, and relevant state agencies and stakeholders work together to develop provider taxes that will support the proposed coverage expansions described above. The 2009 Legislature authorizes the financing necessary to implement the child and adult population expansions, and gives DHS or another entity the authority to utilize these funds for this program.

3. Reduce enrollment barriers.

Starting in 2009, the Authority works with OHP, FHIAP and other partners to ensure enrollment by all eligible children. This effort includes eliminating barriers to enrollment by simplifying the OHP application process, providing outreach with application assistance, increasing the number of school-based health centers, creating a 24-hour nurse advice line, establishing a disease-management program, and extending eligibility for coverage from six months to a year.

4. Conduct targeted and aggressive outreach to multicultural communities.

The Legislature appropriates state funds, with additional Medicaid matching funds, to support: community-based organizations in delivering culturally-specific and targeted outreach and direct application assistance to members of racial, ethnic, and language minority communities; individuals living in geographic isolation; and populations that encounter additional barriers such as individuals with cognitive, mental health or sensory disorders, physical disabilities, chemical dependency, and individuals experiencing homelessness. Resources and interventions are

targeted to meet the goal of 100% enrollment of individuals who are eligible to participate in Oregon public health insurance programs.

5. Implement financing for coverage expansions.

In 2009, appropriate state agencies implement financing for coverage expansions. The agencies design and implement provider taxes within the parameters set by the 2009 Legislature.

6. Legislative direction to develop changes to the Oregon insurance market.

The Legislature authorizes funding and staffing for the Authority to plan changes to the Oregon insurance market. Those changes include but are not limited to: an individual insurance requirement, along with minimum benefit package requirements; individual market reforms; state premium assistance for low and moderate income Oregonians; a “pay or play” payroll tax; and an insurance exchange to administer premium assistance and move system reforms.

7. Prepare for additional coverage expansions.

In 2009 and 2010, the Authority creates a detailed plan and implementation strategy for additional coverage expansions in 2011-15.

TRACK 2: TRANSFORMING OREGON'S HEALTH CARE SYSTEM

DOMAIN II: SET HIGH STANDARDS – MEASURE & REPORT

➤ **Trusted Information**

Objective: Collect and disseminate uniform and complete information on which to make policy decisions and set standards for system improvement.

Strategy: Establish an all-payer, all-claims data collection program.

The current health care delivery system in Oregon does not consistently deliver high-quality care or effectively use resources to deliver evidence-based care to Oregonians. For instance, only 40% of adults over age 50 receive recommended preventive care, and only 84% of hospitalized patients receive recommended care for myocardial infarction, congestive heart failure, and pneumonia.⁸ In addition, quality of care, utilization of specific procedures, and treatment options vary significantly depending on where in the state a patient receives care.⁹

An Oregon-mandated, all-payer, all-claims reporting program is a necessary first step in creating a comprehensive collection of information about the entire patient experience. Through this collection, analysis, and public reporting, providers can benchmark their performance, identify opportunities for quality improvement, and design effective quality improvement initiatives. The purchasers can identify and reward high-performing providers who delivery high-quality, high-value care to their patients, and consumers can access information to help guide critical health care decisions. Policy makers can make improved strategic decisions for the priorities of Oregon, both by providing funding and also through the development of public-private partnerships at the local level for development of community specific initiatives.

The utility of claims information is that it can be used to assess utilization of services (answering questions such as: is there significant variation of utilization of specific services in specific areas and if so why?), examine conditions or procedures (How many people in Medford have asthma and how many are being hospitalized with asthma compared to other areas of the state?), compare payments for specific services (What is the cost and quality variation of diabetes care in the Portland metropolitan area versus the Bend-Redmond area?). Through the creation of an Oregon all-payer, all-claims reporting program, Oregonians will have more comprehensive, uniform information, which will help shape successful strategies for providing high quality and cost efficient health care to all Oregonians, and will monitor progress toward that goal.

In order to implement large-scale, innovative reform of Oregon's health care delivery system, the state will establish a new information system to protect the state's investment and ensure, as

⁸ Cantor JC, Schoen C, Belloff D, How SKH, and McCarthy D. Aiming Higher: Results from a State Scorecard on Health System Performance. The Commonwealth Fund Commission on a High Performance Health System, June 2007.

⁹ Performance Report for Chronically Ill Beneficiaries in Traditional Medicare: Hospitals – Oregon. Provided by Elliot Fischer and the Dartmouth Atlas Project.

much as possible, a high performing and cost efficient healthy care delivery system for all Oregonians.

Strategy: Expand data collection efforts to include data on race, ethnicity, and primary language.

To identify and address disparities in health care access, utilization, disease status and quality of care, Oregon will improve its collection of data on race, ethnicity, and primary language in health care. Data definitions and data collection will be standardized so that sources can easily be combined and compared.

Strategy: Ensure comprehensive reporting by insurers and health facility.

Two agencies are primarily responsible for monitoring the financial performance of insurers and hospitals and ambulatory surgical centers (ASCs): the Oregon Insurance Division and Oregon Health Policy & Research (OHPR), respectively. Currently each agency has broad statutory authority to require financial and related information from subject entities. It may be necessary to provide additional resources in the form of additional personnel or consulting expertise to assure that the reports generated by the Insurance Division and OHPR are produced in a timely manner using industry performance standards.

Two additional reports from health insurers would improve the public's understanding of market conditions:

- Health insurers and other third-party administrators (TPAs) would report to the Insurance Division on a regular basis the contract rates paid to health care providers. The data will be aggregated across providers to protect individual plan proprietary data from public disclosure while still allowing for public reporting to better understand local market conditions. Reports will document the range of annual increases in prices insurers pay to facilities and professional providers (by specialty) in a given market area.

Such reports will improve the “line of sight” or understanding between provider price increases in a local market and the resulting change in health insurance premiums that occur several months later. The State of Minnesota recently enacted legislation requiring such reporting.¹⁰

- The “health” of Oregon’s commercially-insured health insurance market is of significant concern to Oregonians. Currently there is no information available to understand what is happening in local markets: Is the number of insured residents growing or falling?

To rectify this problem, all health insurers and TPAs will report to the Insurance Division their respective memberships by defined lines of business (individual, small group, large group) by zip code. The reported data would be protected from public disclosure, but will be aggregated across all insurers and TPAs by lines of business and local markets. The reports will inform interested stakeholders of local market conditions (“the canary in the mine”), and can be evaluated in terms of changes in provider prices, insurer premiums, local economic conditions, etc.

¹⁰ Senate File No. 3780, 2007-2008 Legislative Session.

During the course of the work of the Board and its committees, concern has been expressed about the significant capital investments by hospitals and ASCs either underway or planned for the future. The Board believes it is in the public interest to require more community involvement in major capital projects.

- The Authority should develop standards for reporting by hospitals and ASCs that plan to invest more than \$x million in a capital project (threshold amount to be determined). The standards would require the facility to hold public meetings in the facility's service area to describe the project, its impact on access, clinical quality, and the cost to non-government payers in the future. While the input received by the facility's governing body is non-binding, it will help the facilities' leadership better understand the perspectives of the individuals and businesses in the community that pay for such projects through their health insurance premiums.

ACTION STEPS:

1. Establish an all payer, all claims data collection program.

In 2009, the Legislature appropriates the necessary financial resources and directs the Office for Oregon Health Policy and Research to establish an all-payer, all-claims data collection program. This data collection program is given the necessary authority to collect uniform administrative claims data from carriers, implement carrier and facility performance reporting, and develop and publicly disseminate evidence-based treatment and effectiveness information.

In partnership with carriers and providers, in 2009 the Authority develops data protocols and requirements to begin the rules process. The Authority begins disseminating information to affected carriers and providers in the same year. From 2009-2010, the Authority implements reporting requirements and, in 2010, begins data collection and analysis.

2. Require the collection of data on race, ethnicity, and primary language.

By state regulation, all health care providers and health plans participating in public health insurance programs collect and report data on patient race, ethnicity, and primary language.

3. Legislative authorization for additional reporting by insurers and TPAs.

The Legislature authorizes the Insurance Division to: A) require health insurers and TPAs to report the contract rates paid to providers and report on the percentage increases in such rates in local markets by facility and other provider groupings; and B) require health insurers and TPAs to report their membership by defined lines of business and zip code and report on changes in the number of insured residents by local markets.

4. Legislative authorization for reporting of proposed capital expenditures.

The Legislature authorizes the Authority to develop standards to be followed by hospitals and ASCs in reporting to local communities planned capital investments that exceed a specified amount.

➤ Set High Standards

Objective: Improve consumers' and others' ability to compare coverage based on cost and quality; reduce irrational variation in care.

Strategy: Develop measures, standards, guidelines, and targets to improve quality in the health care system.

The availability of comparative effectiveness reviews and the clinical guidelines that result from them have been shown to improve patient care. The IOM report, "Crossing the Quality Chasm," stresses that patients are entitled to care based on the "best scientific knowledge" and that care should not vary irrationally. Patients should receive care based on the best available scientific knowledge. However, evidence is often broad and complicated and individual clinicians cannot reasonably be expected to consider it all.

By developing a variety of measures, standards, guidelines, and targets, the various parties engaged in the health care system will have the tools to gauge their performance and progress. Evidence-based measures such as clinical quality measures, clinical guidelines and standards, health and outcomes targets, per capita/CPI cost increase targets, and standards for insurance administrative practices are important tools for identifying unnecessary care and modifying physician practice patterns. A comprehensive claims database will enable utilization benchmarking and measurement of change. A quality claims database will allow for the creation of a robust set of evidence-based measures as well as new benchmarking systems, such as episodes-of-care grouping benchmarks and hospital efficiency benchmarks.

Strategy: Establish a Clinical Improvement Assessment Project in order to access existing and new comparative effectiveness research.

Systematic reviews are the building blocks underlying evidence-based practice; they focus attention on the strengths and limits of evidence from research studies about the effectiveness and safety of a clinical intervention. Under a Clinical Improvement Assessment Project, public purchasers of health care conduct and support research on the comparative outcomes, clinical effectiveness, and appropriateness of pharmaceuticals, devices, and health care services to meet the needs of Medicaid, the State Children's Health Insurance Program (SCHIP), the Public Employees Benefit Board (PEBB), the Oregon Educator's Benefit Board (OEBB), Corrections Health, and University Health as well as the recipients of any publicly purchased health care.

A Clinical Improvement Assessment Project will offer better access to comparative effectiveness reviews for state purchasers of health care as well as private health plans, providers, private purchasers, and the health care system as a whole.

Strategy: Use a Clinical Improvement Assessment Project to implement clinical coverage guidelines and standards.

There is wide variation in medical care for certain conditions between communities in Oregon. For example, some communities have much higher rates of surgery for back problems than other areas. These areas of clinical variation are high priority areas for guideline creation. Other high priority areas for guideline creation are those areas of medicine with high overall expenditures in the state. For example, care for patients with diabetes and congestive heart failure is expensive

due to the number of patients, the complexity of disease, and the costs of complications of these diseases. Many of these conditions already have high quality evidence-based guidelines available at a national level. By creating or adopting guideline standards, and encouraging their use in the treatment of these highly variable and expensive conditions, the state will improve health outcomes while reducing the overall cost of care.

Strategy: Establish an Oregon Quality Institute.

While there are numerous public and private efforts underway across the state to improve health care quality, the state could greatly benefit from a coordinated effort to establish and implement a statewide quality improvement strategy. An Oregon Quality Institute could lead Oregon toward a higher performing health care delivery system by initiating, championing, and aligning efforts to improve the quality and transparency of health care delivered to Oregonians. While a significant piece of this work would focus on the collection and public reporting of health care quality information, other roles for the Quality Institute would focus on helping providers, purchasers, consumers, state government, and other stakeholders effectively use this data to improve quality across the health care system.

If established by the Authority, the Quality Institute could carry out the technical work that would be required to establish a public reporting system for Oregon. Specifically, roles of the Quality Institute would include: convening public and private stakeholders to align all groups around common quality metrics for a range of health care services; ensuring the collection and timely dissemination of meaningful and accurate data about providers, health plans, and patient experience to a wide range of audiences in appropriate formats; ensuring providers have the ability to produce and access comparable and actionable information about quality, utilization of health care resources, and patient outcomes that allows for comparison of performance and creation of data-driven provider and delivery system quality improvement initiatives. In all of its work, the Quality Institute will partner and collaborate with other stakeholders to maximize output and minimize duplication of efforts.

ACTION STEPS:

1. Empower the Authority to enact change.

The Legislature empowers the Authority to develop clinical quality measures, health and outcomes targets, clinical guidelines and standards, per capita/CPI cost increase targets, and standards for insurance administrative practices. The Authority or the Department of Consumer and Business Services requires participation by carriers as part of the DCBS oversight of insurers. The Legislature authorizes DCBS to require that self-insured plans and reinsurers participate as a requirement of the business license or other licensure process.

2. Create a Clinical Improvement Assessment Project

The Legislature creates a Clinical Improvement Assessment Project that builds on existing state structures to bring Oregon's health care providers together to improve the quality and value of health care they provide. It will operate under the oversight of the Authority.

Under the Clinical Improvement Assessment Project:

- The Health Resources Commission will partner with existing state, national, and international entities that are already investing in comparative effectiveness research. The Project will support the use of high quality comparative effectiveness research to make public and transparent policy decisions. By using such research, common policies can be developed across publicly-funded health programs regarding the coverage of new and existing treatments, procedures, and services. By partnering with private health plans, uniform criteria and evidence can be made available to all of Oregon's health care providers for patient care in both the public and private sectors.
- The Health Services Commission (HSC) will develop standard sets of evidence-based guidelines by reviewing and endorsing existing high-quality guidelines whenever possible and convening expert panels to create them when they don't exist. All providers in the state will have access to these guidelines, and the HSC will focus first on those chronic conditions with the highest cost, variation in treatment utilization, and/or variation in quality of care. As developed, policies can require that providers serving patients in publicly funded programs follow these guidelines. The HSC will work with private purchasers and health plans in the development of the guidelines, and common policies can be created to encourage their utilization across both the public and private sectors. The HSC will also be responsible for keeping the Essential Benefit Package up-to-date according to the approved guidelines, comparative effectiveness research conducted by the Health Resources Commission or other trusted sources, and public input.
- The work of the Health Services Commission and the Health Resources Commission would be closely aligned to each other and in coordination with the overall health objectives determined by the Oregon Health Fund Board.

4. Adopt recommended guidelines.

Expert panels, using the best available evidence, identify or develop evidence-based guidelines for conditions with high variability or expense. The state then encourages the adoption of these guidelines. Strategies for adoption could include mandating guideline use by state sponsored insurance programs, voluntary adoption by private insurers, or publishing the guidelines as best practices throughout the state.

5. Establish a Quality Institute.

The Authority establishes an Oregon Quality Institute as a publicly chartered public-private organization that operates under the Authority's guidance to carry out the technical work associated with establishing and maintaining a health care quality data collection and reporting system. As possible, the Quality Institute also develops initiatives to engage consumers, providers, purchasers, state government, and other stakeholders in utilizing this data to improve health care quality. The Legislature makes a substantial, long-term investment in the Quality Institute.

In an alternative arrangement, the Authority could decide to contract with existing entities and organizations to carry out this work, without creating a new Oregon Quality Institute. In either case, significant public funds would need to be dedicated to quality improvement.

➤ **Report Performance**

Objective: Make comparable information about provider performance and costs widely available.

Strategy: Institute public reporting that gives the Legislature, consumers, providers, purchasers and carriers information across payers and providers.

One of the major problems with the current health care system is that comparable information about provider performance and costs is not widely available. Providers need better information to benchmark their performance, identify opportunities for quality improvement and design effective quality improvement initiatives that allow for better health outcomes at a lower cost. Purchasers need ways to identify and reward high-performing providers who delivery high-quality, high-value care to their patients. Consumers need better cost and quality information to help guide critical health care decisions and communities need information about health spending and resource utilization so that health planning decisions can be made to maximize population health. Any effort to contain costs within the health care system will rely on the availability of clear information that allows for the identification of delivery practices that improve individual and population health while reducing costs.

Strategy: Restructure payment systems to encourage high-quality health care delivery.

Health care providers (including physicians, other health care professionals, hospitals, and other centers delivering care) should be accountable for quality, efficiency, health outcomes, and care coordination. Once a public reporting system is established, data should be used to inform payment reform efforts designed to provide incentives to providers delivering high-quality care to their patients.

ACTION STEPS:

1. Authorize the Authority to develop and implement public reporting of health care quality data.

The Legislature authorizes the Authority to establish a system for collecting and publicly reporting data on health care quality. This includes authorization to require providers and/or health plans to submit quality data, although the data system will be based on voluntary reporting wherever possible. Reporting systems developed by the Authority will provide comparable information about quality of care, utilization of health care resources and patient outcomes. To the extent practicable and appropriate, data will be easily accessible to providers, health care purchasers, health plans, and other members of the public in appropriate formats that support the use of data for health care decision-making and quality improvement.

2. Ensure that advances in quality are reaped by individuals of all backgrounds.

In its role as convener and collaborator, the Quality Institute should also be responsible for:

- Training provider organizations and health plans on protocols for collecting race, ethnicity, and primary language data based on the highest national standards. This will ensure consistency and comparability among data sources, increase cultural competency, and reduce provider discomfort with collecting this kind of information from patients.
- Developing a Health Disparities strategy that utilizes data to identify disparities and assist communities with evaluating interventions to reduce disparities.
- Aligning resources to support quality healthcare across all demographic populations in Oregon.
- Disseminating meaningful and accurate information on health quality and utilization of healthcare resources in a manner that is accessible and understandable to individuals from a variety of cultural, ethnic, and educational backgrounds.

3. Establish a Payment Reform Committee.

The Authority establishes a Payment Reform Committee to explore new payment models that reward providers for the quality of care they provide.

DOMAIN III: STIMULATE SYSTEM INNOVATION & IMPROVEMENT
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➤ **Stimulate New Models and Systems of Care**

Objective: Create a coordinated, integrated and equitable health care system.

Strategy: Pursue development of integrated health homes.

The state must seek opportunities to revitalize primary care across the state and re-design the health care delivery system to maximize individual and population health. Primary care infrastructure and reimbursement policies should be designed to encourage patient-centered, coordinated, cost-efficient, longitudinal care and stress the importance of wellness, prevention and effective disease management rather than episodic, illness-oriented care. The integrated health home model (IHH) can serve as a blueprint for this type of re-design and should guide primary care practice transformation across the state. While this model allows for many different care settings to serve as integrated health homes, they all share common features. Integrated health homes establish personal and continuous relationships with patients, provide team-based care, assume responsibility for providing culturally competent care for all of a patient's health care needs, coordinate and integrate care with the care received from other providers and organizations, focus on quality and safety, and provide patients with enhanced access to care services.¹¹

The integrated health home builds strong provider-patient relationships which can improve overall health, empower individuals to better manage their own health, improve quality of care, increase efficiency through care coordination and better disease management and lead to savings across the system. Experience from other states reflects significant savings from enrolling people in integrated health home. By requiring all Medicaid and SCHIP recipients to enroll with an integrated health home and providing integrated health homes with care coordination payments, the Illinois Medicaid program has been able to save \$34 million annually.¹²

By following a similar policy and supporting integrated health homes with networks of case managers, provider learning networks, and dissemination of best practices and clinical guidelines, the North Carolina Medicaid program has reduced its per-member-per month costs by \$37 after four years.¹³ Similar policies for Oregon could lead to savings of \$120 million over ten years, if OHP required all participants to enroll in an integrated health home. If OHP followed North Carolina's lead and created additional support networks for integrated health homes, the state could save as much as \$50 million in the first year, with ten year savings as much as \$2.5 billion.

¹¹ A more comprehensive description of the integrated health home model and current state and national integrated health home pilots can be found in a research paper prepared by the Office for Oregon Health Policy and Research, available at http://www.oregon.gov/OHPPR/docs/The_Medical_Home_Model_Final.pdf.

¹² Press release from the Office of Illinois Governor Rod Blagojevich. April 28, 2008. <http://illinois.gov/PressReleases/ShowPressRelease.cfm?SubjectID=19&RecNum=6784> (downloaded August 1, 2008)

¹³ K. Lorito. 2007. CCNC/Access Cost Savings – State Fiscal Year 2005 and 2006 Analysis. Mercer Government Human Services Consulting. http://www.communitycarenc.com/PDFDocs/Mercer%20SFY05_06.pdf (downloaded July 15, 2008).

Strategy: Prevent health disparities before they occur.

Eliminating health disparities in chronic disease will have a profound economic impact on the state's health care system and will increase earnings over a lifetime and lower poverty rates, particularly for ethnic minorities.¹⁴ The sustainability of the health care system needs to be addressed by recognizing that the health of the individual begins at home and within the context of families, cultures, and communities. Many chronic diseases have had a disproportional impact on communities of color.¹⁵ Eliminating these disparities requires culturally-specific approaches to promoting health and preventing chronic disease.

Strategy: Develop learning collaboratives.

Learning collaboratives allow state agencies and certified integrated health homes to share information about quality improvement and best practices

ACTION STEPS:**1. Create an IHH designation that includes reporting requirements on process, outcome and quality metrics.**

The Legislature directs the Authority to develop a standard and simple process to identify health care practices as integrated health homes. A common definition will be established based on nationally-accepted certification processes and designed to limit administrative burden on providers. Any provider who meets the structural and performance criteria will be eligible for enhanced IHH payment. All public and private health insurers will be required to utilize this designation process if providing care coordination /management payments to providers.

2. Establish standards for reimbursing designated IHHs.

The Legislature directs the Authority to institute long-term sustainable payment policies that appropriately compensate providers and other partners involved in integrated health home systems of care. Compensation will be provided for developing capacity to provide integrated health home services and for providing these services to Oregonians in a high-quality and high-value manner. New payment strategies will be tested and evaluated to determine the potential to improve patient outcomes and experience, as well as provider experience. These new payment strategies will be part of a comprehensive payment reform strategy. A mixed model of reimbursement will be developed, which includes fee for service payments for certain procedures and risk-adjusted bundled payments for providing integrated health home services. Payment should be tied to designation and reporting requirements of common measures.

3. Develop standard requirements with contracted health plans.

The Legislature directs the Authority to develop a system of per-person care management payments for certified integrated health homes. All publicly-funded programs will use care

¹⁴ E.D. Crook and M. Peters, *Health Disparities in Chronic Diseases: Where the Money Is*, (The American Journal of Medical Sciences, 335(4):266-270, April 2008).

¹⁵ A. C. Beal, M. M. Doty, S. E. Hernandez, K. K. Shea, and K. Davis, *Closing the Divide: How Medical Homes Promote Equity in Health Care: Results From The Commonwealth Fund 2006 Health Care Quality Survey* (New York: The Commonwealth Fund, June 2007).

management payments to support integrated health homes. There will be incentives for enrolled members to utilize IHHs, especially those with chronic diseases.

4. Incorporate IHHs first in OHP.

The Oregon Health Plan develops and evaluates strategies to empower consumers to become more involved in their own health and health care by partnering and engaging with integrated health homes. The Department of Human Services Division of Medical Assistance Programs (DMAP) implement and evaluates strategies to provide incentives for OHP participants who enroll with integrated health homes, seek preventative and wellness services, practice healthy behaviors, effectively manage chronic disease with support from health homes. By January 1, 2010, OHP will offer IHHs to its members.

5. Institute payment restructuring to support the implementation of IHHs.

The Division of Medical Assistance Programs will institute payment restructuring to implement the integrated health home concept in the Oregon Health Plan.

6. Partner across state agencies and with other carriers to implement IHHs.

The Division of Medical Assistance Programs will partner first with PEBB, OEBC, and other public employers, and later with regulated carriers, to incorporate designated IHHs in their plan networks and to design benefit packages with incentives for members with chronic diseases to seek care from contracted IHHs.

7. Evaluate the impact of IHH model on a biennial basis for six years.

The Legislature acknowledges and supports initial pilots underway across the state and uses the lessons and best practices from these pilots to design, promote, and/or fund a larger scale continuous rollout of the integrated health home model. This rollout will develop new integrated health home models, as well as new models of reimbursement that adequately compensate and support providers and other associated workforce personnel for delivering integrated health home services. There will be opportunities for consumer involvement on advisory committees monitoring the performance of integrated health homes.

8. Promote population-based approaches.

The Legislature allocates sustainable funding to support an on-going, substantial investment in public health activities that will prevent disease and promote the health of Oregonians. Targeting culturally-specific approaches to disease prevention and health promotion will be part of this investment.

9. Ensure language access.

DMAP takes advantage of growing technological capacity in Oregon by creating a state-wide pool of qualified, certified interpreters and organizations that may be able to utilize and build on technologies being developed for telemedicine or tele-health. DMAP will seek federal matching funds for interpreter services through Medicaid in order to ensure affordable interpreter services for providers who see Medicaid patients.

10. Establish a learning collaborative.

The Legislature directs the Authority to establish a collaborative for state agencies and all certified integrated health homes to share information about quality improvement and best practices. IHHs serving OHP clients will be required to participate in the activities of the collaborative. The state may contract with a state or national organization that specializes in quality improvement in order to facilitate the collaborative. The collaborative must be able to accept grants from public agencies, as well as private foundations and partners.

➤ Behavioral Health Care Integration

Objective: Provide behavioral health care and physical health care within coordinated and integrated systems of care.

Strategy: Integrate behavioral health services.

Chronic behavioral health conditions account for a significant amount of morbidity and mortality and a large portion of health care spending in Oregon. In 2006, the economic costs of substance abuse in this state were nearly \$6 billion.¹⁶ Behavioral health and physical health need to be addressed within the same system of care. Currently the Oregon Health Plan contracts with Fully-Capitated Health Plans (FCHPs) for treatment of physical and addiction conditions, while contracts with Mental Health Organizations (MHOs) provide treatment for mental health conditions. This policy and contracting segmentation potentially causes dis-integration of care among different provider panels who may not be aware of or communicate with other providers in the community serving the same patient.

Ideally there would be one organization contractually obligated to provide the full range of health care services: physical, addiction and mental health. But the integration and coordination of care can happen when local FCHPs and MHOs collaborate on joint policies and develop processes to link providers serving the same patient. The Addictions and Mental Health Division (AMHD) and the Division for Medical Assistance Programs (DMAP) must develop policies, contracts and performance standards that require FCHP-MHO collaboration and co-management of shared patient populations.

ACTION STEP:**1. Develop policies and incentives to integrate behavioral health care.**

AMHD and DMAP develop policies, performance standards and incentives that require contracted plans (FCHPs and MHOs) to develop effective care integration strategies for enrollees.

¹⁶ R. Whelan, A. Josephson, and J. Holcombe. 2008. The Economic Costs of Alcohol and Drug Abuse in Oregon in 2006. EcoNorthwest.

➤ **COMMUNITY-BASED INNOVATION**

Objective: Foster innovation in health care delivery in local communities.

Strategy: Support community-based collaboratives.

Community-based collaboratives in Oregon are developing innovative programs and relationships to better integrate health care across multiple local organizations. If all health care is local, then the transformation of Oregon's health care system will happen locally; within, among and through the scores of organizations, both public and private, involved in health care.

The Board has learned of exciting activities in several Oregon communities that are models for community-driven innovation. Some are geographically focused:

- The 100% Access Initiative (Lane County);
- Health Matters of Central Oregon (Crook, Deschutes and Jefferson counties);
- Jefferson Regional Health Alliance (Jackson and Josephine counties);
- Northeast Oregon Network (Baker, Union and Wallowa counties).

Others are informal networks of health plans, public and private providers, and other organizations, such as: CareOregon's Primary Care Renewal program; Benton County's Public Health and Local Mental Health Authority integration project; Multnomah County's Coalition of Community Health Clinics.

These programs bring together diverse, community-based interests to work on:

- Community wellness programs that include schools, employers, health care providers, social service and other community entities;
- The development of various forms of Integrated Health Homes to better coordinate the delivery of physical, behavioral and oral health;
- Improving chronic disease management to reduce unnecessary use of hospital emergency departments and inpatient admissions;
- In some cases, the development of local "3-share" programs (employers, employees and community) for low-income, uninsured individuals.

Because community-based innovation projects are the "learning laboratories" for the transformative change called for in this Action Plan, it is in the interest of the state to promote such activities and foster the exchange of best practices among communities at different stages of maturity.

ACTION STEPS:

1. Legislative support for community-based collaboration.

The Legislature authorizes the Authority to support, stimulate and monitor community-based collaboration and appropriates for the 2009 – 2011 biennium \$1 million to the Authority for challenge grants to existing or emerging community collaboratives. Grants will range between \$25,000 and \$50,000 per biennium and will require local matching funds and specific performance objectives and measures. In awarding grants, priority will be given to proposals

that include addressing the needs of multi-cultural communities. The grants may be in the form of direct financial or technical assistance. The Authority will also work with existing community collaboratives to determine their readiness to assume the role of an Accountable Health Community.¹⁷

2. State agency support for community-based innovation through administrative waivers.

The Department of Human Services' relevant divisions (AMHD, DMAP and PHD) can waive administrative requirements applicable to contracting organizations participating in a community collaborative. The waiver(s) will be predicated on: 1) a demonstration project that promotes new models of chronic care management that will improve care integration; and 2) performance objectives and related measures to objectively evaluate the project's success.

3. State agency support for community-based innovation through state contracting leverage.

The Department of Human Services will work to strengthen the relationship between health-focused community-based organizations and the health care delivery system. DMAP will design a contracting mechanism that will empower primary care clinics who primarily serve vulnerable populations to build financial agreements with health-focused community-based organizations that provide culturally-specific health promotion and disease management services. DMAP will also ensure that high-value community-based health promotion, disease prevention, and chronic disease management services are eligible for direct reimbursement.

➤ The Public's Health

Objective: Ensure effective investment in Oregonians to prevent and reduce tobacco use, obesity and other major chronic diseases.

Strategy: Link population health to the health care delivery system and communities.

Through making individuals healthier and reducing chronic diseases, there is tremendous potential to improve overall population health, productivity, and reduce health care costs to make cost containment more attainable. As an essential part of health care transformation, creating and maintaining a bridge between population health, the health care delivery system, and communities is essential.

To maximize success, the Authority overseeing health reform must have public health professionals, public and private, integrally involved for population evaluation and decision-making. The Authority should also emphasize broad representation on committees from professionals outside of the "classic" public health and health care delivery sectors (i.e., education, transportation). Through broad participation, the Authority will ensure health impacts to be evaluated and addressed through multiple sectors.

¹⁷ E.S. Fisher, et al. 2007. Creating Accountable Care Organizations: The Extended Medical Staff. *Health Affairs* 2007;26(1):w44-w57.

Tobacco use and obesity are the two most influential modifiable risk factors for the five leading causes of death in Oregon¹⁸. Funding and implementing effective initiatives to prevent and reduce tobacco use, improve nutrition, and increase physical activity will result in a healthier, more productive population with significantly reduced health care costs. A recent report from the Trust for America's Health projected that if Oregon invested \$10 per person on proven community-based disease prevention programs focused on increasing physical activity, improving nutrition, and reducing tobacco use, the state could save over \$32 million annually in one to two years and over \$200 million annually in 10 to 20 years. This could lead to a ten year savings for the state of \$1.7 billion.¹⁹

ACTION STEPS:

1. The Authority coordinates development of the Healthy Oregon Action Plan in 2009.

This singular, comprehensive plan must include statewide, regional and community level benchmarks and strategies to prevent and reduce tobacco use, prevent and reduce obesity and other major chronic diseases. This plan will incorporate and build on work published by the Oregon Public Health Division in the Oregon Statewide Tobacco Control Plan 2005-2010 and the Statewide Physical Activity and Nutrition Plan 2007-2012, and includes both public and private organizations including employers, schools and community organizations.

Example benchmarks of the plan include but are not limited to the following:

- Reduce the percentage of 8th graders who smoke cigarettes to 5%
- Reduce the percentage of 11th graders who smoke to 10%
- Develop and implement effective population specific tobacco control programs directed at specific ethnic and cultural groups affected by tobacco use disparities
- Increasing by 10% the number of workplaces promoting physical activity and healthy eating
- Increase by 10% the number of employers who offer health care coverage for effective health care prevention and treatment of chronic diseases
- Increase the number of major health plans and insurers that cover obesity prevention
- All school and child care settings implement policies requiring all food served to meet or exceed current age-appropriate USDA Dietary Guidelines
- Increase by 10% the number of Oregon children who meet minimum recommendations for physical activity
- Increase by 5% the number of Oregon adults and children who meet the recommendation for daily physical activity

¹⁸ Mokdad AH, Marks JS, Stroup DF, Gerberding JL. 2004. Actual Causes of Death in the United States, 2000. JAMA 291(10):1238-1245.

¹⁹ Trust for America's Health. 2008. Prevention for a healthier America: investments in disease prevention yield significant savings, stronger communities. <http://healthyamericans.org/reports/prevention08/Prevention08.pdf> (downloaded August 11, 2008).

2. The Oregon Legislature enacts and appropriates funds a Community-Centered Health Initiatives Fund (CCHI) in 2009.

This fund is to be used to provide funding to develop and implement culturally and socially appropriate primary and secondary prevention activities in line with the benchmarks and goals established by the Healthy Oregon Action Plan. The Public Health Division, using policies and guidelines approved by the Authority, would fund and continuously evaluate initiatives at the state, regional and community level to encourage innovation and effective programs.

3. The 2009 Oregon Legislature enacts an increase of the tobacco tax to fund all or portions of action steps #1 (Healthy Oregon Action Plan), action step #2 (Community-Centered Health Initiatives Fund) and provide county public health departments assistance for tobacco use and chronic disease prevention and reduction programs that discontinued or reduced with loss of timber funds.

Oregon currently underfunds tobacco use prevention and reduction efforts by over 80% according to the Centers for Disease Control. The current biennial budget for the Tobacco Education and Prevention Program in the Oregon Public Health Division is \$6.9 million²⁰. An increase in the tobacco tax of \$0.50 would result in 19,000 fewer youth smokers with related lifetime health savings of \$332.5 million, and 6,000 deaths avoided. The overall long-term health savings of the \$0.50 tax increase would be \$419.9 million.²¹ There is currently no sustainable, long-term commitment from the Oregon Legislature for funding of obesity related prevention and reduction programs. These efforts are currently 100% funded through local and federal grants, which restrict long-term viability and sustainability.

4. Implement programs and initiatives targeting prioritized strategies and benchmarks established in the Healthy Oregon Action Plan in 2010 (Reference Action Step #1).**5. Develop criteria and request for proposals for CCHI funding in 2010 (Reference Action Step #2).**

The criteria for the CCHI should include but are not limited to one or more of the following:

- Be based on community input;
- Be based on evidence and data, including population health measures reported and have evaluation
- Will address behavior change at the individual, community and system levels;
- Coordinate efforts of local county health departments, community-based organizations, schools, employers and health care delivery system entities;
- Work to reduce health care disparities;
- Be contingent on effectiveness and will be evaluated for effectiveness on an ongoing basis

²⁰ Oregon Statewide Tobacco Control Program 2005-2010. Available from: www.oregon.gov/DHS/ph/tobacco/pubs.shtml

²¹ Lindblom E. 2008. Oregon cigarette excise tax increases: estimated new revenues, cost savings, and other benefits and effects. <http://tobaccofreekids.org/research/factsheets/pdf/0148.pdf> (Downloaded August 18, 2008).

6. The Public Employees Benefit Board develops the Oregon Employee Wellness Action Plan in 2009.

This plan would address workplace conditions to encourage healthy behaviors, such as healthy eating and physical activity. The state should also collaborate with private employers and health plans to establish best practices for effective workplace wellness programs.

7. Prioritize and implement strategies in the Oregon Employee Wellness Action Plan in at least 50% of Oregon state agencies in 2010 (Reference Action Step #6).**➤ Accountable Health Communities**

Objective: Create a tool to measure performance at the community level and create a locus of accountability for quality and cost across the continuum of care.

Strategy: Develop virtual Accountable Health Communities that serve as an analytical framework to compare health outcomes, quality, and cost between different communities.

Accountable Care Organizations have been proposed by researchers at Dartmouth College as a vehicle to foster shared accountability for quality and cost among all providers serving a defined population across the continuum of care. The key model empirically links primary care and tertiary care institutions within a community to define local delivery systems large enough to support comprehensive performance measurement and provide or effectively manage the full spectrum of patient care. Aggregating quality and cost data allows these local delivery systems to evaluate population-based measures, including those which account for the efficiency and coordination between various providers serving a population. In addition, it creates a tool to measure individuals' longitudinal experience with the health care system. This model allows for comparisons of performance across local delivery systems and the identification of communities with high utilization rates and per capita spending, as well as areas able to more efficiently use resources to improve population health.²² Expanding this concept to "Accountable Health Communities" enables the focus to encompass a full range of care systems and also include broader measures of community and public health.

Aggregating and publishing cost and quality data at the Accountable Health Community level is a vital step to fostering local accountability for health system performance. These Accountable Health Communities can be utilized as a framework from which to analyze and compare outcomes across different communities and can guide stakeholder groups within these communities to use data to make health planning and resource utilization decisions that maximize individual and population health and delivery system quality and efficiency. In addition, they can serve as a framework within which new payment methods that reward efficiency and quality can be tested.

²² E.S. Fisher, et al. 2007. Creating Accountable Care Organizations: The Extended Medical Staff. *Health Affairs* 2007;26(1):w44-w57.

ACTION STEPS:**1. The Authority will define Accountable Health Communities across the state and will report quality and cost data accordingly.**

The Authority or an entity designated by the Authority will develop a method for defining Accountable Health Communities across the state. All health outcomes, quality, and cost data reported by the Authority, Oregon Quality Institute, or other government agency will be aggregated to account for Accountable Health Communities' performance. The Legislature ensures that the development of Accountable Health Communities is tied to state's increased access to the claims data that will make performance appraisal possible.

2. The Authority will engage community stakeholder groups in using Accountable Health Community data to drive quality improvement interventions.

The Authority will explore opportunities to encourage and support community stakeholder groups to use Accountable Health Community level data to drive quality improvement interventions and inform health planning and resource utilization decisions. In some communities, established community collaboratives promise to play a lead role in creating effective interventions to respond to quality and cost data. Other communities will need to establish collaborative stakeholder groups to translate data into action and drive change at the community level. In particular, the Authority's Payment Reform Committee will partner with these community stakeholder groups to use aggregated data in designing payment reform initiatives that encourage providers across a community to integrate and coordinate care services.

➤ Administrative Simplification

Objective: Decrease administrative spending by simplifying and standardizing administrative processes.

Strategy: Develop standard formats and processes for eligibility, claims, payment and remittance transactions.

Administrative expenses account for a large percent of total health care spending and there are significant opportunities to increase administrative efficiency across the health care system. Reform efforts in Minnesota have demonstrated that there is significant money to be saved through a standardization of administrative transactions between providers and payers. In 2007, Minnesota passed an update to the state's Healthcare Administrative Simplification Act, which requires all health care payers and providers to electronically exchange information for eligibility verification, claims, and payment and remittance advice transactions using standard content and format established by the Department of Health. Projected savings for 2008-2012 are \$215 million.²³ Based on Minnesota's methodology, Oregon can reasonably expect to save over \$400 million over ten years if similar standards were adopted.

²³ J. Golden. February 7, 2008. Health Information Technologies and Health Care Transformation. Presentation at the State Coverage Initiatives Winter Meeting. Nashville, TN.

A number of stakeholder groups, including the Oregon Association of Hospitals and Health Systems, the Oregon Medical Association, and various insurance carriers, have joined together to develop a set of voluntary standards for administrative transactions. While the state should not spend limited resources on duplicative efforts, it is important for the state, as a large purchaser and payer, to be an active player in efforts to standardize administrative processes. In addition, in order to maximize administrative efficiency, all providers and payers must adopt the same standards. Thus, while voluntary standards might be an important first step in reducing administrative costs, it might be necessary for the state to establish requirements for all providers and payers in the state in order to reach full adoption of common standards.

ACTION STEPS:

1. Develop standard formats and processes for eligibility verification, claims, and payment and remittance advice transactions.

The Department of Consumer and Business Services (DCBS) collaborates with public and private stakeholders to develop standard formats and processes for the electronic exchange of eligibility verification, claims, and payment and remittance advice transactions. By December 31, 2009 DCBS endorses a single standard for format and content of administrative transactions for all payers and providers in the state.

2. Ensure all providers and payers adopt state standards for electronic administrative transactions.

DCBS sets benchmarks for levels of provider and payer adoption of administrative transaction standards, leading to complete adoption by July 31, 2011. DCBS monitors levels of voluntary adoption and assesses need for legislation or administrative rule to require all providers and payers to adopt standards.

➤ End of Life Care

Objective: Provide high-quality, dignified end of life to every Oregonian.

Strategy: Create a statewide voluntary, electronic Physician Orders for Life Sustaining Treatment (POLST) Registry to ensure the availability of the POLST form at the time of need.

Oregon has long been recognized as a leader in the provision of dignified end of life care and should continue to take steps to ensure that patients' wishes about life-sustaining treatments are known and followed. In the case of individuals with advanced chronic illness, the POLST form can serve as an important tool to convey patient wishes. The POLST is different from an advanced directive, because it is signed by a physician or nurse practitioner, thus converting wishes for life-sustaining treatments into medical orders that can be followed by nursing facilities or emergency medical technicians. The OHSU Center for Ethics, through a voluntary program, has distributed over one million POLST forms and POLST forms are used in all Medicare-certified hospice programs in the state and in over 90% of all nursing facilities. However, an OHSU survey found that in one in four cases where a POLST had been filled out, it could not be found by emergency personnel in time to act on it. An electronic registry could

help ensure that POLST forms are available at the time of need, by allowing EMS personnel to call a central number to determine if a patient has a POLST form and if so, access the orders on the form. A model Portland registry is currently under development.

Strategy: Ensure payment systems adequately reimburse providers for services necessary to provide dignified end-of-life care, including decision support and palliative care services.

There is good evidence that many patients and families are not aware of their options for care at the end of life and have not discussed with their health care providers their wishes with respect to invasive treatments, do not resuscitate orders, hospice and palliative care, and other treatments at the end of life. In order to provide high quality end of life care, providers must work with patients and their families to make health care decisions aligned with the values and goals. Decision support processes are critical to helping patients understand the likely outcomes of various care options, allowing them to reflect on what is personally important, to consider the risks and benefits of each option, and to make decisions with their support team. In addition, when a patient faces a life-threatening illness, it is critical that they have access to palliative care services, which include specialized approaches that focus on improving quality of life, through the prevention, assessment and treatment of pain, symptoms and stress associated with serious illness. Currently, providers are not reimbursed for time spent engaged in decisions support discussions with patients and current payment structures do not support palliative care teams to care for patients at the end of life. Reimbursement policies should be revised to reflect the importance of these vital services and encourage the delivery system to provide comfort and support to patients at the end of life.

ACTION STEPS:

1. Establish a statewide voluntary, electronic POLST registry.

The Legislature approves funding for the establishment and maintenance of a voluntary, electronic POLST registry. This registry would build off of current efforts to develop a Portland registry.

2. Create clinical guidelines and for end of life care.

The Legislature approves increased funding the Health Services Commission to develop clinical guidelines for end of life care, including decision support services and palliative care. This work will include methods for integrating payment for these services.

3. Adopt recommended guidelines.

All state sponsored insurance programs adopt the clinical guidelines and payment policies recommended by the Health Resources Commission. The state will publish these guidelines as best practices throughout the state and encourage adoption by private insurers.

DOMAIN IV: UNIFY PURCHASING POWER
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➤ **Coordinated Purchasing Policies Among Public Entities**

Objective: Influence the direction and pace of system transformation in local markets and statewide through coordinated and aligned purchasing policies by the state and other government entities. Encourage voluntary adoption and participation by private purchasers.

Strategy: **Develop model contract standards and policies that can be adopted by the State of Oregon (Oregon Health Plan, PEBB, OEPP).**

The Authority oversees the development of a model contract to county, city and other local governments (and their association plans) through creation of Public Employers Health Cooperative. The Authority and the Cooperative collaborate with private purchasers (labor trusts, self-insured employers, Oregon Coalition of Health Care Purchasers, association plans, etc.) to adopt similar standards and policies.

The pace of innovation in local delivery systems rests, in large part, with the goals and requirements expressed by purchasers – public and private – either through their respective insurers, or, alternatively, directly to the provider community through collaborative and cooperative actions.

The Department of Consumer & Business Services (DCBS) estimates the number of insured Oregonians through employment-sponsored coverage at 1.84 million.²⁴ Employees of state government, state education institutions, and local governments and their dependents exceed 500,000 lives. Enrollment in the Oregon Health Plan currently stands at close to 420,000 people. With the coverage expansions proposed in this Action Plan, the combined populations of non-federal public employees (and dependents) and the OHP will approximate 1,000,000.

County and regional comparisons are shown in the table on the following page. This data reflects employees only, and does not include estimates of dependent coverage.

This strategy does not suggest that public employers who adopt model contract standards must have similar benefit designs or cost sharing. The collective action envisioned is around performance requirements for providers and health care systems (clinical and service standards and reporting), the use of common evidence-based guidelines for utilization management and comparative effectiveness guidelines for new technologies.

The Integrated Health Home (described earlier) concept can be quickly introduced in communities if purchasers collectively bring the scale (members using IHHs) to providers to support the business/clinical model. In the case of IHHs and other models of chronic disease management, public employers should provide financial incentives to members to use an IHH or

²⁴ Oregon Department of Consumer and Business Services, Insurance Division. *Health Insurance in Oregon*, May 2008.

community-based chronic disease program. Incentives could include waived or lower co-pays, lower co-insurances, or services not subject to a deductible.

Public Employees & OHP as Percent of Total Employment By Region

	State ²	Local	OHP ³	Total Govt	Pvt	Total	Total Govt as % of Total
Clackamas	2,200	15,700	23,451	41,351	130,700	172,051	24.0%
Multnomah	12,000	48,300	80,856	141,156	385,200	526,356	26.8%
Washington	2,500	19,400	34,904	56,804	226,000	282,804	20.1%
Regional Total	16,700	83,400	139,211	239,311	741,900	981,211	24.4%
Marion	23,200	19,200	42,770	85,170	110,700	195,870	43.5%
Benton	17,580	2,710	4,975	25,265	26,910	52,175	48.4%
Linn	1,080	6,360	14,386	21,826	34,510	56,336	38.7%
Regional Total	41,860	28,270	62,131	132,261	172,120	304,381	43.5%
Lane	22,300	16,300	36,534	75,134	127,300	202,434	37.1%
Douglas	1,180	6,220	13,684	21,084	30,850	51,934	40.6%
Jackson	4,500	7,890	21,850	34,240	72,380	106,620	32.1%
Josephine	850	2,790	12,015	15,655	22,040	37,695	41.5%
Region Total	5,350	10,680	33,865	49,895	94,420	144,315	34.6%
Deschutes	1,210	6,590	12,194	19,994	65,340	85,334	23.4%
Crook	210	900	2,136	3,246	5,610	8,856	36.7%
Jefferson	360	2,370	3,238	5,968	3,630	9,598	62.2%
Regional Total	1,780	9,860	17,568	29,208	74,580	103,788	28.1%

² Includes State Education

³ Includes Managed Care and Fee for Service

Oregon Employment Department: www.qualityinfo.org/olimsj/OlimsZine

Based on the interests of the participating public employers, the Public Employers Health Cooperative could eventually contract directly with providers for specified services such as Centers of Excellence contracts such as cardiac or cancer services.

State purchasing programs should be “rapid adopters” patient decision aids to assist enrollees in joint decision-making with their physician for those conditions that are “preference sensitive” in nature. The state can play an important role in identifying reliable patient decision aids, testing their application and evaluating their impact on clinical treatment and patient satisfaction. The coordinated use of patient decision aids in local markets by participating public employers can speed the evaluation of their efficacy.

The Oregon Prescription Drug Program (OPDP) is an innovative joint contract for pharmacy benefits that includes both the State of Oregon and Washington State. As of July 31, 2008, OPDP has enrolled 83,560 Oregonians in a prescription discount card and 18,671 persons in group contracts. On October 1, the group number will increase to 104,000 with the inclusion of

Oregon Educators Benefit Board members. State policy should require all health plans contracting with the state to provide their pharmacy benefit management (PBM) services through OPDP unless they can demonstrate greater savings through an alternative arrangement.

ACTION STEPS:

1. Legislative authorization for the Authority to develop model contracting standards.

The Legislature authorizes the Authority to develop model contracting standards for state agencies that purchase health care services. Working with and through the Health Services Commission, the Health Resources Commission and organizations involved in clinical quality metrics, the Authority will initially focus on the development of: A) a standardized set of quality performance measures; B) evidence-based guidelines for major chronic diseases, services with unexplained variations in frequency or cost and “supply sensitive” services; and C) comparative effectiveness guidelines for select, new technologies.

2. Convene public employers to implement purchasing strategies to improve the value of health care purchased.

The legislative direction to the Authority will include broad authority to convene representatives of public employers to collaborate with the state in the development and implementation of joint, voluntary purchasing policies, standards and programs to improve the value of health care services purchased by public employers and effectuate the reforms contained in this Action Plan.

3. Require the use of the Oregon Prescription Drug Program by state agencies.

The Legislature directs state agencies that purchase health care services to implement contracting standards that require the use of the Oregon Prescription Drug Program unless the contractor or prospective contractor can demonstrate greater savings through alternative arrangements.

➤ Health Insurance Exchange

Objective: Stabilize the current individual health insurance market and establish a foundation for future market reforms.

Strategy: Create an Insurance Exchange to Consolidate the Individual Market.

The state will develop an insurance exchange infrastructure that can grow in capacity over time. An exchange would initially consolidate the individual market in an effort to standardize and streamline administration, promote transparency for consumers, improve quality and stem cost increases for individual insurance purchasers. Over time it could be used as the platform for the state to provide premium assistance to low and moderate income Oregonians.

The Board’s Exchange Work Group recommended that an exchange be implemented as part of a larger set of market reforms, including an individual requirement for insurance, guaranteed issue, and state premium participation for low and moderate income Oregonians.²⁵ The Board

²⁵ For the recommendations of the Exchange Work Group, please see Appendix D.

recognizes the importance of these reform proposals, but believes an exchange could provide immediate value while Oregon implements delivery system improvements that will make sustainable coverage expansions affordable for the state and its residents. Therefore, in the short-term, current medical underwriting requirements would remain in effect in the individual market. Individuals denied coverage would continue to have the option of enrolling in the Oregon Medical Insurance Pool.

Exchange Structure and Participation

The state would create an Oregon Health Insurance Exchange (OHIE), either as a new entity or through an existing agency, board or commission. All individual market purchasers will buy insurance through OHIE.

OHIE will develop a request for proposals from licensed insurers interested in participating in the exchange. Participating insurers must comply with OHIE's contract standards, including but not limited to:

- Offering a range of specified plan options;
- Meeting provider network requirements;
- Participating in standardized contract requirements, such as uniform evidence-based utilization standards, disease management programs, etc.;
- Meeting transparency rules;
- Use of a medical screening tool and common rejection rules; and
- Meeting additional standards in areas such as administrative costs, rating rules, etc.

OHIE's operating expenses will be supported through a premium-based monthly per-member fee.

Benefits for Consumers and Insurers

An exchange will be the organizer of a new individual market. Participating insurers will offer a range of health plan choices, attractive to consumers based on benefit design and price, but the total number of plan choices will be smaller to lessen consumer confusion. An exchange can improve information transparency for consumers. An interactive web-site will facilitate shopping with comparative information by insurer, plan and network. Costs, benefits and ultimately performance reports will be available to current and prospective enrollees.

By standardizing and streamlining contracting and administrative functions, an exchange will work to reduce administrative costs. In addition, participating insurers would benefit from a risk adjustment mechanism that can limit financial exposure associated with members with high-cost medical claims. Risk adjustment frees insurers from risk selection (through benefit design) to focus on risk management.

Transitioning to an Exchange-Based Market

All current individual market purchasers will transition through a "roll over" schedule into OHIE coverage. Those currently insured will choose an insurer and plan and enroll without medical underwriting, since they were previously medically underwritten into the current market. Some

restrictions on plan entry may be necessary to avoid adverse selection.²⁶ After the transition period, the current individual market will cease to exist.

The role of insurance agents and brokers in the individual market will be affected by this change. Currently insurers contract with agents and pay them fees for each enrollee. The OHIE will provide many of the services agents and brokers now offer in this market. The role for agents and brokers will be established by the governing body of OHIE.

An Exchange as Structure for Future Reforms

The exchange will form a structure that can be used to support medium- and longer-term coverage expansions through premium assistance, tax credits and the use of Section 125 plans. As many people at the Board and Committee level have expressed an interest in the benefits an exchange can have for small-group purchasers, over time the exchange could be expanded to allow entry by employer groups. This could provide choice to employees and reduce administrative costs for employers.

The OHIE is also the venue through which the development of a publicly-owned health plan could be investigated. A public health plan could become an option for individual insurance coverage through the exchange, offering consumers a non-commercial, publicly-accountable plan that meets all the standards set by the exchange.

ACTION STEPS:

1. Create an Oregon Health Insurance Exchange.

The Legislature creates an Oregon Health Insurance Exchange (OHIE), either as a new entity or through an existing agency, board or commission. OHIE's governing body will be charged with operationalizing the exchange in Oregon's current individual insurance market. The Legislature will authorize OHIE to develop and implement a risk adjustment mechanism applicable to insurers participating in the exchange. In addition, the authorizing legislation will grant OHIE the option to develop and implement a reinsurance program applicable to all participating insurers.

The Insurance Division, working with the OHIE governing body, will continue enforcing rating and market conduct regulations applicable to insurers participating in the exchange. The Insurance Division will review and approve rates proposed by insurers participating in OHIE. The OHIE's governing body will develop an insurance exchange within current individual market.

The Legislature will authorize the OHIE governing body to work with insurers and other state agencies to access insurer, plan and network information in order to provide comparative information to consumers.

²⁶ Individuals wishing to transition without medical underwriting may be limited to purchasing insurance that is at a similar level of comprehensiveness to their previous coverage. Purchasers may apply for more comprehensive coverage, but such a "buy up" in coverage may require a new medical screening.

2. Evaluate the need for a publicly-owned health plan option.

The Legislature authorizes the OHIE governing body to evaluate the need for and, if warranted, development of, a publicly-owned health plan option that will operate within OHIE.

➤ Regulatory Options

The actions proposed under Track 2, Transforming Oregon's Health Care System, generally align with the recommendations of the Institute of Medicine's, *Crossing the Quality Chasm*, and the strategies and programs advocated by the Institute for Healthcare Improvement, specifically the IHI *Triple Aim* program that focuses on community-based development of new systems of care through transparent information and process improvements.

The two recommendations that follow depart from the others in that they are regulatory in nature. The Board is considering these strategies because of the significant increases in health care premiums in the recent past. There is deep concern among many Oregonians about the sustainability of the small group (under 51 employees) and individual health insurance markets in light of increases in the range of 11% to 20%+.

Objective: Control the increases in administrative expenses included in premiums by health insurers.

Strategy: Authorize the Department of Consumer & Business Services, Insurance Division, to regulate the annual growth rate in administrative expenses charged by health insurers.

The premiums charged by regulated Oregon health insurers in the small group and individual markets must be filed, reviewed and approved by the Insurance Division. The Division is responsible to ascertain that the rates are appropriate and necessary given incurred claims history, medical trends, etc.

The Legislature could authorize the Insurance Division to review the overall growth rate in a health insurer's administrative expenses and determine if the rate of growth is unreasonable. Historically, administrative expenses have been reported as a percent of total premium (e.g., 12%). This approach "indexes" administrative expenses to increases in medical costs. In reality, the cost drivers of insurers should be more closely aligned with the general Consumer Price Index or the cost pressures in the financial sector generally.

The Insurance Division should monitor increases in administrative costs on a per-member-per-month (PMPM) basis which accounts for marginal cost increases or decreases associated with an insurer's increase or loss of membership. Increases in administrative expenses in excess of a published standard (CPI + x%) should be denied unless there are extenuating circumstances.

ACTION STEP:

1. **The Legislature authorizes the Insurance Division to develop methodologies and standards for reviewing the administrative expenses of health insurers and to deny proposed increases in the administrative expense portions (“loads”) of premiums subject to appeals procedures.**

Objective: Control the annual increases in prices charged by providers.

Strategy: Authorize an appropriate state agency to establish annual maximum limits (“ceilings”) on price increases charged by health care providers in a similar class (e.g., licensed health care facilities).

Health care claims costs incurred by an insurer and paid for by a purchaser are a function of allowable unit prices multiplied by utilization. Anecdotal evidence suggests that provider unit prices are increasing at rates several times general inflation. There are many explanations for price increases higher than CPI: costs of care delivered to the uninsured, under-funded public programs, wage and salary costs related to workforce shortages, etc.

Some will contend, however, that the absence of price competition in most Oregon markets is a contributing factor. In addition, the Board has heard concerns that price increases may not decline with major investments by the state for expanded coverage and improved provider reimbursement.

One of two approaches could be adopted to limit price increases. The state would limit the increase in prices charged by a provider to the public or negotiated between a provider and a third-party payer:

- To an increase of no more than a fixed percentage (CPI + x%) from a base year.
- To a fixed multiple of the provider’s Medicare reimbursement rates (e.g., 130% times Medicare reimbursement)

ACTION STEP:

1. **The Legislature considers the merits of proposed legislation authorizing the state to regulate the annual increases in provider prices using one of the methodologies noted above or an alternative approach that achieves the same objective.**

DOMAIN V: CREATE A 21ST CENTURY HEALTH CARE WORKFORCE

Objective: Ensure that Oregon's health care workforce is sufficient in numbers and training to meet the demand that will be created by proposed coverage expansions and system transformations.

Strategy: Identify needs, resources and gaps, and develop recommendations for attaining the training, recruitment and retention of all levels of health care providers in all regions of Oregon

ACTION STEPS:

- 1. Fund the Authority to develop a statewide health care workforce strategy.**
- 2. Authorize the Authority to collect data needed to develop a strategic plan for workforce development.**

Currently in Oregon, there is not a place where either the state or private industry can go and get current and reliable data about our health care workforce. There are approximately 160,000 jobs in the health care sector of Oregon's labor market, excluding those employed by state, county, municipal or tribal governments. Between March 2007 and March 2008, Oregon's health labor force grew an additional 5,600 jobs. Even with a slowdown in the economy, the number of health care jobs overall is predicted to grow nearly 27% by 2016.²⁷

However, Oregon's population is projected to grow by 13% over the next decade, and the population over 65 is expected to grow by an estimated 33%. Add to this, anticipated growth from the access expansion contemplated in other recommendations by the Health Fund Board and it is easy to guess that we are facing a workforce crisis. The impending workforce shortages may dramatically undermine access to care and adversely impact the delivery system. The human capital shortages could erode patient care and outcomes, and overwhelm the clinical workforce remaining to juggle the need for services. Ironically, "guessing" about the anticipated shortage is largely what Oregon is left to do; particularly in primary care.

Despite licensure requirements, we lack data to help illuminate where physicians and other professionals are practicing, whether they practice full-time or part-time; if they are contemplating retirement, their locus of practice, and at how many sites they may serve, etc. It is difficult to solve a problem without accurate and on-going information of its dimensions. Numerous groups look at workforce issues in health care, including the Office of Community College Workforce Development, the Oregon University System, the Oregon Workforce Investment Board, the K-12 system, the Center for Nursing and others. However there is no accountable entity that is directed to develop a coordinated strategy to meet the health care workforce needs of Oregon. The Oregon Healthcare Workforce Institute was established with that in mind three years ago. Set up as a private not-for-profit corporation, and envisioned as a public/private partnership, it has been hobbled by a lack of consistent, dedicated funding from the state and a broad cross-section of the health care industry.

²⁷ Oregon Healthcare Workforce Institute. *2008 Profile: Oregon's Health Care Workforce*.

While many organizations have important roles in workforce development, it is essential to have a designated entity responsible for coordinating efforts and sharpening focus. Mitigation of our workforce shortage challenge lies in combining strategies to use our existing workforce more efficiently, increase our supply and retention, and change the incentives in our payment system which work to exacerbate an inappropriate mix between specialists and primary care providers. Recommendations for integrated health homes and the implicit critical role of primary care in chronic care management will depend on how effectively we are able to respond to the workforce supply challenge.

3. Develop a comprehensive, on-going strategic plan and planning process to assure Oregon has an adequate, highly trained health care workforce and coordinate with existing groups focused on workforce issues. Elements of the plan should include but need not be limited to the following:

- Collect, analyze and report on current work force statistics
- Identify emerging trends and issues related to workforce supply;
- Develop methods to project and forecast supply and demand through 2020 in Oregon;
- Develop an on-going database of training activities within Oregon and forecast production schedules and volumes;
- Develop recommendations for changes in the design and funding of training programs to maximize the impact of state investments;
- Increase the in-state production and retention of health care workforce in Oregon, with emphasis in primary care providers;
- Develop recommendations for incentives to recruit & retain providers from outside of Oregon, particularly in primary care;
- Develop licensure strategies for a 21st Century health care workforce
- Advocate for improved federal work force policies and funding, including increased residencies;
- Develop target ratios for various categories of health care provider-to-population to direct goal-setting.

4. Collect additional data through the licensure process that will provide Oregon with an on-going database about its current workforce.

5. Implement strategies to train, attract and retain an appropriate supply of primary care providers in all geographic areas of Oregon.

Oregon lacks a coherent strategy to assure an adequate and highly trained health care workforce to meet the needs of the 21st Century. Data available are primarily the result of occasional, one-time projects or grants financing data collection sporadically and inconsistently. Currently the best data exists on the nursing workforce by virtue of information collected through the licensing process and analyzed by the Center for Nursing. Other professions licensed do not have parallel activities. Collecting key additional data through the licensing process could provide much needed insight into the characteristics of our current on-the-ground workforce and clarify challenges to assure future supply and detect trends.

An example of a one point in time study conducted by the Office of Health Policy and Research for the Department of Human Services and the Oregon Medical Association was published in May, 2007, and reported some of the following about our physicians:

- Oregon's physician workforce is less racially and ethnically diverse than the state's population;
- Certain regions of the state (northwest) have on average an older physician workforce with 25% over 60;
- Twenty-two percent of the state's physicians have plans to retire within five years;
- Small practices (3 to 10 physicians) are the most commonly reported practice size (35.6%); and
- Sixty-eight percent are single specialty practices;
- The percentage of physicians reporting their practice as completely closed to new Medicare patients increased from 11.8% in 2004 to 23.7% in 2006.

There are new emerging workforce needs which currently do not require licensure and likely won't require licensure. New methods of identifying need and forecasting supply and demand will have to be developed. An example of such a workforce segment would be in health information technology.

Why an emphasis on primary care? Probably this is best answered by the following: "Within the United States, states with more primary care physicians per capita have better health outcomes, including mortality from cancer, heart disease, or stroke. In the United States, states with higher proportions of specialist physicians have higher per capita Medicare spending. Conversely, [having] a greater number of primary care physicians [is] associated with increased quality of health services, as well as a reduction in costs . . ."²⁸

²⁸ Position Paper, American College of Physicians, *Annals Intern Med* 148: 1, 2008.

DOMAIN VI: ELECTRONIC HEALTH INFORMATION TECHNOLOGY

NOTE TO BOARD: **This section reflects preliminary discussions of the Governor's Health Information Infrastructure Advisory Committee (HIIAC) and is subject to change.**

Objective: Achieve widespread, effective use of health information technology (HIT) in Oregon

ACTION STEPS:

The State of Oregon should:

- Endorse four Electronic Medical Record (EMR) Vendors based on their EMR's exhibition of the following properties:
 - Meeting or exceeding CCHIT standards
 - Valuable Clinical Decision Support Tools to be used by providers at the point of care
 - Interoperable data exchange with other EMRs, Personal Health Records, and the Oregon Health Record Bank
 - Adherence to HIIAC privacy principles
 - Ability to record, store, and report quality of care and health outcome measures
- Endorse four EMR Service Companies that can provide the following services to provider groups using one of State-endorsed EMRs:
 - Implementation support
 - Conversion from paper records or another EMR to a State-endorsed EMR
 - Ongoing support of the EMR
 - Interface support
 - Practice optimization using the EMR
 - Clinical process improvement using the EMR
 - Quality reporting support
 - Participation in health information exchange
- Use its RFP process to identify “state endorsed” vendors and use this process to solicit the most aggressive price – giving those providers who purchase from these vendors similar benefits as are obtained by group purchasing
- Subsidize provider use of the endorsed EMR Vendors and the endorsed EMR Service Companies
 - Subsidies in the form of a grant or low-interest loan, with amount based on:
 - Service to an underserved population
 - Service to Oregon Medicaid population
- Set benchmarks for the adoption of electronic medical records, clinical decision support tools and e-prescribing and evaluate progress toward meeting those goals.

By creating certainty, the state can diminish a number of the barriers currently preventing the adoption and use of health information technology. Certainty can be created by instituting

standards and providing ongoing support for those systems meeting standards. Using the state's RFP process and negotiating power, costs of both the systems themselves and the ongoing support necessary to maintain these systems, can be made more affordable and more reliable.

By guaranteeing the interoperability of EMRs, simplifying the choice of vendors and providing a pre-set menu of features and pricing, the state will increase confidence among providers and encourage the adoption of health information technology systems. Additionally, assistance with the large investment these systems require will be very effective, especially among rural and Medicaid providers.

Benchmarks and evaluation are necessary to continue improvement in this area.

➤ **Clinical Decision Making And Evidence Based Medicine**

Objective: Adoption of electronic health records with the capacity to provide efficient and effective decision support processes and tools so that clinicians can easily follow evidence-based guidelines to improve health outcomes and reduce cost.

ACTION STEPS:

The State of Oregon will:

- Create and support The Oregon Quality Institute to convene and collaborate with health plans and providers to align around a common set of health quality measures. The Quality Institute should:
 - Develop a common set of health care measures based on evidence endorsed by nationally recognized organizations
 - Evaluate and endorse clinical guidelines to provide Oregon based resource for providers and patients
- Require PEBB, Medicaid, and other public purchasers of health care to choose from a common set of clinical quality measures in evaluating medical provider performance and health outcomes.
- Require State endorsed health information technology systems to include effective clinical decision support tools that align with quality measures chosen by Quality Institute

By providing clear treatment guidelines and health quality measures, the state, through the Quality Institute, can increase the positive influence of quality measures on direct medical practice. By giving priority to guidelines that are endorsed by nationally recognized professional organizations that write and evaluate guidelines based on evidence based medicine, necessary transparency will be provided. The state will, in effect, provide a "seal of approval" for Oregon medical providers and assist in aligning along a common set of guidelines for more consistent medical care between disparate medical offices and specialties.

The state's use of its purchasing power in the area of health care, and its use of consistent quality measures, would greatly increase the adoption and influence of these measures. This would be greatly amplified if the Quality Institute could elicit the voluntary "buy in" from private insurers.

➤ **Health Information Exchange**

Objective: Use of DMAP's Health Record Bank (currently being created with funding from a Medicaid Transformation Grant) as a fundamental building block for a statewide system for health information exchange which ensures that patients' medical information is available and accessible when and where they need it.

ACTION STEPS:

The State of Oregon will:

- Ensure the DMAP Oregon Health Record Bank (HRB) will be built to be interoperable with the commercial plans servicing PEBB, OEBC and Corrections , and ultimately all commercial plans
- Ensure the DMAP HRB encompasses strong privacy and security protections and resolves the issues of patients' rights with respect to the use and ownership of their information
- Design and implement a public education program targeted at both providers and patients

DMAP's Health Record Bank provides an opportunity for the state to build upon the investment and work that is already being done in this area. The input of the private sector will be key to ensuring the HRB will be interoperable with those outside Medicaid and ultimately PEBB, OEBC and Corrections. With little or no funding available for pilot projects, Oregon can build a comprehensive health information exchange system by leveraging the money already received for the HRB project.

Privacy and security concerns, by both providers and patients, must be appropriately addressed in order to gain their trust and confidence so that they will agree to participate in these systems.

➤ **Privacy And Security**

Objective: To ensure the highest level of privacy and security of Oregonian's personal health information in an electronic exchange environment

ACTION STEPS:

The State of Oregon should:

- Statutorily prescribe when and with whom an individual's personal health information may be exchanged electronically. Legislation should address:
 - Notice to and authorization from the patient or patient's personal representative prior to sharing a patient's data through a health information exchange (HIE);
 - An opportunity for the patient to not agree to sharing data through a HIE without penalty;
 - A patient request that part of that patients' record NOT be shared and that request must be honored;
 - Providers not being penalized by a patient's unwillingness to allow their data to be shared through a HIE;
 - Timely notification to patient of a breach and a meaningful remedy;
 - A private right of action for the consumer and patient after breach has occurred;
 - A State Attorney General right of action on behalf of individuals to seek remedy;
 - Patient access to their record in a timely manner with an opportunity to correct errors; and
 - No third party access to information.
 - Establish a Certification Board for all entities involved in the electronic exchange of personal health information;
- AND/OR
- Provide for strict enforcement of meaningful penalties for the negligent, reckless or intentional release or misuse of personal health information.

Health information exchange will yield better health outcomes and reduce costs – but patients need to agree to have their personal health information exchanged electronically in order to achieve these benefits. Patients will need to trust that their personal health information is being appropriately shared and used – and their privacy protected – before they will agree to participate in electronic health information exchange. Oregon needs to ensure the privacy of personal health information in order to enjoy the benefits of better health outcomes and reduced costs.

Statutory rights in this area will allow both patients and providers to participate in electronic health information exchange with full trust and confidence.

Another way to engender consumer confidence is to ensure that only the most secure exchange systems are adopted in Oregon. By certifying exchange participants, Oregon can determine that the systems in use will provide the level of privacy and security Oregonians expect and require.

Penalties for negligent, reckless and intentional breach and/or misuse of personal health information could also serve to drive only the most secure and protective systems to be adopted and implemented in Oregon.

DOMAIN VII: FEDERAL ADVOCACY

Objective: Assure alignment of federal laws and regulation on Oregon’s efforts to expand coverage, maximize Oregonians’ health, and otherwise improve the health care system in Oregon.

Oregon has played a leading role in health care reform with its unique approach to rationalizing services under the Oregon Health Plan’s prioritized list. By taking the actions presented in this Action Plan, Oregon will continue to be an innovator among states and will be well positioned to advocate for change at the federal level that is needed to support state health reform efforts.

Strategy: Pursue the recommendations of the Federal Laws Committee.

The Federal Laws Committee identified several areas of federal policy that impact Oregon’s health reform efforts. Action is needed at the federal level to remove barriers to state efforts to expand coverage and improve health care delivery systems. Key recommendations include:

- **Medicaid:** To expand Medicaid and premium assistance coverage, Oregon will need to request approval from the federal Centers for Medicare and Medicaid Services (CMS). CMS should approve Oregon’s waiver requests. Further, CMS should engage in a timely manner the review, renewal and approval of states’ Medicaid waivers. CMS should adopt a framework and expedited approval process to assist states that want to launch demonstration projects in payment reform within the Medicaid program.
- **Medicare:** Congress should reform the process for setting Medicare rates to more equitably align reimbursement across the country. CMS should pursue Medicare payment reform that emphasizes evidence-based care, integrated health homes and an array of services that support these models.

Medicare Advantage HMO and PPO plans play an essential role in serving Oregon’s senior and disabled population. Congress should preserve this option for Medicare beneficiaries and permit the expansion of Medicare Advantage Special Needs Plans.

- **ERISA:** Congress should create “safe harbor” policies for state health care reform elements (such as “pay or play” payroll taxes) that would protect states from ERISA court challenges.
- **Federal Income Tax Code:** To increase the affordability of health insurance, Congress should modify the federal personal income tax code to provide equal tax benefits to all taxpayers purchasing health insurance, whether purchasing via an employer, as a self-employed person, or as an individual on the open market. Low-income individuals should be offered the option of a refundable credit against their tax liability for health insurance premiums.
- **Provider Workforce:** Congress should oppose any efforts to reduce federal funding for health care workforce education. Moreover, Congress should enhance such funding in select critical shortage areas. In addition, Congress should raise the federal cap on Medicare funding for Graduate Medical Education residencies.

- **Indian Health Services Programs:** Given the unique relationship between Tribes and the Federal government, Congress should adequately fund Tribal health services.

Strategy: Seek opportunities for Oregon to influence the national health reform debate.

Oregon's reputation as a health care innovator offers opportunities for state leaders to participate in the national health reform debate. Some of these include:

- Oregon's congressional delegation should continue to pursue comprehensive health care reform at the national level and should sponsor legislation to remove federal barriers to health reform.
- Oregon's Congressional delegation and interested stakeholders should build support for Medicare rate reform by joining with other states experiencing low Medicare reimbursements.
- The Oregon legislature should pass a joint resolution requesting Congressional action to correct reimbursement inequities in Medicare and preserve the Medicare Advantage HMO and PPO options for Oregon beneficiaries.
- The Authority, in collaboration with other agencies in the executive branch, should continuously look for opportunities within the federal health care reform debate to advance Oregon's health care priorities.

ACTION STEPS:

1. Pursue change at the federal level.

The Legislature will authorize the Authority to advocate at the federal level for the recommendations developed by the Federal Laws Committee.

2. Pursue change at the state level.

The Federal Laws Committee identified several areas for action at the state level to address barriers to the goals of SB 329 and the Board. (See the Federal Laws Committee report for detailed recommendations.) The Authority will advocate for these recommendations in the Legislature.

DOMAIN VIII: AN OREGON HEALTH AUTHORITY

Objective: To have a single entity within state government that is responsible to the Governor, Legislature and the citizens of Oregon for the performance of Oregon's health care system with respect to access, cost, quality, and value.

Strategy: Create an Oregon Health Authority.

The Oregon Health Authority will have broad accountability for oversight of Oregon's health care system and explicit authority in select areas to develop and implement policies that will achieve the goals outlined in SB 329.

ACTION STEP:

1. The 2009 Oregon Legislative Assembly adopts legislation creating an Oregon Health Authority with the necessary accountabilities, authorities and resources to oversee the implementation of the comprehensive plan developed by the Oregon Health Fund Board.

Oregon has a long history of citizen boards, commissions and task forces in the area of health care policy. In most cases they have been charged with specific, focused duties, usually advisory. SB 329 created the Oregon Health Fund Board and assigned it one task: develop a comprehensive plan for health care reform in Oregon for consideration by the Governor and Legislature in 2009. In the absence of legislative action in 2009, the Board and The Healthy Oregon Act will sunset on January 2, 2010.

To successfully implement the recommendations of this Action Plan and to further develop the plans and actions beyond 2009- 2011, there must be an entity within state government with broad powers of accountability. The Board recommends building from the framework and experience of the Oregon Health Policy Commission (see ORS 442.035) and establish the Oregon Health Authority which would replace the Health Policy Commission and the Oregon Health Fund Board. The composition, duties and authorities, and administrative support structure are summarized below.

Membership:

The Authority will be a citizen board, nominated by the Governor and confirmed by the Oregon Senate. It will have no more than 9 members, representative of Oregon's diversity in terms of geography, gender, race and ethnicity. The Chair of the Authority will be named by the Governor. Similar to the OHFB, a majority of the members will not be professionally involved in health care delivery or finance, but will represent the interests of health care consumers and purchasers. In carrying out its duties, the Authority will act in the best interests of the citizens of Oregon.

In nominating prospective members of the Authority, the Governor will identify persons with demonstrated and acknowledged leadership skills in their professional and civic lives. The Authority will, in Oregon health care policy, be analogous to the Oregon Transportation Commission, the State Board of Education or the State Board of Higher Education.

Members will serve for 4-year, staggered terms of office. No member can serve for more than 8 years.

Organization:

The Board will adopt bylaws that include officers, meeting policies and procedures and related matters. The Office for Oregon Health Policy and Research (OHPR) will serve as the administrative agency supporting the activities and operation of the Authority.

The Authority will meet at least six times per year, but is anticipated in the first years of operation to meet on a monthly basis. Members are entitled to compensation and expenses as provided in ORS 292.495.

Based on the availability of appropriated funds, the Authority will meet in each of Oregon's five Congressional districts at least once every two years.

The Authority may establish subcommittees and may appoint advisory committees to advise it in carrying out its duties. Members of advisory committees shall be eligible to receive actual and necessary travel and other expenses incurred in the performance of their official duties.

Statutory Duties of the Authority:

1. Act as the policy-making and governing body for a health care data collection program established within the Department of Human Services or among state agencies as appropriate for the acquisition, compilation and analysis and public reporting of data from health care providers, other state and local agencies including the state Medicaid program, third-party payers and other appropriate sources.
2. Develop strategic policy and business plans and legislative proposals for implementing the OHFB's comprehensive plan from 2009 to 2015.
3. Act as the policy-making and oversight body for the following divisions of the Department of Human Services responsible for Oregon Health Plan (physical, behavioral and oral health) and Oregon's public health programs and activities:
 - A. Division of Medical Assistance Programs (DMAP)
 - B. Addictions & Mental Health Division (AMHD)
 - C. Public Health Division (PHD)
4. Act as the policy-making and oversight body for the Office of Private Health Partnerships responsible for the Family Health Insurance Assistance Program (FHIAP).
5. Establish policies, standards, and performance criteria for health care contracts administered by DMAP, AMHD, and OPHP. Develop goals, baseline performance measures and policies and programs that eliminate health inequities associated with gender, race, ethnicity, and socioeconomic status. Receive routine reports from managing agencies on contractor performance, trends, member satisfaction, and related issues.

6. Collaborate with Public Employees' Benefit Board (PEBB) and the Oregon Educators Benefit Board (OEBB) to achieve optimal policy coordination among state agencies that purchase health care benefits.
7. Develop and oversee a public employer health coalition that includes leadership from PEBB, OEBB, cities, counties, other local government entities and the associations of such entities to work cooperatively to obtain increased value from local and regional provider systems. The Authority will be authorized to undertake cooperative/joint contracting for health care services on behalf of public entities that elect to participate. The public employer health coalition will collaborate with the Oregon Coalition of Health Care Purchasers and other similar organizations to improve the quality, cost effectiveness and value from local and regional provider systems.
8. Convene a Payment Reform Council to investigate opportunities in both public and private sector programs to develop and implement new methodologies of provider reimbursement that reward comprehensive management of diseases, quality outcomes and efficient use of resource inputs.
9. Oversee the development, adoption and continuous refinement of uniform, statewide health care quality standards (metrics) that will be used by all purchasers, third-party payers and providers as the quality performance benchmarks in Oregon. The Authority will achieve this objective through one of the following options:
 - A. The Quality Institute of Oregon as outlined in the report of the Quality Institute Work Group; or, alternatively,
 - B. Through contract with a not-for-profit, Oregon-based entity recognized for its achievements in health care quality. The governing body of the entity should be broadly representative of the health care leadership of the state and its policy development processes should include the leading health care quality experts in Oregon from medicine and other health care professions, academia, hospital and health care systems, health insurers, consumers and purchasers.
10. Working with and through the Health Services Commission (HSC) and the Health Resources Commission (HSC), oversee the development of clinical standards and guidelines for use by providers and insurers. The initial work should focus on clinical services with unexplained variation in utilization, services that are deemed to be "supply sensitive," new technologies for which comparative effectiveness evaluations hold promise for more appropriate use of the technology. The activities and work products developed through this process will be subject to state action protection defense against claims of anti-trust.
11. Act as the policy-making and oversight body of the activities of the Public Health Division. In this capacity, the Authority will authorize and guide development of Community-Centered Health Initiatives designed to address critical behavioral risk factors, especially those that contribute to chronic disease. In consultation with the Public Health Division, the Authority will establish a set of public health goals, strategies, programs and performance standards to improve the health of all Oregonians. The Authority will monitor the investments and activities designed

to achieve such goals, report regularly to the Legislature and public on accomplishments and direct changes in policy and strategy where necessary.

12. Be responsible for the development and implementation of a first-generation Oregon Health Insurance Exchange (OHIE) to serve the individual health insurance market. The Authority will consult and work closely with the Department of Consumer & Business Services, Insurance Division in designing, implementing and governing OHIE to assure minimum disruption to Oregonians participating in the individual health insurance market.

13. Serve as the state entity accountable for the development of Oregon's Health Care Workforce strategy. Activities will include collection of data from responsible licensing boards and commissions, determine of long-term needs in Oregon based on provider and population demographics and projected capacity of Oregon educational and training institutions to meet those needs, and develop recommendations to recruit, train and retain qualified individuals into the health care professions. An important aspect of this work will be to promote a wide understanding of a 21st Century health care workforce in light of emerging new models of care.

14. Collaborate with the Governor's Health Information Infrastructure Advisory Committee to assure that Oregon is a national leader in the adoption and interoperability of electronic health records.

15. In close coordination with the Executive and Legislative branches, work with Oregon's Congressional delegation to advance adoption of, or changes in, federal policy that will promote Oregon's health reform plans.

16. Brief the Governor and legislative leadership on the performance of Oregon's health care system relative to the goals established by the Authority. Propose changes to or new statutory initiatives as necessary and appropriate to achieve the goals of SB 329.

17. The Authority may promulgate administrative rules to carry out its statutory powers.

18. Carry out other duties delegated by statute or upon the request of the Governor.

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