

Department of Human Services 2009-11 Policy Option Package

Division Name: Administrative Services Division

Program Name: Office for Oregon Health Policy and Research, Oregon Health Fund Board,
Oregon Prescription Drug Program

Policy Option Package Initiative: Vulnerable Oregonians Have Access to Health Care

Policy Option Package Title: Healthcare Reform- SB 329

Policy Option Package Numbers: 169, 179, 199, 209, 251, 261, 271,

Related Legislation: LC OHFB-01(686); OHFB-02(687); OHFB-03(688); OHFB-04(689);
OHFB-05(693);

Summary Statement:

This Policy Option Package initiates some of the first steps of comprehensive health care reform recommended by the Oregon Health Fund Board (OHFB), which complement the Governor's health initiatives. This POP provides the necessary resources to OHFB for health policy planning, and data collection and analysis. If not funded, there will be limited ability to begin key design pieces of health care reform, including developing cost containment strategies and redesigning the delivery system including payment reform, primary care revitalization, and improving population health as well as providing better public information about cost and quality of health care in Oregon. OHFB's recommendations also address end of life and further development of a health insurance exchange. These are all keystone building blocks for the foundation of health care reform in Oregon.

1. WHAT WOULD THIS POLICY OPTION PACKAGE (POP) DO AND HOW WOULD IT BE IMPLEMENTED?

The purpose of this POP is initiate the first steps of comprehensive health care reform recommended by the Oregon Health Fund Board (OHFB), which support the Governor’s health care initiatives. This POP has several key components, which are outlined below:

1) Continuation of OHFB and an “all payer, all claims” data collection program

This POP continues the work of OHFB to fully develop comprehensive health care reform by providing necessary resources for health policy planning, and data collection and analysis in support of the Governor’s health initiatives, which are essential to meet Office of Health Policy and Research’s (OHPR) statutory responsibility as outlined in ORS 442.025. This POP specifically provides the tools necessary to:

- Continue the work of OHFB and provide additional resources for health policy planning and analysis in support of the Governor’s health initiatives;
- Collect, compile, analyze and interpret health care, comparative effectiveness, and health services data essential to meet OHPR’s statutory responsibility as outlined in ORS 442.025, giving specific direction to OHPR to monitor hospital performance and establish area-wide and state planning for health services, staff and facilities based on evidence;
- Develop state policy related to electronic health records in support of the Governor’s Executive Order creating the Health Information Infrastructure Advisory Committee (HIIAC) within OHPR.
- Provide resources to OHFB to establish committees to support the development of an Oregon Health Insurance Exchange and to study health care payment reform in support of delivery system reform and primary care revitalization. The committees shall make recommendations to the 2011 Legislature.

- Create an all-payer, all-claims data collection program, which will enable the state to monitor and provide analysis of health care use and costs in the state. Shared knowledge and the free flow of information and transparency across the health care system are considered keystones to health care reform and delivery system redesign. Providers need better information to benchmark their performance, identify opportunities for quality improvement, and design effective quality improvement initiatives. Purchasers need ways to identify and reward high-performing providers who deliver high-quality, high-value care to their patients. Consumers need better cost and quality information to help guide critical health care decisions. An all-payer data collection program aimed at improving quality and increasing transparency is a vital part of any effort to transform Oregon’s health care delivery system into a high-performing, high-quality system that meets the health care needs of all Oregonians.

In addition, this package contains a fund-shift to fulfill legislative directive for the Oregon Prescription Drug Program to become self-sustaining.

2) Integrated health homes and healthy communities

This POP is partnered with the DHS POPs for payment reform in OHP and public health-focused community collaboration around primary and secondary prevention, and will support key activities and initiatives recommended by OHFB to strengthen the effectiveness of primary care services, improve population health outcomes, achieve higher levels of prevention, improve the quality of care delivered, and contribute to reducing the cost of health care. This POP would lead to common standards for an integrated health home and quality outcomes measurement that can drive the improvements necessary for Oregonians to have efficient, effective health care delivered at the right place, at the right time. Specifically, this package provides the tools necessary to:

- Establish a common definition of “integrated health home” (also known as medical home) to be used by public and private stakeholders, based on organizational and structural requirements and performance criteria. Develop a standard set of integrated health home quality measures.

- Develop a standard and simple process to certify health care practices as integrated health homes. The process would be based on nationally accepted certification processes and be designed to limit the administrative burden on providers. Any provider who meets the structural and performance criteria established by the certification process would be able to be certified as an integrated health home. All public and private health insurers would be required to use this designation process.
- Establish a collaborative for state agencies and all certified integrated health homes to share information about quality improvement and best practices. The state would contract with a state or national organization that specializes in quality improvement to facilitate the collaboration. The collaboration would accept grants from public agencies and private foundations and partners.
- This work will assist the DHS Division of Medical Assistance Programs (DMAP), in partnership with other purchasers and health plans, including PEBB and OEBC, to develop, pilot and evaluate strategies to provide rewards/incentives to public health plan participants who enroll in integrated health homes, seek preventive and wellness services, practice health behaviors and effectively manage chronic disease. Initial pilots would focus on patients with chronic conditions.
- This work will assist DMAP, in collaboration with PEBB and OEBC, to establish standard requirements for contracts with any health plans providing insurance to enrollees in publicly funded programs that promote the provision of integrated health home services, especially for enrollees with chronic conditions.
- This work will allow OHFB to coordinate efforts with the DHS Public Health Division (PHD) to develop aggressive goals for Oregon in the reduction of tobacco use, obesity and other chronic disease risk factors. These efforts will compliment PHD's efforts to partner with counties, schools, employers and other community organizations to develop a strategic plan to achieve these goals. Oregon would have the ability to develop the framework necessary for Oregon communities and PHD to implement an effective and accountable comprehensive obesity prevention and education program to improve the health of

Oregonians and to address the serious costs to public and private health care in Oregon for treating chronic conditions such as diabetes, heart disease, stroke, cancer, asthma and arthritis.

The package, with its associated POPs, would be implemented under the direction of OHFB in collaboration with DHS and its various divisions including DMAP, PHD, and OHPR and the Office for Multicultural Health, working with an advisory group of health care stakeholders. This work will use existing staff in OHPR and OHFB, and will provide funding for public meetings with stakeholders, consulting for expertise in the concept of integrated health homes, and consulting for expertise in payment reform and quality measurement. This POP will build on ongoing efforts of other projects in the state, including the quality measurement efforts of the multi-stakeholder group, the Oregon Healthcare Quality Corporation; the medical home pilots by several of the state's health plans and the efforts of PEBB to implement its vision of quality improvement and the adoption of medical homes.

3) Improved transparency in health care reporting

This package is intended to improve the accuracy and comprehensiveness of public reporting of health care facility and health plan financial performance. This POP requires that all licensed health plans and health facilities in the state report certain financial data. Price and quality transparency are foundational for the work of OHFB and are essential first steps toward a more accountable and responsive health care delivery system. The health care system is expensive. In Oregon, health care is a \$19 billion industry that consumes approximately 12 percent of the state's Gross Domestic Product (GDP). Average health insurance premiums in Oregon increased 65 percent between 2000 and 2005, more than four times the growth in wages. Currently the state does not have adequate mechanisms in place to know exactly what it is paying for. Informed purchasing requires firsthand knowledge of price, quality and service.

To improve the accuracy and comprehensiveness of public reporting of health care facility and health plan financial performance, this package provides the tools necessary to:

- Require all regulated health insurers and third party administrators to submit data to a private entity on their contracted prices with health care providers and develop reports that disclose the changes in contracted prices from one year to the next for hospitals, ambulatory surgery centers, free-standing ambulatory centers and some classes of physicians.
- Report by carrier premium increases by regions to facilitate consumer/purchaser awareness of the relationship between changes in contracted prices between providers and insurers/TPAs and the cost of health insurer locally.
- Require all regulated health insurers and TPAs to report their respective membership by line of business and ZIP code.
- Report on the administrative costs incurred by Oregon's regulated health insurers, including comparisons by line of business, percent of premium and per member per month basis.
- Required DCBS to review any regulated health insurer that submits an increase in administrative costs that exceeds CPI + X% and allow DCBS to disapprove any increase determined not to be justified.
- Require all hospitals and ambulatory surgery centers to report to their respective communities through a public hearing when the annual capital investment plan pending approval by the Board of Directors of such facility exceeds \$x million or whenever the plan includes financing through the hospital financing authority.
- Convene a committee to develop standards applicable to all regulated health insurers relating to the formats and processes for determining eligibility, claims processing, payment transactions and other administrative functions in an effort to streamline and standardize administrative processes.

4) Clinical improvement assessment project

This package would initiate the development of a Clinical Improvement Assessment Project for Oregon. Building on existing state structures, under the oversight of OHFB, this will be a critical resource for

bringing Oregon's health care providers improve the quality and value of health care they provide. Specifically, it contains the tools necessary to:

- Support the Health Resources Commission (HRC) to partner with existing state, national and international efforts to invest in comparative effectiveness research, support high quality comparative effectiveness research, and use the best available data and evidence to make public and transparent policy decisions. By using comparative effectiveness 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 could be made available to all of Oregon's health care providers for patient care in both public and private sectors
- Support the Health Services Commission (HSC) to develop standard sets of evidence-based guidelines for all providers serving Oregonians, starting with the treatment of chronic conditions, by reviewing and endorsing existing high-quality guidelines whenever possible, and convening experts to create them when they don't exist. Policies would be developed to require providers serving patients in publicly funded programs to follow these evidence-based guidelines. The HSC will work with private purchasers and health plans in the development of these guidelines to encourage their use across both the public and private sectors.
- The work of HSC and HRC would be closely aligned to each other and coordinate with the overall health outcomes determined by OHFB.

5) End-of-life care:

This package will create a statewide POLST registry as directed in Senate Bill 329 and provide funding for HSC to develop clinical guidelines for the provision of palliative care services.

Physician Orders for Life Sustaining Treatment (POLST), developed to improve communication of patients' wishes and documentation of medical orders, was designed to improve the quality of care people receive at the end of life. 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. Even those patients and families who are aware of their service options and have communicated their wishes to their primary care providers may not have those wishes honored, due to communication failures among providers or because appropriate documents have not transferred across care settings. The OHSU Center for Ethics, through a voluntary program, has distributed more than 1 million POLST forms. POLST forms are used in all Medicare-certified hospice programs in the state and in more than 90% of all nursing facilities. It has one primary goal, which is to communicate and honor patient preferences.

A voluntary electronic registry offers a further opportunity to ensure that patient preferences are honored when people cannot speak for themselves. Often, in the heat of an emergency, the POLST is not initially found. The electronic registry would allow EMS personnel to call a central number to determine if a patient had a POLST form and, if so, access the orders on the form. A model Portland registry is under development; this would build on those efforts. If successful, it would eliminate the problem of the paper form not being found in a time of crisis, patient preferences not being honored, and unnecessary care being provided.

This POP also provides funding to HSC to develop clinical guidelines for palliative care services. Palliative care is a specialized care approach that focuses on improving the quality of life of patients facing life-threatening illness through the prevention, assessment and treatment of pain, symptoms and stress of serious illness.

In a reformed delivery system, providers work with patients and their families to make health care decisions aligned with their 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 the support of their care team. Discussion with a patient about end-of life issues is a critical aspect of care. Reimbursement for time to discuss issues around end-of-life care and the options for providing palliative care encourages the delivery system to provide these services at a time when the patient and his or her family can fully participate, rather than delaying until critical emergencies arise, often resulting in unwanted life support or interventions at the end of life. This POP help provides comfort and support for patients struggling with end-stage chronic diseases. The consulting dollars will be directed toward developing clinical guidelines for palliative care services and recommending methods for integrating payment for palliative care services into systematic payment reform.

2. WHY DOES DHS PROPOSE THIS POP?

OHFB was established by the 2007 Legislature, with a sunset date of January 2, 2010. While the comprehensive plan will be completed as outlined in SB 329, after extensive discussions with the Governor's office there is a general consensus that the comprehensive plan for the state will need to be implemented in stages. This staging will require detailed policy and program design, and this element will enable that work to continue, while initiating the initial key first steps that are the foundation of transformation of Oregon's health care system.

At an estimated \$19 billion in annual total spending, health care accounted for approximately 12% of the state's gross domestic product in 2008 and has grown an average of 8% annually since 1991. Family premium costs and medical inflation continue to outstrip growth in income. More than 600,000 Oregonians are uninsured and 37% live below 200% of the federal poverty level. The state, as a major purchaser of health services, and DHS as a provider of services for poor and vulnerable Oregonians, are directly impacted by these statistics.

This POP includes some of the first steps of comprehensive health care reform recommended by OHFB, which complement the Governor's health initiatives. These steps:

- Continue OHFB's work to further develop the subsequent stages for reform by providing the necessary resources for health policy planning, and data collection and analysis, which are essential to understanding the value of health care services being purchased and the success of health care reform in Oregon.
- Transform the delivery system by integrating care so the right care is delivered at the right time and in the right place, which has been shown to improve the cost and quality of health care. Reforming the payment system to pay for outcomes instead of just services can drive a change in the delivery system toward better management of chronic diseases and prevention, as well as better patient satisfaction.
- Provide efforts to improve population health. The costs to public and private health care in Oregon for treating chronic conditions such as diabetes, heart disease, stroke, cancer, asthma and arthritis are unsustainable. At least 68% of Oregon adults have one chronic disease and 89% have one or more risk factors for chronic diseases including tobacco use, obesity, inactivity, and low fruit and vegetable consumption. Two-thirds of Oregon adults and a quarter of Oregon's children are overweight/obese. An even greater proportion of DHS clients and other Oregonians with low socioeconomic status are affected by these conditions.
- Improved transparency of cost and quality of health care allows the public and those purchasing health care services for their employees to understand the value of their investment and make informed choices in the services they use.
- Provide better access to comparative effectiveness reviews and evidence-based clinical guidelines that will be helpful to state purchasers of health care as well as to private health plans, providers, private purchasers and the health care system as a whole. 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. Public purchasers of

health care should be conducting and supporting 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, and the recipients of any publicly purchased health care.

These packages together will be provide the ability to begin key design pieces of the plan, including developing cost containment strategies and delivery system redesign (e.g., payment reform, primary care revitalization, improving population health and providing better public information about cost and quality of health care in Oregon). OHFB's recommendations also address end of life and further development of a health insurance exchange. These are all keystone building blocks for the foundation of health care reform in Oregon.

3. HOW DOES THIS FURTHER THE AGENCY'S MISSION OR GOALS?

This POP ties to the DHS goal of ensuring access to coverage for Oregon's vulnerable populations and improving Oregonians' health. Access to affordable, quality health care is a key element of the DHS mission of helping people become independent, healthy and safe.

4. IS THIS ELEMENT TIED TO A DHS PERFORMANCE MEASURE? IF YES, IDENTIFY THE PERFORMANCE MEASURE. IF NO, HOW WILL DHS MEASURE THE SUCCESS OF THIS POP?

OHFB and OHPR share the Institute of Medicine's definition of a high quality health system: It is safe, effective, patient-centered, timely, efficient and equitable. This element will provide for the work of OHFB to continue planning and to implement plans to improve the health care delivery system in Oregon by

reducing costs and improving access and quality. These efforts should lead to improvements in each of the following KPMs:

KPM 22: Childhood immunizations

KPM 25: Routine health care provided to OHP clients

KPM 27: Safety net clinic use

KPM 29: Customer service

DHS Public Health Division Measure 20 - Tobacco Use; Measure 26 – Racial/Ethnic Variation of Routine Healthcare;

It also is tied to a new 2008 Key Performance Measures for DMAP related to prevention, primary care and ambulatory care measures to increase prevention of illness and reduction of expensive hospital stays.

Further, OHP's KPM when it was administratively located within DAS was:

DAS KPM 19: Health policy – Percent of key health care policy stakeholders who rate the usefulness, objectivity and reliability of health care data provided by OHP as “good” or “excellent.”

5. DOES THIS POP REQUIRE A CHANGE(S) TO AN EXISTING STATUTE OR REQUIRE A NEW STATUTE? IF YES, IDENTIFY THE STATUTE AND THE LEGISLATIVE CONCEPT.

SB 329, which created OHFB, contains a sunset provision effective January 2, 2010. Temporary provisions creating OHFB are placed within ORS Chapter 414 and will require amendment. DHS has submitted an LC to do this. In addition, there are four additional LCs connected with this element. The associated LCs are:

LC 686 – Continuation of OHFB and an all-payer/all-claims data collection program

LC 689 – Integrated health homes

LC 688 – Improved transparency in health care

LC 687 - Clinical Improvement Assessment Project

LC 693 – End-of-life care

6. WHAT ALTERNATIVES WERE CONSIDERED AND WHAT WERE THE REASONS FOR REJECTING THEM?

The alternative to continuing the work of OHFB is to attempt these planning and design efforts in individual agencies in a less timely, less integrated and perhaps less effective manner. Without the continuing work of a highly focused coordinating entity such as OHFB, progress toward containing health care costs, transforming the delivery system, and improving access, population health and quality of care will be impaired. This element continues several efforts directed to the first and critical step to reform the delivery system and get at the underlying driver of health care costs – chronic diseases. Redesigning the delivery system to achieve improved quality and value of health care purchased with public funds under OHP, (PEBB and OEBC) can lead to improved health of Oregonians, particularly those served by these plans. It also can lead to cost containment for future sustainability of these forms of health care coverage. Not proceeding with this element will result in continued rising costs to OHP, limiting its ability to provide coverage to vulnerable populations and will lead to increased costs to other public purchasers such as PEBB and OEBC. It will have an impact on private purchasers as well, particularly small business who face rising health care costs in providing coverage to their employees.

The initial steps in the packages that make up this element are key for transforming Oregon’s health care system as the state works toward comprehensive health reform. The state faces increasing and unsustainable health care costs without these innovations.

7. WHAT WOULD BE THE ADVERSE EFFECTS OF NOT FUNDING THIS ELEMENT?

If not funded, there will be limited ability to begin key design pieces of OHFB's comprehensive plan, including delivery system redesign, payment reform, primary care revitalization, improved population health, transparency in cost and quality reporting, and a health insurance exchange. OHFB's recommendations would remain just a plan without any actual program development. These are all keystone elements of the first stage of health care reform in the state. Later stages of reform will have been formulated, but detailed strategies and implementation planning will still need to be done in areas of health care insurance market reform. The continuation of OHFB with the additional staff and funding for OHPR is intended to increase the state's ability to prepare timely, comprehensive and accurate analyses in support of the Governor's, Legislature's and DHS's shared health agenda.

Without the component packages of this element, efforts to transform the health care system across the multiple public purchasers could be fragmented and uncoordinated. The standards and outcomes these packages will help initiate are integral in contracting health care services by other public purchasers in collaboration with private sector. For example, OHFB will not be able to identify the most efficient, high-quality communities without a comprehensive financial data reporting system. If this element is not funded, there will be no steps implemented to get at the underlying driver of health care costs – chronic diseases. Redesigning the delivery system to achieve improved quality and value of health care purchased with public funds under OHP, PEBB and OEBC will help lead to improved health of Oregonians, particularly those served by these plans. It also can lead to cost containment for future sustainability of these forms of health care coverage. The state and other public and private purchasers face ever increasing and unsustainable health care costs without these innovations. These are all keystone elements for building the foundation of health care reform in Oregon

8. WHAT OTHER AGENCIES (STATE, TRIBAL AND/OR LOCAL GOVERNMENT) WOULD BE AFFECTED BY THIS ELEMENT? HOW WOULD THEY BE AFFECTED?

Workload in other health agencies may be reduced because OHPR and the OHFB act as key conveners and collaborators, reducing the need for these activities in each agency. This package will allow for further efforts toward streamlining functions around health care delivery and design within state agencies. DHS divisions will collaborate and coordinate to implement portions of this element. Adopting the packages in this element can work toward “bending the curve” of the state health care spending, which can ensure sustainable funding for health services in the state.

Additional agencies that will be affected by the packages in this element include:

- EMS personnel will have enhanced access to information, avoiding unnecessary interventions with patients by being able to access their POLST forms through the registry.
- DCBS (the agency with the appropriate general authorities) will collect data from licensed health plans and supports their role in this element.

9. WHAT ASSUMPTIONS AFFECT THE PRICING OF THIS POP?

Implementation Date(s): July 1, 2009 for the element (with continuation of OHFB needed by January 1, 2010)

End Date (if applicable): _____

a. Will there be new responsibilities for DHS? Specify which division(s) and describe their new responsibilities.

- | | |
|---|---|
| <input checked="" type="checkbox"/> Administrative Services | <input type="checkbox"/> Addictions and Mental Health |
| <input type="checkbox"/> Children, Adults and Families | <input checked="" type="checkbox"/> Public Health |
| <input checked="" type="checkbox"/> Division of Medical Assistance Programs | <input type="checkbox"/> Seniors and People With Disabilities |

The various packages under this element have coordinated efforts between the Oregon Health Fund Board and the Office for Oregon Health Policy and Research, both within the Administrative Services Division via the Director's Office. These efforts also include specific activities for DMAP in payment reform and Public Health in population-based preventive strategies, both as part of the Integrated Health Homes and Healthy Communities package, however other components of this element will need the OHFB and OHPR to be closely aligned and coordinated with these two divisions and the other DHS divisions for optimal implementation.

b. Will there be new administrative impacts sufficient to require additional funding? Specify which office(s) and describe how it will be affected.

- | | |
|---|---|
| <input type="checkbox"/> Human Resources | <input type="checkbox"/> Payment Accuracy and Recovery |
| <input type="checkbox"/> Information Security/Privacy | <input type="checkbox"/> Investigations and Training |
| <input type="checkbox"/> Document Management | <input type="checkbox"/> Facilities |
| <input type="checkbox"/> Audit and Consulting | <input checked="" type="checkbox"/> Contracts and Procurement |
| <input type="checkbox"/> Information Services (computers) | <input type="checkbox"/> Budget, Planning and Analysis |
| <input type="checkbox"/> Financial Services (accounting) | <input type="checkbox"/> DHS Office of Communications |

Impact on Contracts and Procurement is to be determined.

- c. **Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.**

NO, including the portions of the package relating to the Oregon Health Plan which will have no effect on caseload. The element's packages will benefit existing OHP clients and public employees.

- d. **Will it take new staff or will existing positions be modified? For each classification, list the number of positions and the number of months the positions will work in each biennium. Specify if the positions are permanent, limited duration or temporary.**

For continuing work within OHFB to develop a comprehensive plan for health reform in Oregon.

- Establish (1.0 FTE, 18 months, Step 10) PF PEM I to administer OHFB.
- Establish (1.0 FTE, 18 months, Step 9) PF OPA3 to provide policy analysis for OHFB.

For continuing work within OHPR and support for the all payer data collection program,

- Establish (1.0 FTE, 24 months, Step 5) PF RA1. Permanent position authority for a position that has existed previously as an LD to perform ongoing and increasing need for hospital financial analysis.
- Establish (1.0 FTE, 12 months, Step 8) OPA4 PP for ongoing policy analysis for HPC and MAC
- Establish (1.0 FTE, 21 months, Step 5) PF OPA4 to synthesize policy in order to assist the Governor's office in coordination of HIIAC activities and reporting as it develops recommendations for the developing health information infrastructure.
- Establish (1.0 FTE, 21 months, Step 5) PF OPA3 to develop quality, cost and other reporting for the legislature, Governor's office and staff and the public.
- Establish (1.0 FTE, 21 months, Step 5) PF RA3 to work with external vendors and develop quality data analytical protocols for the all payer, all claims data collection program.

- Establish (1.0 FTE, 24 months, Step 9) PF PM2 to manage Medicaid-related evaluation projects and to provide Medicaid evaluation support
- OPDP program: Shift (1.0 FTE, 24 months, Step 10) PEM F from GF to OF
- OPDP program: Shift (1.0 FTE, 24 months, Step 7) OPA3 from GF to OF
- OPDP program: Shift (1.0 FTE, 24 months, Step 3) OS2 from GF to OF

For Integrated Health Homes and Healthy Communities package:

- The OHPR role in standard setting will be managed with current staffing.
- DMAP's role will be managed with current staffing
- Division of Public Health role in prevention will require for 1) Obesity Prevention and for 2) Community Grants

For the Improved Transparency in Healthcare package:

- FTE, PP, OPA3, C0873, 21 months. The detailed financial analysis outlined in this POP and the accompanying legislation requires senior level, sophisticated analytical capability.

For the Clinical Improvement Assessment Project package:

- Establish 2 FTE Operations and Policy Analyst 4 (C0873, 21 months, PP).
- One position will be assigned to the Health Services Commission and one to the Health Resources Commission to augment the current staffing

For End of Life Care:

- Will be managed with current state staffing

- e. **What are the start-up costs, such as new or significant modifications to computer systems, new materials, outreach and training?**

For continuation of the OHFB and Data Collection Program:

Consulting costs as follows for OHPR and OHFB:

- Supporting the development of a health insurance exchange:
 - \$450,000 for actuarial analysis and macroeconomic modeling.
 - \$200,000 for consulting services for health insurance exchange design choices and implications
- \$650,000 for outsourcing data management to a skilled vendor with a depth of experience in collecting and cleaning healthcare claims data.
- \$250,000 for consulting services for developing options for payment reform
- \$300,000 for consulting services to develop a comprehensive healthcare facility financial analysis system
- \$200,000 for consulting services for development and design of Accountable Care District data aggregation
- \$50,000 for web development support for public reporting of healthcare cost and quality data
- \$52,840 for improved comparative effectiveness analytical tools

For the Integrated health homes and Healthy Communities:

Standards for integrated health home certification and quality measures will need to be periodically updated to reflected clinical advances and improved measurement capabilities, but will require fewer meetings to review changes and consultation with experts.

- \$500 per meeting @ 12 meetings
- Mileage costs associated with reimbursing volunteers for travel to and from meetings.

- \$50,000 for ongoing consulting needs to keep current and advance standards.

For DMAP portion:

For Division of Public Health portions: 1) Obesity Prevention 2) Community Grants

For Improved Transparency in Healthcare

- Standard services and supplies associated with positions.
- \$200,000 for consulting services to develop a comprehensive healthcare facility financial analysis program
- \$150,000 for transfer to DCBS for a health insurance plan financial analyst

For Clinical Improvement Assessment Project:

- Standard services and supplies associated with positions.
- Ongoing professional development, employee training costs.
- \$4,000 for computer equipment exceeding allotment in services and supplies.
- \$50,000 for meetings and other outreach efforts to work with private plans on collaboration in the work of both Commissions.
- \$200,000 for access to evidence-based reviews (e.g., Cochrane's) and comparative effectiveness analyses.
- \$8,000 for software licensing (SPSS)

End of Life Care

1. \$740,000 for development and housing of POLST registry

2. \$250,000 for consulting services and for convening stakeholders and experts to develop palliative services clinical guidelines through the Health Services Commission which is housed within OHPR.

f. What are the ongoing costs?

For continuation of the OHFB, OHPR and Data Collection Program:

- Standard services and supplies associated with positions
- Ongoing professional development outside of standard S&S (e.g., specialized statistical training)
- Meeting and associated costs
- \$650,000 for vendor support for the all payer, all claims data collection system
- \$50,000 for consulting support to maintain a healthcare facility financial analysis program.
- \$50,000 for consulting support to continue development and analysis of accountable care districts.

For the Integrated Health Homes and Healthy Communities

Standards for integrated health home certification and quality measures will need to be periodically updated to reflected clinical advances and improved measurement capabilities, but will require fewer meetings to review changes and consultation with experts.

- \$500 per meeting @ 12 meetings
- Mileage costs associated with reimbursing volunteers for travel to and from meetings.
- \$50,000 for ongoing consulting needs to keep current and advance standards.

For Improved Transparency in Healthcare

- Standard services and supplies associated with positions.

- Ongoing employee training/professional development costs beyond standard services and supplies
- Travel for professional staff to attend regional or national meeting for financial professional development.
- \$50,000 for consulting services to ensure integrity of and maintain financial analysis program
- \$150,000 for transfer to DCBS with inflation factor to be determined at a future date

For the Clinical Improvement Assessment Project:

- Standard services and supplies associated with positions.
- Ongoing professional development/employee training costs.
- \$4,000 for computer equipment exceeding allotment in services and supplies.
- \$50,000 for meetings and other outreach efforts to work with private plans on collaboration in the work of both Commissions.
- \$200,000 for access to evidence-based reviews (e.g., Cochrane’s) and comparative effectiveness analyses.
- \$8,000 for software licensing (SPSS)

For End of Life Care

- The registry costs would continue with an inflation factor to be determined.

g. What are the potential savings?

Overall this element aims to consolidate and coordinate existing functions and activities in health care in the agency and with other health-related agencies’ work. It also aims to “bend the curve” of

healthcare costs in these initial health reform steps towards improved access and quality of healthcare. Efforts were considered that would minimize the impact on GF in using existing positions and building on existing expertise, which makes the costs less than if developing many of these projects from the ground up. The element also includes applying Medicaid matching funding where possible.

While not quantifiable, a major objective of the multiple packages included in this element is to increase efficiencies and savings in the cost of health care for OHP clients, as well as other state-purchased health insurance. It is well-documented that access to and coordination of primary and preventive care decreases the exacerbation of conditions that can result in more costly care, emergency room usage, and hospitalization costs. National studies, such as “Bending the Curve” by the Commonwealth Fund, advocate the objectives outlined in this element to align financial incentives with health quality and efficiency. For example, their analysis shows nationally that strengthening primary care and care coordination can save the federal government, state and local governments an estimated \$160 billion over 10 years if done on a federal level. Further estimates for specific savings in Oregon are being developed. Aspects of savings included in this element include:

- a comprehensive system of financial and quality transparency is considered a key element in reducing health care costs in the state.
- By broadening the impact of the work of Clinical Improvement Assessment by the Health Services Commission and the Health Resources Commission, savings can be achieved by improved use of evidence-based decisionmaking in the Medicaid program, but also will extend to healthcare services in other publicly-funded programs such as PEBB and OEBB.
- Unknown at this time, but existing data suggest that hospice and advance directives can save between 25% and 40% of health care costs during the last month of life, with savings decreasing to 10% to 17% over the last 6 months of life and decreasing further to 0% to 10% over the last

12 months of life. The most likely cost savings will come from the avoided costs of unwanted hospitalizations, additional hospital days, and unwanted interventions.

h. Based on these answers, is there a fiscal impact?

Yes.

i. What are the sources of funding and the funding split for each one? Include grant names and fund type, such as “Medicaid, General and Federal Funds.”

There are different mixes of funding for the packages included in this Element:

- The Oregon Health Fund Board (OHFB) is a 61 GF/ 39 FF fund split based on the number of Medicaid-eligible participants for whom the Board impacts. Several of the packages outlined in this element would have a similar fund shift due to a similar impact. That includes those packages related to the Clinical Improvement Assessment Project, Aspects of the Integrated health Home and Healthy Communities package relating to setting standards and common quality measures for the State, as well as End of life Care package including the POLST registry and palliative care guidelines.
- The Division of Medical Assistance Programs is a 50 GF/ 50 FF fund split due to the impact relating directly to the Oregon Health Plan.
- The Division of Public Health is a 100 GF funding for its efforts (?)
- The Office for Oregon Health Policy and Research (OHPR) is a 50 GF/ 50 FF fund split because the statutory role of the office is to monitor and establish state policy for the Oregon Health Plan.

- The Oregon Prescription Drug Program (OPDP) is shifting from 100% GF funding to 100% OF funding. The program is completely self-sustaining in the 09-11 biennium and forward through an assessment based on number of claims processed.