

Oregon Health Policy Board

AGENDA

January 12, 2010

Market Square Building
1515 SW 5th Avenue, 9th floor
1pm to 5pm

#	Estimated Time	Item	Presenter	Action Item
1	1:00	Welcome and call to order Consent agenda: <ul style="list-style-type: none"> • Minutes from Dec. 8, 2009 meeting • 2010 Board meeting schedule • Final charters for Health Care Workforce Committee, Public Employers Health Care Purchasers Committee, State Health Improvement Committee, and Health Systems Performance Committee. 	Chair Eric Parsons	X
2	1:10	Director's Report <ul style="list-style-type: none"> • OHA transition • February legislative session • Healthy Kids and OHP Standard updates 	Bruce Goldberg (written report)	
3	1:20	Review and adopt Medical Liability Taskforce Charter	Chuck Hofmann	X
4	1:30	Membership confirmations and chair selections for: <ul style="list-style-type: none"> • Health Systems Performance Committee • State Health Improvement Program Committee • Medical Liability Taskforce 	Chair	X
5	1:45	OHA Work Plan Consent Items <ul style="list-style-type: none"> • Insurance Market Reform Plan (Health insurance exchange including public option and reinsurance) • Comprehensive coverage and financing plan • Essential benefit plan • Administrative simplification 	Tina Edlund	X
6	2:00	Progress reports <ul style="list-style-type: none"> • Patient-centered primary care standards (Jeanene Smith) • Health Information Technology Oversight Council (Carol Robinson) 	Jeanene Smith Carol Robinson	

#	Estimated Time	Item	Presenter	Action Item
8	2:45	Break		
9	3:00	All Payer All Claims Database Update (Sean Kolmer)	Sean Kolmer	
10	3:15	All-Payer All Claims Data invited testimony	Chair	
11	4:40	Public Comment		
12	5:00	Adjourn	Chair	

Next meeting:

February 9th, 2010

8 am to 12 noon

Market Square Building

1515 SW 5th Avenue (Between Market and Clay)

9th floor

Live web streamed at: [January 12, 2010 Live Web Streaming](#)

DRAFT

Oregon Health Policy Board Minutes
December 8, 2009
8:30 am – 3:30 pm
Sheraton Hotel Portland Airport, Portland Oregon

Item 1 - Call to Order/Roll Call

Eric Parsons called the Oregon Health Policy Board (OHPB) meeting to order. All Board members were present. Oregon Health Authority (OHA) staff present were Bruce Goldberg and Tina Edlund.

Item 2 – Review and Approve Agenda and Minutes

The December 8 OHPB agenda was reviewed. No further changes were noted. The agenda was approved with no further discussion. The November 10, 2009 meeting minutes were reviewed by the Board. Nita Werner moved to adopt the minutes as presented; Felisa Hagins seconded the motion. There was no further discussion by the Board. The minutes were approved.

Item 3 –Facilitated Discussion: Decision Making, Board Roles and Responsibilities

Facilitator Diana Bianco led the group through a facilitated discussion of; 1) coming to a shared understanding of the Board’s roles and responsibilities and 2) decision making process of what consensus means. Consensus must be transparent and all Board members must participate in the decision making process. The discussion centered on how Board members will come to a 100 percent consensus, or if they should go with the majority vote of the Board.

- Nita Werner thought that if a member does not agree, they need to bring their thoughts up to the rest of the Board. There should be respectful decision making.
- Mike Bonetto thought the Board should give 100 percent commitment and not consensus. It is the Chair’s prerogative to make suggestions if the Board cannot come to 100 percent consensus. Additional language and further definition needs to be added to the work plan to guide the Board on how it reaches objectives. Reports from the committees will set a foundation for the Board to monitor their success.
- Joe Robertson said that once the Board reaches a decision, the whole Board must be 100 percent committed and supportive of that decision. “Agree and commit or disagree and commit.”
- Lillian Shirley commented that if it’s for the greater good, she can live with the decision. We need a shared understanding of the commitment. The Board makes a decision and the agency figures out how to make it happen. The Board needs to support what the agency provides.
- Chuck Hofmann said collective wisdom is better than individual wisdom. Decisions can be made by consensus and by vote. There are different uses of consensus approach for planning versus implementation. A vote may be necessary at times. Chuck would be comfortable living with the decision. The Board needs to convey to the new committees that we may not adopt all of their recommendations. The Board wants to hear highlights of discussion and the consensus of each committee.

- Eileen Brady agrees that there are two different types of wisdom. Consent is to agree to commit to the process because the Board wants 100 percent consensus. Standing together brings strength. Eileen wants a report on consensus statistics from the committees.
- Eric Parsons thought that there is more of an impact if the Board reaches a decision collectively. If the Board cannot, the Chair will call for a vote. When we know the process we have an obligation to discuss the best outcome and to be confident of the outcome. The Board should act unanimously. If not, the Chair will call another vote, continue with further discussion, and then the Board would re-vote.
- Joe Robertson said the commitment piece and collective wisdom is better than individual wisdom.
- Carlos Crespo said if the Board cannot come to 100 percent consensus, leadership can make an effort to hear all Board voices, and when the Board reaches a decision, he will support the decision. Carlos asked if it was an option to allow public comment after the Board discusses an issue.
- Felisa Hagins said she believes that if the decision is for the greater good, then it is good to commit to the group decision. It is everyone's responsibility to take temperature of the group and then strive to reach consensus.

Diana summarized the Board's discussion: when the group reaches a decision, all will support it. The group doesn't want to be fractured, and would like to reach consensus. Consensus will be the general order of business. Transparency and robust discussions are central. Everyone has a role and everyone plays their role. When the Board is unable to get to 100 percent consensus, the Chair should be given prerogative and will call a vote or explore other routes (e.g., halt discussion and revisit later).

Item 4 – Committee Considerations and Work Plan – Tina Edlund

Tina Edlund discussed the four committees and the possibility of a fifth committee and the Work Plan.

Health Care Workforce Committee – The Board reviewed the draft Health Care Workforce Committee charter. Tina Edlund explained that the statute called for Oregon Health Policy and Research (OHPR) and the Oregon Center for Nursing (OCN) to collaborate on workforce data. The data will be available in January 2010. The revised charter will include the professions included in the statute. Data on mental health & addictions professionals beyond medical professionals (e.g., social workers) are not included in the database. Pulling that data in would require statutory change. Chair Parsons called for discussion.

- Nita Werner commented that deficient areas in the database need to be addressed while the database is being created.
- Eileen Brady voiced concern about deliverables and added that the charter needs to be robust. Eileen also stressed the urgency for committee to move forward with quick action.

- Lillian Shirley questioned if we can deliver what we currently have, and asked if the Board has a role in the intellectual work of this committee.
- Dr. Robertson said he is interested in the actionable part of this committee. We need to be sure a transaction component exists. How are we going to implement resource support? The pipeline is long and we need to start something now. The urgency is great. Dr. Hofmann asked about work plan language regarding strategy and objectives. The Board designated Dr. Goldberg and Tina Edlund to summarize the Board's thoughts and move forward.
- Eric Parsons added that the two committees and conceptual approval are subject to some modifications.

Public Employers Health Purchasing Committee – The Board reviewed the draft Charters for the Public Employers Health Purchasing Committee. The objective of the committee is to look at and understand health care needs and what we purchase and how we pay for it. There needs to be one set of standards, alignment and unification. This committee will look at areas where new policies and standards regarding quality can be established. The committee will work with local governments to integrate standards into their policies and look at reasonable performance not replacing benefit and groundwork. The committee needs to look at deliverables, bundling, payment reform and new methodologies. The committee will establish standardization of good payment methods.

Health Improvement Plan Steering Committee - Jane Moore from Public Health talked about the Health Improvement Plan Steering Committee. This committee aligns with the work being done in Public Health. The committee will bring forward a strategic plan update every five years. The steering committee was formed to ensure a wide array of stakeholders were at the table. A facilitator will oversee this process. The scope of this committee is prevention, detection, early management. The group is going through deliverables and moving toward an action plan, working toward an aggressive timeline in 2010. The plan will be launched at a statewide conference.

Jane Moore said there will be revisions in language regarding deliverables to make it less confusing.

- Eric Parsons said the committee needs to be bold and come back with real facts and real answers. The Board was in general agreement about the committee's role, responsibility and decision making needs.

Tina Edlund talked about the formation of additional committees in addition to the two currently in statute, a Health Systems Performance Committee, Statewide Health Improvement Committee and a Medical Liability Taskforce.

Medical Liability Taskforce- Board members would like to ensure that liability issues particular to rural areas are addressed by this committee, that we ensure that legal professionals are included and that the consumer perspective is included.

- Carlos Crespo is assigned as Board liaison to this committee. Eileen stated that these committees have no official connection to Board members, but Board could attend these committees in groups of two and serve as a conduit for information to the Board and urged Board members to take ownership and attend the meetings.
- Carlos Crespo agreed there should be cross member committee members participation by the Board and agrees to help with translation.
- Eric Parsons said the Board chair and vice chair should attend these meetings to improve communication. Board members will indicate to Eric Parsons or Tina Edlund which committees they would like to attend.

Health Systems Performance Committee - This permanent committee reviews alternative payment methodologies and makes payment methodology recommendations to the Board. This committee will also make recommendations for a model dashboard for the Oregon Health Authority and for the state. The quality and cost relationship is the charge of this committee.

Board member discussion emphasized the need for this committee to focus on the value proposition, the connection to purchasing and directed the committee to balance the need for data against the need for action and implementation.

Workplans

Tina Edlund laid out in Committee Charters.

Chair Parsons asked the Board for formal actions to adopt the four charters and to establish a liability committee. All committees can be added to or revised. Lillian Shirley motioned, Chuck Hofmann seconded the motion. No further discussion. Motion was carried by a unanimous voice vote.

Chair Parsons called for a motion to adopt the Work Plan. Motion made by Chuck Hofmann, seconded by Eileen Brady. No further discussion. Motion carried by a unanimous voice vote.

Item 5 - Board Discussion- Opportunities and Obstacles for the Work Ahead

Barney Speight provided a brief history about health care reform in Oregon and what health reform environments didn't work in the past. Mr. Speight also talked about payment mechanisms, affordability and fundamental change.

Item 6 –Federal Legislation Review – Amy Fauver

Amy Fauver provided an update on comparing state and federal pending health care legislation and implementing timelines.

Item 7 – Public comment from Health Advocacy Allies – Ellen Pinney

Ellen Pinney introduced her group and provided an overview of the Oregon Health Action Campaign's (OHAC) role in assisting the Board to accomplish its goals set forth by the legislature. OHAC addressed four key reform and processes when they become current in the Board's workplan. The group believes that the single market insurance exchange, an essential benefits package as a floor plan for all plans, a public option with the exchange, and the affordability of premiums and out of pocket costs for people at various income levels are essential. The elimination of disparities in health outcomes is essential. Public input and

engagement throughout this process is critical. Individual presentations were made by Laura Etherton (Insurance Exchange), Betty Johnson (Public Option), John Mullin (Affordability), Mark Mathis (Religious side – Including everyone), Ron Williams (Making Health Care Equitable) and Bob Brown (Increasing Public Input).

Chair Parsons asked if future Board meetings are better for each member in the morning or afternoon. There were mixed responses, so it was decided to have alternating schedules. Meeting adjourned 3:50 pm

Next Meeting:
The Market Square Building
January 12, 2009
1:00 – 5:00 pm

DRAFT

Oregon Health Policy Board

2010 Meeting Schedule

Unless otherwise noted, all meetings will be held at:

The Market Square Building

1515 SW 5th Avenue (between Market and Clay)

9th floor

Portland, OR 97201

This location has live web streaming available so that meetings will be available for viewing across Oregon via the internet:

[Live Web Streaming](#)

Getting there:

Mass transit

The Market Square Building is served by several bus lines as well as direct service from the Max and Street Car. The Tri-Met trip planner at www.trimet.org will provide the most direct mass transit route for you.

Coming by automobile from the south on I-5

Take Exit 299B/City Center (US 26) onto Harbor Dr toward # 1A/Naito Parkway

Bear left on SW Clay

Turn Left on SW 5th Ave

Arrive on the Right

Parking

There is the Auditorium Garage located at 1400 SW 3rd Ave, one block from the Market Square Building @ \$11.50 daily rate. Smart Park: [Smart Park](#)

We recommend mass transit.

Meeting Schedule 2010

*All meetings are on the **second Tuesday of the month**. Times are subject to change so please check the current meeting schedule at www.oregon.gov/oha/ohpb to confirm dates, times and location:*

Jan 12:	1:00 to 5:00 pm	July 13:	1:00 to 5:00 pm
Feb 9:	8:00 am to 12:00 noon	Aug 10:	8:00 am to 12:00 noon
Mar 9:	1:00 to 5:00 pm	Sept 14:	1:00 to 5:00 pm
April 13:	8:00 am to 12:00 noon	Oct 12:	8:00 am to 12:00 noon
May 11:	1:00 to 5:00 p.m.	Nov 9:	1:00 to 5:00 pm
June 8:	8:00 am to 12:00 noon	Dec 14:	8:00 am. to 12:00 noon

OREGON HEALTH POLICY BOARD
Policy-making and Oversight Role

DRAFT 1-04-10

The Oregon Health Policy Board (OHPB) is the policy-making and oversight body for the Oregon Health Authority, § 9(1) HB 2009. All of the board's actions and decisions are guided by accountability toward the triple aim of improving population health, improving the individual's experience of care and lowering per capita health care costs.

The Board is aided in its functions by its committees and the Oregon Health Authority

Policy-making

The OHPB has two distinct areas of policy-making responsibility: Oregon Health Authority policy and public policy. The board evaluates, adopts and promotes policy for the Oregon Health Authority. In addition, the OHPB evaluates and recommends public policies to the state legislature.

As they make decisions about policies, the board will review relevant information from the Oregon Health Authority and from board committees. The OHPB also will convene and solicit information from the public. The board may re-evaluate policy in light of additional information or changed circumstances (e.g., changes in federal law, etc.).

The board's decisions will inform its reports and recommendations to the Oregon Health Authority and, as appropriate, the Legislative Assembly. Implementation of certain policy objectives may require legislative approval or funding.

- Policy-making will include, but not be limited to, the topics identified by the Legislature in HB 2009:
 - access to affordable, quality health care for all Oregonians by 2015
 - uniform, statewide health care quality standards
 - evidence-based clinical standards and practice guidelines
 - cost containment mechanisms
 - health care workforce
 - comprehensive health reform
 - health benefit package
 - health insurance exchange

Administration and implementation of policies is assigned to the Oregon Health Authority, in addition to their other duties and functions.¹

Oversight

The board will evaluate progress toward achieving policy objectives through oversight of the Oregon Health Authority's implementation of processes and policies. The board will support the OHA as it implements the goals and policies set out by the board. The board will focus on strategic objectives, rather than tactical or operational work, which is the purview of the OHA.

¹ *Final policy-making authority for OHA as the state Medicaid agency must be retained by OHA to meet federal requirements.

**Oregon Health Policy Board
Medical Liability Task Force Charter**

Approved by OHPB on *[Insert Date]*

I. Authority

The Oregon Health Policy Board, under House Bill 2009, Section 8(1) may establish advisory and technical committees as the Board considers necessary to aid and advise in performance of its functions. The Board establishes the Medical Liability Task Force to examine current state medical liability laws and policies, their impact on the cost and delivery of healthcare, and to develop a range of medical liability reform proposals for consideration by the Oregon Health Policy Board and the Oregon Legislature. The Committee will be guided by the Triple Aim of improving population health, improving the individual's experience of care and reducing per capita costs. The Committee will also be guided by the Oregon Health Fund Board's final report, "Aim High: Building a Healthy Oregon," (November 2008), particularly in reference to Building Block 4: Stimulate System Innovation and Improvement:

Improve population health by:

- Improving access to care in order to limit the impact of disease on the population as a whole.

Improve the individual's experience of care by:

- Improving access to care by assuring healthcare providers do not cease to provide specific services in response to liability concerns.

Reduce per capita costs by:

- Reducing the costs associated with defensive medicine.

This Task Force is temporary and will be disbanded upon the acceptance of its recommendations as may be amended by the Oregon Health Policy Board and final action by the 2011 Oregon Legislature unless the Board assigns additional duties.

II. Committee Makeup

The Medical Liability Task Force is composed will be composed of select members with expertise, experience and knowledge of medical liability reform issues including physicians, attorneys and other stakeholders, as well as a representative of the Patient Safety Commission.

III. Deliverables

The Medical Liability Task Force will investigate the current medical liability system and suggest opportunities for reform in Oregon including, but not limited to, caps on non-economic damage

awards, disclosure-and-offer programs, shifting the adjudication of medical malpractice claims to administrative panels or specialized judicial courts, and the creation of “safe harbors” where physicians are insulated from liability if they adhere to evidence-based practices or practice according to findings from credible comparative-effectiveness research (CER).

The work of the Task Force will result in recommendations for a range of innovations and state action in the medical liability system. Recommendations should prioritize patient safety and the reduction of medical errors, encourage better communication between physicians and patients, reduce the occurrence of frivolous lawsuits, and reduce liability premiums, while also ensuring that patients are compensated in an equitable and timely way for medical injuries.

Recommendations for a range of innovations for state action will be completed and presented to the OHPB by October 1, 2010. Recommendations for associated Legislative language, where appropriate, will be completed by January 1, 2011.

IV. Committee Dependencies

The Medical Liability Task Force will seek information from:

- a. Health Services Commission [evidence-based guidelines]
- b. Health Resources Commission [comparative effectiveness]
- c. Health Care Workforce Committee
- d. Oregon Medical Association
- e. Oregon Trial Attorneys Association

The Medical Liability Task Force will provide draft recommendations for input to:

- a. OHA senior staff
- b. Oregon Health Policy Board

V. Staff Resources and Board Liaison

Senior OHA Staff: Lynn Marie Crider, Jeanene Smith

Board liaison: Chuck Hofmann

VI. Committee Membership

Insert membership table

**Oregon Health Policy Board
Health Care Workforce Committee**

Approved by OHPB on December 8, 2009

I. Authority

The Health Care Workforce Committee is established by House Bill 2009, Section 7 (3)(a). This charter defines the objectives, responsibilities and scope of activities of the Health Care Workforce Committee. The Committee will be guided by the Triple Aim of improving population health, improving the individual's experience of care and reducing per capita costs. The Oregon Health Fund Board's final report, "Aim High: Building a Healthy Oregon," (November 2008) outlines the following ways in which training a new health care workforce addresses the triple aim:

Improves population health by:

- Ensuring an adequate numbers of health care providers in all areas in Oregon
- Improving access to primary care services by increasing the number of primary care providers

Improves the individual's experience of care by:

- Ensuring individuals have access to the providers they need in their communities
- Ensuring the diversity of Oregon's population is reflected in its provider workforce
- Ensuring providers are prepared to provide culturally competent care

Reduces per capita costs over time by:

- Ensuring providers are working at the top of their licenses
- Expanding the use of community health workers to provide cost-effective care

This charter will be reviewed annually to ensure that the work of the Committee is aligned with the Oregon Health Policy Board's strategic direction.

II. Deliverables

The Health Care Workforce Committee is chartered to coordinate efforts in Oregon to recruit and educate health care professionals and retain a quality workforce to meet the demand created by the expansion in health care coverage, system transformation and an increasingly diverse population. The Workforce Committee will advise and develop recommendations and action plans to the OHPB for implementing the necessary changes to train, recruit and retain a changing health care work force that is scaled to meet the needs of new systems of care: recommendations for patient-centered primary care homes and the implicit role of primary care in chronic care management will depend on how effectively we are able to respond to the workforce supply challenge.

One important objective of the Health Care Workforce Committee is to become the most complete resource for information about the health care workforce in Oregon by improving data collection and assessment of Oregon's health care workforce through regular analysis and reporting of workforce supply and demand. Initial efforts will focus on the health care workforce database created through HB 2009, which will include detailed demographic and practice data for the following professions: occupational therapists and certified occupational therapy assistants; physicians and physician assistants; nurses and nursing assistants; dentists and dental hygienists; physical therapists and physical therapy assistants; pharmacists and pharmacy technicians; and licensed dietitians.

The Health Care Workforce Committee will focus its work on identifying resources, needs, and supply gaps, and ensuring a culturally competent workforce that is reflective of Oregon's increasing diversity. To the extent possible, the Committee will coordinate and align recommendations of other health care workforce initiatives in its biennial recommendations to the Oregon Health Policy Board.

The Committee shall deliver to the Board the following:

- A work plan that outlines specific, well-defined strategies and products, both short-term and long-term, upon which the Committee will be working with supporting justifications.
- An inventory of all grants and other state resources available for addressing the need to expand the health care workforce to meet the needs of Oregonians for health care. This will include recommendations to the Board about state investments in health care workforce development.
- Recommendations to OHA staff for metrics and an analytical framework to examine the Oregon Health Care Workforce Database in order to identify emerging trends and issues related to changing workforce needs in a new delivery system.
- A biennial report to the Board of recommended strategies, actions and policy changes, including statutory changes if required, that support the recruitment, retention and distribution of Oregon's health care workforce, with an emphasis on primary care. The strategies and actions should include licensure strategies for a 21st century health care workforce.

III. Timing

- The Committee work plan will be completed by March 2010.
- The Committee will provide the inventory of grants and other state resources to the Board no later than May 2010.

- Recommendations for the Oregon Workforce Database analytical framework will be completed by June 2010.
- A report including recommendations for state policy changes that may be required to ensure an adequate health care workforce will be completed by December 31, 2010.

IV. Dependencies

The Health Care Workforce Committee will seek information from:

- a. Patient-Centered Primary Care Advisory Committee
- b. State Health Improvement Plan Committee
- c. Health Systems Performance Committee

The Health Care Workforce Committee will provide draft recommendations and action plans for input to:

- a. OHA senior staff
- b. Oregon Health Policy Board

V. Staff Resources

The Oregon Workforce Institute will provide senior-level staffing for the Health Care Workforce Committee

OHA policy analyst: Lisa Angus

VI. Committee Membership

		Institution	Name
Education	1	Dept of Community Colleges and Workforce Development	Terri Johanson, Policy Advisor
	2	Linn-Benton Community College	Ann Malosh, Dean (VICE-CHAIR)
	3	Oregon Institute of Technology	Lita Colligan, Associate VP
	4	Mt. Hood Community College	Donna Larson, Administrator
	5	Rogue Community College	Peter Angstadt, President
	6	Portland Community College	Karen Sanders, Div. Dean, Health & Allied Health
	7	OHSU	John Moorhead, MD, Emergency Medicine (CHAIR)
	8	OHSU	Mark Richardson, MD, Dean, Sch of Medicine
	9	Veteran's Administration	David Nardone, MD
	10	Oregon Area Health Education Center	Lisa Dodson, MD
	11	Cascade East Area Health Education Center	Jennifer Valentine, Exec. Director
	12	Pacific University	Sarah Hopkins-Powell, Exec. Dean
	13	Blue Mountain Community College	Dan Lange, VP, Instruction
	14	Eastern Oregon University	Pending
Professions Employers	15	OR Center for Nursing	Kris Campbell
	16	Dentistry	Daniel Saucy, self-employed
	17	Dental hygiene	Kristen Simmons, Willamette Dental
	18	Behavioral health	David Pollack, MD, OHSU
	19	Behavioral health	Kathleen Tomlin, Addiction Medicine, Kaiser
	20	Providence Health System	June Chrisman, Chief Human Resource Officer
	21	Kaiser Permanente	Bonnie Bender, Planning Coordinator
	22	Mercy Medical Center	Kelly Morgan, President and CEO
Dev. Initiatives	23	NW Health Foundation	Judith Woodruff
	24	Urban League	Marcus Mundy

**Oregon Health Policy Board
Public Employers Health Purchasing Committee Charter**

Approved by OHPB on December 8, 2009

I. Authority

House Bill 2009 [Section 7(2)] directs The Oregon Health Policy Board (“Board”) to establish the Public Employers Health Purchasing Committee (“Committee”). The Committee shall include individuals who purchase health care for:

- Public Employees’ Benefit Board (PEBB);
- Oregon Educators Benefit Board (OEBB);
- Public Employees Retirement System (PERS);
- City governments;
- County governments;
- Special districts; and
- Private, non-profit organizations that receive the majority of funding from the State of Oregon and request to participate

The Committee will be guided by the Triple Aim of improving population health, improving the individual’s experience of care and reducing per capita costs. The Committee will also be guided by the Oregon Health Fund Board’s final report, “Aim High: Building a Healthy Oregon,” (November 2008), particularly in reference to Building Block 3: Unify Purchasing Power:

Improve population health by:

- Promoting primary care, prevention, and wellness services through public contracting
- Expanding access to insurance coverage
- Promoting the use of evidence-based clinical standards

Improve the individual’s experience of care by:

- Increasing the use of patient-centered models of care that engage patients in decision making
- Using contract standards to increase the quality of care

Reduce per capita costs by:

- Building efficiency and value standards into public purchasers’ health care contracting
- Reducing pharmaceutical spending

This charter shall be reviewed annually to ensure that the work of the Committee is aligned with the Oregon Health Policy Board’s strategic direction.

II. Objectives

The Committee shall:

- Evaluate the aggregate market presence of public employer purchasers and other state-sponsored programs in local and regional Oregon markets.
- Compare and contrast the performance of local health care markets in Oregon in terms of utilization, cost and quality trends.
- Working with the Oregon Health Policy Board and relevant committees of the Board, develop uniform quality, cost and efficiency benchmarks that can be incorporated in health care purchasing programs of state and local governments and private sector entities.
- Develop purchasing policies, standards and model contract terms for health benefit programs that incorporate the best available clinical evidence (using evidence-based guidelines as a tool), recognized best practices and demonstrated cost-effectiveness for health promotion and disease management.
- Develop processes for collaboration among public employers and other interested purchasers of health benefits to foster the broad, statewide implementation of uniform and aligned purchasing policies and standards that emphasize value-based benefits.

III. Deliverables

The Committee shall deliver to the Board:

- A work plan that outlines specific, well-defined contracting policy and standards (focused on increasing quality and bending the cost curve) on which the Committee will be working, with supporting justifications.
- Reports that document the contracting policies, standards and model contract terms developed by the Committee, the implementation timeframes for health programs operating under the Oregon Health Authority and the actions taken to encourage other public and private employers to implement such policies, standards and model contract terms.
- An annual report recommending topics for investigation and study by the Board and its committees, or commissions and committees operating under the Authority, that would assist the Committee in future endeavors.

IV. Dependencies

The Public Employers Health Purchasing Committee will seek information from:

- Oregon Health Policy Board [policy]
- Patient-Centered, Primary Care Home Standards Advisory Committee [standards]
- The Health Leadership Task Force [value-based benefit, standards]
- Oregon Health Care Purchasers' Coalition [value-based purchasing, standards]

- Health Systems Performance Committee (OHPB) [quality standards, etc.]
- Health Services Commission (OHPB) [evidence-based guidelines]
- Health Resources Commission (OHPB) [comparative effectiveness studies]
- Office of Health Policy & Research [all-payer, all-claims data program]

The Public Employers Health Purchasing Committee will provide draft contracting policies, standards and model contracts for input to:

- OHA senior staff
- Oregon Health Policy Board

V. Timing

The Committee will provide its initial work plan to the Board no later than March, 2010; and its preliminary report, including recommendations for statutory changes, no later than June, 2010. A final report will be submitted in September 2010.

The Committee shall subsequently report to the Board on its activities and recommendations at least bi-annually.

VI. Staff Resources

Senior OHA Staff: Barney Speight

Policy Staff: Kelly Harms

VII. Committee Membership

Organization	Name, Title
Public Employers' Benefit Board (PEBB)	Diane Lovell, Board Member Joan Kapowich, Administrator
Oregon Educators' Benefit Board (OEBC)	Steve McNannay, Board Member Joan Kapowich, Administrator
Public Employees Retirement System (PERS) Health Insurance Program	Zue Matchett, Manager
County Government	Madilyn Zike, Human Resources Manager, Marion County Caren Cox, Multnomah County Employee Benefits Office Ronda Conner, Deschutes County
City Government	Lynn McNamara, Director, City-County Insurance Services (CIS) Cathy Bless, City of Portland
Special Districts	Linda Shames, Port of Hood River
Private, Not-For-Profit	TBD
Oregon Coalition of Health Care Purchasers (OCHCP)	Barbara Prowe, Executive Director

Oregon Health Policy Board
Oregon Health Improvement Plan Committee

Approved by OHPB on [insert date]

I. Authority

The Oregon Health Policy Board, under House Bill 2009, Section 8(1) may establish advisory and technical committees as the Board considers necessary to aid and advise in performance of its functions. The Board establishes the Oregon Health Improvement Plan Committee to recommend to the Board and continually refine uniform, statewide health care quality standards for use by all purchasers of health care, third-party payers, health care providers and consumers. The Committee will be guided by the Triple Aim of improving population health, improving the individual's experience of care and reducing per capita costs. The Committee will also be guided by the Oregon Health Fund Board's final report, "Aim High: Building a Healthy Oregon," (November 2008), particularly in reference to Building Block 4: Stimulate System Innovation and Improvement:

Improve population health by:

- Focusing on wellness, prevention and chronic disease management to improve population health
- Focusing on evidence-based interventions that incorporate policy, systems and environmental approaches to promote population health at the state and community levels.
- Supporting communities in developing local solutions to community health problems
- Supporting development of community-based initiatives to reduce chronic disease in the population

Improve the individual's experience of care by:

- Encouraging individuals to establish personal, continuous relationships with patient-centered health practices, engaging individuals in improving their own health, making it easier for people to access culturally appropriate mental health and physical health services, and improving the quality and safety of care they receive
- Improving access to community-based preventive services to reduce disease risk factors in individuals
- Allowing patients to be more engaged in their own health care

Reduce per capita costs by:

- Allowing health resources to be spent more effectively and efficiently at the local level
- Reducing the utilization of health care services by decreasing chronic disease

This charter shall be reviewed annually to ensure that the work of the committee is aligned with the Oregon Health Policy Board's strategic direction.

II. Objective

The committee is chartered to provide leadership, direction and oversight for the development of an Oregon Health Improvement Plan (name TBD), under the direction of the Oregon Health Policy Board (OHPB). This plan supports a key OHPB goal to improve the health of all

Oregon Health Policy Board
Oregon Health Improvement Plan Committee

Approved by OHPB on [insert date]

Oregonians by promoting and supporting lifestyle choices that prevent and manage chronic diseases. The plan will outline evidence-based interventions that incorporate policy, systems and environmental approaches to promote population health at the state and community levels. The plan will emphasize a strategy that links population health to the health care delivery system and communities.

The Committee's purpose is to conduct a strategic planning process that involves public and private sector organizations and individuals and engages policy makers, schools, government, business and community leaders. The result will be a comprehensive, multi-sector, multilevel action plan to improve population health through a decrease in tobacco and obesity and the prevention, early detection and management of chronic diseases such as asthma, arthritis, cancer, diabetes, heart disease and stroke.

III. Scope

The Committee's recommendations will serve as the foundation to develop the statewide health improvement plan. The work of the committee is based on several key factors outlined in HB 2009, the Health Fund Board report (November 2008) and public health practice related to a statewide health improvement plan/program:

1. Population health (or public health), the health care delivery system and communities must work together to promote and support individual and community health for all Oregonians;
2. Create and maintain a bridge between population health and communities as an essential part of improving the health of all Oregonians;
3. Population health, chronic disease prevention, early detection and management is a high priority for the Oregon Health Authority and its divisions;
4. The "plan" will be grounded in culturally and socially appropriate evidence-based primary and secondary prevention interventions to prevent and manage chronic diseases;
5. The plan will be grounded in policy, systems and environmental interventions at the state and community levels;
6. The plan will address the impact of development on population health;
7. A range of community partners, including behavioral health and multicultural stakeholders will be actively engaged in the strategic planning process;
8. The plan will include performance criteria and measurable outcomes to demonstrate improvements in population health status and a reduction of chronic disease risk factors;
9. The plan will include the collection of data related to the social determinants of health (e.g., poverty, employment, disparities) and related economic data;
10. The plan will include strategies to reduce health disparities.

IV. Deliverables

- A. A plan is created and approved by consensus of the committee that will:

Oregon Health Policy Board
Oregon Health Improvement Plan Committee

Approved by OHPB on [insert date]

- a. List measurable objectives related to tobacco use, obesity prevention, and chronic disease prevention, early detection and management, including baseline and target metrics;
 - b. Outline metrics that will define health empowerment zones: communities that experience disproportionate disparities in health status and health care;
 - c. Outline metrics that define progress towards these goals;
 - d. Outline an implementation strategy, budget and timeline.
- B. A statewide stakeholder coalition for implementation is identified and selected. The coalition will:
- a. Have sufficient influence to impact the issue;
 - b. Have sufficient reach to impact the issue;
 - c. Be representative of geographic and demographic diversity;
 - d. Include representation from behavioral health organizations;
 - e. Include representation from the Oregon Health Authority's health care purchasers including Medicaid;
 - f. Be representative of business, public sector and non-governmental organization wellness and senior leadership teams;
 - g. Have official backing and endorsement of the plan from stakeholder organizations.

V. Timeline

Key milestones include:

1. Committee meetings are held regularly, beginning January 2010
2. Committee reports to the Oregon Health Authority Board, beginning Spring 2010
3. Plan outline completed, February/March 2010
4. Stakeholder meeting held, March 2010
5. Designated task force groups meet, February/March through September 2010
6. Public hearings held around the state for input, Summer 2010
7. Finalized health promotion/health improvement plan by September 2010
8. Plan released at statewide conference in Fall 2010
9. A 2-year operational plan is finalized by June 2011
10. A 2-year progress report is completed by Fall 2012

VI. Committee Membership

The committee will be composed of members with expertise, experience and knowledge in the implementation of a broad range of evidence-based interventions supporting and promoting population health at the state, regional and community levels. Members will also be representative of Oregon's geographic and demographic diversity. Members will be selected through a nomination and application process.

Oregon Health Policy Board
Oregon Health Improvement Plan Committee

Approved by OHPB on [insert date]

VII. Dependencies

The Health Improvement Plan Committee will seek information from:

- a. Health Care Workforce Committee
- b. Public Health Advisory Board
- c. Coalition of Local Health Officials
- d. The All-Payer, All-Claims (APAC) data program

The Health Improvement Plan Committee will provide information to:

- a. Health Systems Performance Committee
- b. Public Employers Health Care Purchasers Committee

The Health Improvement Plan Committee will provide draft recommendations for input to:

- a. OHA senior staff
- b. Oregon Health Policy Board

Staff Resources

The work outlined above will be supported by:

- Oregon Health Authority Divisions, including Oregon Public Health Division (OPHD)
- An external contractor facilitates the committee and its work and provides technical assistance to task force groups, supported by the Health Promotion and Chronic Disease Prevention (HPCDP) section, Oregon Public Health Division
- Staff support to the committee from OPHD programs, led and coordinated by HPCDP

**Oregon Health Policy Board
Health Systems Performance Committee Charter**

Approved by OHPB on December 8, 2009

I. Authority

The Oregon Health Policy Board, under House Bill 2009, Section 8(1) may establish advisory and technical committees as the Board considers necessary to aid and advise in performance of its functions. The Board establishes the Health Systems Performance Committee to recommend to the Board and continually refine uniform, statewide health care quality standards for use by all purchasers of health care, third-party payers, health care providers and consumers. The Committee will be guided by the Triple Aim of improving population health, improving the individual's experience of care and reducing per capita costs. The Committee will also be guided by the Oregon Health Fund Board's final report, "Aim High: Building a Healthy Oregon," (November 2008), particularly in reference to Building Block 2: Setting High Standards:

Improve population health by:

- Developing a complete picture of where Oregon is doing well and where there is room for improvement so that effective, targeted initiatives aimed at improving population health can be developed
- Coordinating a statewide strategy to improve quality of care
- Providing communities with information about resource utilization that is needed to make health planning decisions that maximize population health

Improve the individual's experience of care by:

- Giving people the information they need to compare available health plans
- Allowing health care consumers to make informed decisions about the providers they see based on the quality of care they provide

Reduce per capita costs by:

- Providing a clear picture of how resources are used in health care
- Allowing for the identification of providers/regions that are providing cost-effective and high-value care and those that are utilizing more resources without achieving better outcomes, thereby reducing variations in care patterns and the provision of unnecessary care
- Increasing public accountability for the way health dollars are spent
- Encouraging competition between health plans and between providers based on the value of services provided and thus allowing health care purchasers to make informed purchasing decisions
- Giving providers the information they need 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

This charter shall be reviewed annually to ensure that the work of the committee is aligned with the Oregon Health Policy Board's strategic direction.

II. Committee and Sub-Committee Makeup

The Health Systems Performance Committee will have two subcommittees: one focusing on recommendations for payment policy and standards and the second focusing on standards and metrics related to value: both quality and cost in health care. The two subcommittees together will constitute the Committee. Each subcommittee may bring in additional content experts to assist them in developing their recommendations for methodologies, standards and metrics. Recommendations to the Board require a majority vote of the full Health Systems Performance Committee.

III. Deliverables

The Health Systems Performance Committee is established to investigate, evaluate and develop recommendations to the Board for transparent payment methodologies that provide incentives for cost-effective, patient-centered care and reduce variations in cost and quality of care. The Committee will provide technical performance measurement and reporting expertise and make recommendations to the Board about and continually refine uniform, statewide health care quality standards in support of a high performing health system and the further development of value-based benefit design for use by all purchasers of health care, third-party payers and health care providers.

Short Term

1. A report recommending to the Board transparent payment methodologies that may be incorporated in health care purchasing programs of state and local government and private sector entities and that provide incentives for the efficient delivery of care which (April 2010).
2. A report recommending to the Board a set of core quality and efficiency measures that align with the priorities of the State Health Improvement Plan, the Patient-Centered Primary Care Advisory Committee and are based on nationally validated, evidence-based metrics addressing variations in utilization and cost. The report will include recommendations for statistically valid levels of reporting by geography and/or provider level (e.g., hospital, hospital system, accountable care organization, clinic, etc.). Once adopted by the Board, the Oregon Health Authority will produce a performance dashboard which includes the recommended core measures. (Core measures recommendation: April 2010, OHA dashboard: September 2010)

Long Term

1. Based on data from the Oregon Health Authority on utilization, outcomes and cost, a report recommending areas for attention by the Board by procedure, condition and geography by June 2011.
2. Recommend and develop an Oregon Health Systems Scorecard that includes key quality, cost/efficiency metrics. The scorecard will include standardized, comparable measures of quality, cost and efficiency and will include geographic and provider-level analysis where statistically appropriate. The first Oregon Health System Scorecard will be completed no later than June 2011.

The Committee will also perform other duties and responsibilities, consistent with this Charter and governing by-laws, as may be delegated to the Committee by the Board.

IV. Committee Dependencies

The Health Systems Performance Committee will seek information from:

- a. Patient-Centered Primary Care Advisory Committee
- b. State Health Improvement Plan Steering Committee
- c. Health Care Workforce Committee
- d. Health Resources Commission
- e. Health Services Commission
- f. The Oregon Health Care Quality Corporation
- g. The Health Leadership Taskforce
- h. The Oregon Coalition of Healthcare Purchasers

The Health Systems Performance Committee will provide information to:

- a. Public Employers Health Care Purchasers Committee
- b. Health Resources Commission
- c. Health Services Commission
- d. The Oregon Health Care Quality Corporation
- e. The Health Leadership Taskforce
- f. The Oregon Coalition of Healthcare Purchasers

The Health Systems Performance Committee will provide draft recommendations for input to:

- a. OHA senior staff
- b. Public Employers Health Care Purchasers Committee
- c. Oregon Health Policy Board

Quality standards will be developed and reviewed by the Committee on an ongoing basis. Updates and recommendations will be made to the Board on a quarterly basis.

V. Staff Resources

Quality and Efficiency Subcommittee: Gretchen Morley

Payment Reform Subcommittee: Jeanene Smith, Barney Speight, Rob Stenger

VI. Committee Membership

Insert membership table

DRAFT

**Oregon Health Policy Board
Administrative Simplification Initiative
DRAFT Work Plan**

Presented to OHPB on January 12, 2010

I. Reform Initiative Overview

HB 2009 directed the Office for Oregon Health Policy and Research to convene a stakeholder workgroup to develop uniform standards for health insurers "including but not limited to standards for (a) eligibility verification, (b) health care claims processes, [and] (c) payment and remittance advice." The bill authorized the Department of Consumer and Business Services to adopt rules incorporating the standards.

The goal of this provision in HB 2009 is to reduce health insurance administrative cost by streamlining insurer-provider transactions through use of increased electronic exchange of administrative data. This activity is intended to help achieve the aim of reasonable per capita costs for health care coverage. By substantially reducing the cost of insurer-provider transactions (which have been estimated to consume approximately 13% of the health care dollar), aggregate administrative costs will be reduced.

II. Context

Federally, both the House and Senate health care reform bills include requirements for the U.S. Department of Health & Human Services to adopt uniform standards for electronic eligibility verification, claims, payment remittance admittance advice and other administrative transactions between insurers and providers. Within Oregon, the Oregon Business Council's Health Leadership Task Force has convened a workgroup on administrative simplification and is likely to make recommendations for improvement of web-based eligibility verification and claims status inquiries as well as provider credentialing processes.

III. Timeline and Deliverables

- OHPB has:
 - Gathered information on the problem and federal and state initiatives to address it.
 - Developed an *annotated list of simplification options*.
- OHPB will:
 - Survey providers and large insurers to gather baseline data and input on priorities and compile the *survey results* for the Board by March 2010.
 - Assemble a workgroup to recommend priorities for state administrative simplification work in February 2010.
 - Conduct 4-5 meetings from February to June 2010 to consider staff reports and input from experts, private workgroups, stakeholders, and the public concerning prioritized administrative simplification options.
 - Prepare *placeholder legislative concepts* for the Oregon Health Authority, the Oregon Health Policy Board, the Department of Consumer & Business Services, and the Governor if it appears that additional legislative authority may be necessary to achieve the initiative's objectives by March 2010.
 - Prepare *recommendations for the Department of Consumer & Business Services* on initial recommendations in June 2010.

IV. Dependencies

- OHPR will monitor to ensure that state administrative simplification work does not duplicate or conflict with other administrative simplification activities:
 - U.S. Department of Health & Human Services [uniform companion guides or operating rules required by both House and Senate health care reform bills]
 - Health Information Technology Oversight Council [health information exchange strategic plan]
- OHPR will seek information from:
 - Health Information Technology Oversight Council [timing and architecture of health information exchange for the state]
 - Private entities working on administrative simplification, including the Oregon Business Council's Health Leadership Task Force and the Council for Affordable Quality Care's Committee on Operating Rules for Information Exchange [recommendations, best practices, uniform operating rules]
 - Other states, including Minnesota, Massachusetts, Utah, and Washington [best practices, uniform operating rules and companion guides]
 - Workgroup including providers, insurers, purchasers, consumers, and representatives from the Health Information Technology Oversight Commission [recommended priorities and standards]
- OHPR will provide information to:
 - Health Information Technology Oversight Commission [recommended uniform standards and timelines]
- OHPR will make recommendations to:
 - Oregon Health Authority [recommended statutory changes]
 - Department of Consumer & Business Services [recommended uniform standards]

V. Stakeholder Input Process

OHPR will survey providers and insurers before convening the workgroup. OHPR will plan to post the simplification options to be considered by the workgroup on the web, open workgroup meetings to the public, and share public comment with the workgroup.

VI. Opportunities for Board Input

OHPR will provide the summary of its provider and insurer surveys (March 2010) and a report of recommendations (June 2010).

VII. Staff Resources: Jeanene Smith and Lynn-Marie Crider, Office for Oregon Health Policy and Research

**Oregon Health Policy Board
Baseline Benefit Package Initiative
Draft Work Plan**

Presented to OHPB on January 12, 2010

I. Overview

Section 16 of HB 2009 directs the Health Policy Board to approve a health benefit package to be used as the baseline for all health benefit plans offered through the Oregon Health Insurance Exchange, where the benefit package shall:

- Promote the provision of services through an integrated health home model that reduces unnecessary hospitalizations and emergency department visits.
- Require little or no cost sharing for evidence-based preventive care and services, such as care and services that have been shown to prevent acute exacerbations of disease symptoms in individuals with chronic illnesses.
- Create incentives for individuals to actively participate in their own health care and to maintain or improve their health status.
- Require a greater contribution by an enrollee to the cost of elective or discretionary health services.
- Include a defined set of health care services that are affordable, financially sustainable and based upon the prioritized list of health services developed and updated by the Health Services Commission.

This section of the legislation strives to further the goals of the triple aim in the following ways:

Improve population health by:

- Increasing the utilization (through lower cost sharing) of services aimed at managing chronic disease, including those with the highest disease burden: diabetes, obesity, asthma, depression and hypertension.

Improve the individual's experience of care by:

- Encouraging the use of patient-centered primary care homes through reductions in cost sharing for services received in that setting.

Reduce per capita costs by:

- Incentivizing the use of value-based services through no or minimal cost sharing. Increased utilization of these services will reduce downstream costs by lowering the incidence of preventable complications and preventing unnecessary emergency department visits.
- Limiting coverage of discretionary services that will have little or no impact on downstream costs.
- Eliminating the coverage of services which have little or no impact on either an individual's or the population's health.

II. Context

Oregon has been defining basic/essential/baseline benefits since the creation of the Health Services Commission (HSC) in 1989. The HSC is a twelve-member Governor-appointed, Senate-confirmed board consisting of five physicians (including one doctor of osteopathy), a dentist, a public health nurse, a social services worker and four consumer representatives. Since February 1994 the benefit package under Oregon's Medicaid demonstration has been determined by the legislature's funding of the HSC's Prioritized List of Health Services. The Prioritized List consists of 678 lines consisting of condition-treatment pairs (e.g., medical therapy for type I diabetes) ranked by importance based on clinical effectiveness, cost-effectiveness and public values. The prioritization methodology in effect since January 2008 places an emphasis on preventive services and chronic disease management. Lines 1-502 are currently covered for the OHP Plus population. The legislature has established additional

exclusions/limitations in determining the OHP Standard benefit package available to non-categorically eligible Oregon Health Plan clients.

In June 2008 the Oregon Health Fund Board's Benefits Committee presented its report recommending a high-deductible essential benefit package (EBP) for potential use in conjunction with an individual mandate. The EBP used the Prioritized List as a basis, dividing it into four different tiers, with cost sharing increasing as one moves to lower tiers on the List, with no coverage for Tier IV services (corresponding to nonfunded services under OHP Plus). Within the same tier, the EBP calls for reduced cost sharing for services accessed within a patient-centered primary care home. Also recommended was the development of a set of "value-based services" that should be provided with little or no cost sharing (outside of any deductible). These services should reduce downstream costs by lowering the incidence of preventable complications and preventing unnecessary emergency department visits. The EBP also calls for the identification of "discretionary services" that: 1) do not substantially avert downstream costs or adverse consequences of a disease or condition or 2) may substantially avert downstream costs or consequences of a disease or condition, but which are used to treat a disease or condition for which there are lower cost or more efficacious treatments available. The EBP suggests that additional limitations on coverage by duration, frequency and/or total dollar amount for these services be put in place.

The HSC is building upon the work of the OHFB Benefits Committee by developing lists of value-based services and discretionary services and making any changes necessary to the Prioritized List of Health Services to incorporate these concepts.

III. Timeline and Deliverables

Month	Staff Work	OHPB Input and Key Decision Points	Public & Stakeholder Engagement	Interim and Final Deliverables
January	Develop initial draft value-based services (VBS) based on systematic evidence reviews	Review work plan for baseline benefit package (BBP)	1/14/10 HSC meeting	Initial draft value-based services (VBS) & discretionary services (DS); Finalize 4/1/10 Prioritized List
February	Develop & send files for 4/1/10 Prioritized List for MMIS load	Hear presentation on OHFB work; Review initial draft VBS/DS	2/11/10 HSC meeting; Convene stakeholder group on cost sharing	Final draft VBS/DS
March	Identify modifications to line items including VBS		3/11/10 HSC Workgroup meeting	Population & Individual Impact Measures for modified line items
April	Produce draft 2012-13 Prioritized List using approved methodology		4/15/10 HSC Workgroup meeting	Proposed 2012-13 Prioritized List; Stakeholder group on cost sharing provides recommendations
May	Develop draft files for Actuarial Services Unit (ASU) based on	Presentation on proposed 2012-13 Prioritized List; review final draft	5/13/10 HSC meeting	2012-13 Prioritized List & final VBS/DS

	proposed 2012-13 Prioritized List	BBP with VBS/DS		
June	Send final files to ASU for 2012-13 Prioritized List; incorporated final BBP into draft exchange report			Overview included in draft Exchange and market reform report

IV. Dependencies

Federal Legislation: The differences between the Senate and House versions of health reform legislation will be ironed out through the conference process in early 2010. The shape of the final legislation, as well as whether the legislation passes out of both chambers once it is finalized, could have a significant impact on the benefits covered and cost sharing included in the baseline benefit package.

Parallel Work Efforts: Other projects are going on that affect the shape and timing of the baseline benefit package work, most notably the development of an exchange business plan and other market reforms that may affect the overall context in which the baseline benefit package is offered.

V. Stakeholder Input Process

In addition to the Oregon Health Policy Board meetings where this topic will be discussed, all Health Services Commission meetings, including those of its subcommittees, workgroups and task forces are open to the public, with time reserved for public comment. The HSC consistently reaches out to specialty providers for input involving services in their area of expertise. This model will be followed as the HSC develops lists of value-based services and discretionary services and the resulting Prioritized List of Health Services that reflects these new categories of service. The HSC has standing subcommittees with broad representation in the fields of mental health care, chemical dependency and oral health care from which to draw input from.

VI. Key Decision Points for Board

Early in the process (February), the Health Services Commission and its staff will receive the Health Policy Board's input on the work to develop lists of value-base services and discretionary services in shaping a baseline benefits package as proposed by the Oregon Health Fund Board's Benefits Committee. Before the HSC finalizes the baseline benefits package in May, the Board will have an opportunity to provide input and final direction, particularly in the area of cost sharing levels for the baseline benefit package.

VII. Staff Resources:

Sponsor: Jeanene Smith, MD
Lead Staff: Darren Coffman
Clinical Staff: Ariel Smits, MD, Catherine Livingston, MD

**Oregon Health Policy Board
Comprehensive Health Reform Plan Development
Draft Work Plan**

Presented to OHPB on January 12, 2010

I. Overview

HB 2009 assigns the Oregon Health Policy Board the responsibility of developing a plan to provide and fund access to affordable, quality health care for all Oregonians by 2015. The OHPB is to submit this plan to the Legislative Assembly by December 31, 2010.

The OHPB's work will build on the Oregon Health Fund Board's report "Aim High: Building a Healthy Oregon," which provided a vision for offering coverage to all Oregonians by:

- Expanding 100% access for all children and adults;
- Achieving a fully operationally Oregon Health Authority successfully implementing the OHFB-recommended reforms to help transform the health care system and improve the health of Oregonians; and
- Creating a health insurance exchange, an essential benefit package and other strategies designed to achieve 100% access to healthcare for all Oregonians.

The OHPB's task is to develop the next stage of this plan based on the reforms Oregon has begun and what is still to be accomplished, outlining concrete next steps. The comprehensive reform plan will seek to address the triple aim in the following ways.

Improves population health by:

- Increasing access to preventive and early care, in order to limit the impact of disease on the population as a whole

Improves the individual's experience of care by:

- Helping more people access high quality care when they need it and in more appropriate settings
- Allowing individuals to stay insured over the long-term, allowing them to form continuous relationships with their providers

Reduces per capita costs by:

- Expanding access to primary care services, reducing the utilization of costly and inefficient care in the emergency room and preventing unnecessary hospitalizations
- Reducing the cost shift to private payers so that more people have coverage and providers no longer need to recoup the cost of care for the uninsured by charging the insured more

II. Context

The work of the Oregon Health Fund Board and its committees and the direction provided by House Bill 2009 provide a solid foundation for developing the next stage of reform. Throughout 2010, Oregon will continue to implement coverage expansions for children and low-income adults, while implementing key delivery system reforms and developing a business plan for implementation of an exchange. Additionally, federal reform bills pending in Congress will greatly affect Oregon's reform plans if passed. The bills will contain funding and federal parameters for reforms, including a health insurance exchange, public subsidies, and insurance market reforms. The final plan submitted to the legislature in December 2010 will take into account the progress the state has made on reform work and integrate any new federal legislation.

III. Timeline and Deliverables

Oregon Health Policy and Research will prepare report outlines and drafts for Board review throughout the year, integrating program elements required by federal reform legislation if passed and current progress of reform activities in the state. After a period of initial public comment, a draft report will be provided to the Board in late summer/early fall 2010 for Board review and revision. A second public input period will be held and the report will be finalized based on the Board review of public comment in November. The final report will be submitted to the legislature by December 31, 2010.

Month 2010	Staff Work	OHPB Input and Key Decision Points	Public & Stakeholder Engagement	Interim and Final Deliverables
January	<ul style="list-style-type: none"> Development of draft outline. Monitor federal reform 			
February	<ul style="list-style-type: none"> Monitor federal Reform 	<ul style="list-style-type: none"> Review outline, modify as needed, and approve 		<ul style="list-style-type: none"> Draft outline of major components in plan
March	<ul style="list-style-type: none"> ID potential legislative Placeholders Monitor Federal Reform. If passes, incorporate in more detailed outline. 			
April	<ul style="list-style-type: none"> Staff provide more detailed outline, incorporating federal reform if applicable. 	<ul style="list-style-type: none"> Board provided more detailed outline of comprehensive plan for review and feedback. 	<ul style="list-style-type: none"> Public and stakeholder input solicited through various venues and media 	<ul style="list-style-type: none"> More detailed outline of major components in plan
May			<ul style="list-style-type: none"> Public input continues 	
June	<ul style="list-style-type: none"> Staff summarize public and stakeholder input 	<ul style="list-style-type: none"> Board reviews public input 		<ul style="list-style-type: none"> Summary of public input
July	<ul style="list-style-type: none"> Staff identify key decision points for Board 	<ul style="list-style-type: none"> Board provides input on key decision points 		
August		<ul style="list-style-type: none"> Board provided draft report for review 	<ul style="list-style-type: none"> Public input on draft report provided through various venues and media 	<ul style="list-style-type: none"> Draft comprehensive plan
September	<ul style="list-style-type: none"> Staff integrating Board input on draft plan Staff summarize public input 	<ul style="list-style-type: none"> Board provided summary of public input on draft plan 		<ul style="list-style-type: none"> Summary of public input
October	<ul style="list-style-type: none"> Staff work to finalize plan 			

November	<ul style="list-style-type: none"> Staff continue to finalize plan document 	<ul style="list-style-type: none"> Board provided draft plan for final tweaking 		
December		<ul style="list-style-type: none"> Board submits final comprehensive plan 		Final comprehensive plan

IV. Dependencies

The final reform plan submitted by the OHPB to the legislature will need to integrate elements from the following areas:

- Passage of federal reform;
- Key timelines and recommendations for development of a health insurance exchange, public plan option, and other insurance market reforms; and
- Current status of key health system and public health reforms already underway.

V. Stakeholder Input Process

During the development of the comprehensive plan, the OHPB can utilize the strong foundation of public input received during the Oregon Health Fund Board process. Additionally, the process outlined above provides for two very broad and inclusive public input periods. One of these periods will follow the development of the detailed outline for the report and is intended to solicit input on what Oregonians want to see included in the comprehensive plan. The second public input period will allow Oregonians to respond to the draft full report and have their concerns considered as the report is finalized. Opportunities for public input will include invited testimony at board meetings, public forums, and submission of input by email or mail.

VI. Key Decision Points for Board

The timeline above provides the Board with many opportunities to review and shape the content as the comprehensive reform plan is being developed. Additionally, the Board will have the opportunity to review and discuss public input received and determine how best to incorporate that input in the final report.

VII. Staff Resources: Jeanene Smith, MD and Gretchen Morley, Office for Oregon Health Policy and Research

**Oregon Health Policy Board
Insurance Market Reform
Draft Work Plan**

Presented to OHPB on January 12, 2010

I. Reform Initiative Overview

State Legislation: House Bill 2009 (Chapter 595, Oregon Laws 2009) directs the Oregon Health Authority to develop plans for the following insurance market reforms: an insurance exchange; a public health insurance plan option; and reinsurance strategies.

- The Oregon Health Authority, in consultation with the Director of the Department of the Department of Business and Consumer Services, will develop a plan for the staffing, funding and administration of the Oregon Health Insurance Exchange within the Oregon Health Authority. The plan is due to the Legislature by December 31, 2010. [HB 2009, Section 17(1)]
- The Oregon Health Authority will develop a plan for the development of a publicly owned health benefit plan that operates within the exchange. The plan is due to the Legislature by December 31, 2010. [HB 2009, Section 9(1)(j)]
- House Bill 2009 indicated that the exchange plan may include a determination of the need to develop and implement a reinsurance program. [HB 2009, Section 1(b)(G)]

House Bill 2755 directs the Department of Consumer and Business Services to work with the Office for Oregon Health Policy and Research on a study of the options available for using reinsurance and other risk-spreading mechanisms in the individual and small employer group health insurance markets. The report, which is due by December 1, 2010, will focus on the following topics:

- Whether a single state reinsurance plan is feasible, would offer value to individual and small employer group health insurance markets, and provide savings to consumers;
- Whether health insurance markets other than individual and small employer group health insurance markets would benefit from reinsurance alternatives; and
- If reinsurance alternatives adopted in other states and being considered by the federal government could be implemented in Oregon.

Federal Legislation: The House and Senate both passed versions of national health reform legislation in 2009. It is expected that the two versions of the reform bill will be reconciled through the conference process. The resulting bill may then be passed by both houses. It appears likely that the compromise bill will look more like the Senate's version than that produced by the House. Both versions include an exchange. The Senate bill creates state-based exchanges, while the House bill creates a single national exchange (but does allow states to start their own as well).

Intended Outcomes: Improve Oregonians' access to affordable, accessible health insurance.

Market reforms (including an exchange, a public plan option and a risk-spreading mechanism such as reinsurance) can be contributing factors in the effort to improve population health, the individual's experience of care, and the cost of care. Such an impact is increased when these reforms are established within the context of other market reforms (such as an individual mandate, premium subsidies and a guaranteed issue market).

Improve population health by: Increasing access to affordable, quality health insurance

Improve the individual's experience of care by: Improving consumers' understanding of available choices

Reduce per capita costs by: Increasing competition on price instead of risk selection

II. Timeline and Deliverables

Month 2010	Staff Work	Board Input, Key Decision Points	Public/Stakeholder Engagement	Interim and Final Deliverables
January	<ul style="list-style-type: none"> Develop straw plan Follow federal reform 			
February	<ul style="list-style-type: none"> Present straw plan development work Develop straw plan Follow federal reform 	<ul style="list-style-type: none"> Review exchange design options Education on federal bill progress 		<ul style="list-style-type: none"> Straw plan options document
March	<ul style="list-style-type: none"> Submit placeholder legislative concepts to DHS Follow federal reform 			
April	<ul style="list-style-type: none"> Submit placeholder legislative concepts to DAS Follow federal reform 	<ul style="list-style-type: none"> Review written update 	<ul style="list-style-type: none"> Targeted stakeholder input on straw plans 	<ul style="list-style-type: none"> Update on exchange and market reform development progress
May	<ul style="list-style-type: none"> Flesh out exchange and market reform work based on stakeholder input, develop detailed report outline Follow federal reform 			
June	<ul style="list-style-type: none"> Utilize board feedback to begin draft report 	<ul style="list-style-type: none"> Review/provide feedback on key decision points 		<ul style="list-style-type: none"> Detailed outline on report and key decisions
July	<ul style="list-style-type: none"> Write draft report 			
August	<ul style="list-style-type: none"> Edit draft report based on input 		<ul style="list-style-type: none"> Get feedback on draft recommendations 	
September	<ul style="list-style-type: none"> Prepare draft legislative concepts for possible 2011 legislation 	<ul style="list-style-type: none"> Draft report to board 		<ul style="list-style-type: none"> Draft report

Month 2010	Staff Work	Board Input, Key Decision Points	Public/Stakeholder Engagement	Interim and Final Deliverables
October	<ul style="list-style-type: none"> Finalize legislative concepts Prepare report for board review 			<ul style="list-style-type: none"> Legislative concepts due DCBS/OHPR status report on reinsurance work due to Legislature
November	<ul style="list-style-type: none"> Finish final draft report for board review Incorporate comments into final report 	<ul style="list-style-type: none"> Review and approve final report 		
December	<ul style="list-style-type: none"> Finalize report to legislature 			<ul style="list-style-type: none"> Final exchange and market reform report due DCBS/OHPR reinsurance report due to Legislature

III. Dependencies

Federal Legislation: The differences between the Senate and House versions of health reform legislation will be ironed out through the conference process in early 2010. The shape of the final legislation, as well as whether the legislation passes out of both chambers once it is finalized, will have a huge impact on the work laid out in Oregon's House Bill 2009. Without passage of federal reform, the dollars attached to the current bills would not come to the states.

Parallel Work Efforts: Several other projects are going on that affect the shape and timing of market reform and exchange development work. This includes the work on the comprehensive plan for coverage and financing, an essential benefit package, and a small business product.

IV. Stakeholder Input Process

As noted in Section II (Timelines and Deliverables), stakeholders will be consulted for their input at two key points. In April staff will work with a variety of stakeholder groups from a range of perspectives to get their feedback on several proposed straw plans. This input will be used, along with Board feedback, to develop a draft report on exchange development. In August, stakeholder groups will be consulted for their thoughts on the draft recommendations. This input will be used to help draft a report for Board review and comment.

Stakeholder feedback will occur through discussions with groups engaged in health care and health reform in Oregon. Staff will work with group organizers to schedule discussions at the groups' regular meetings whenever possible. Where needed, staff will arrange other meetings with stakeholder groups to collect input on the straw plans and proposed recommendations.

In addition, public comment will be received by the board in person and in writing.

V. Key Decision Points for Board

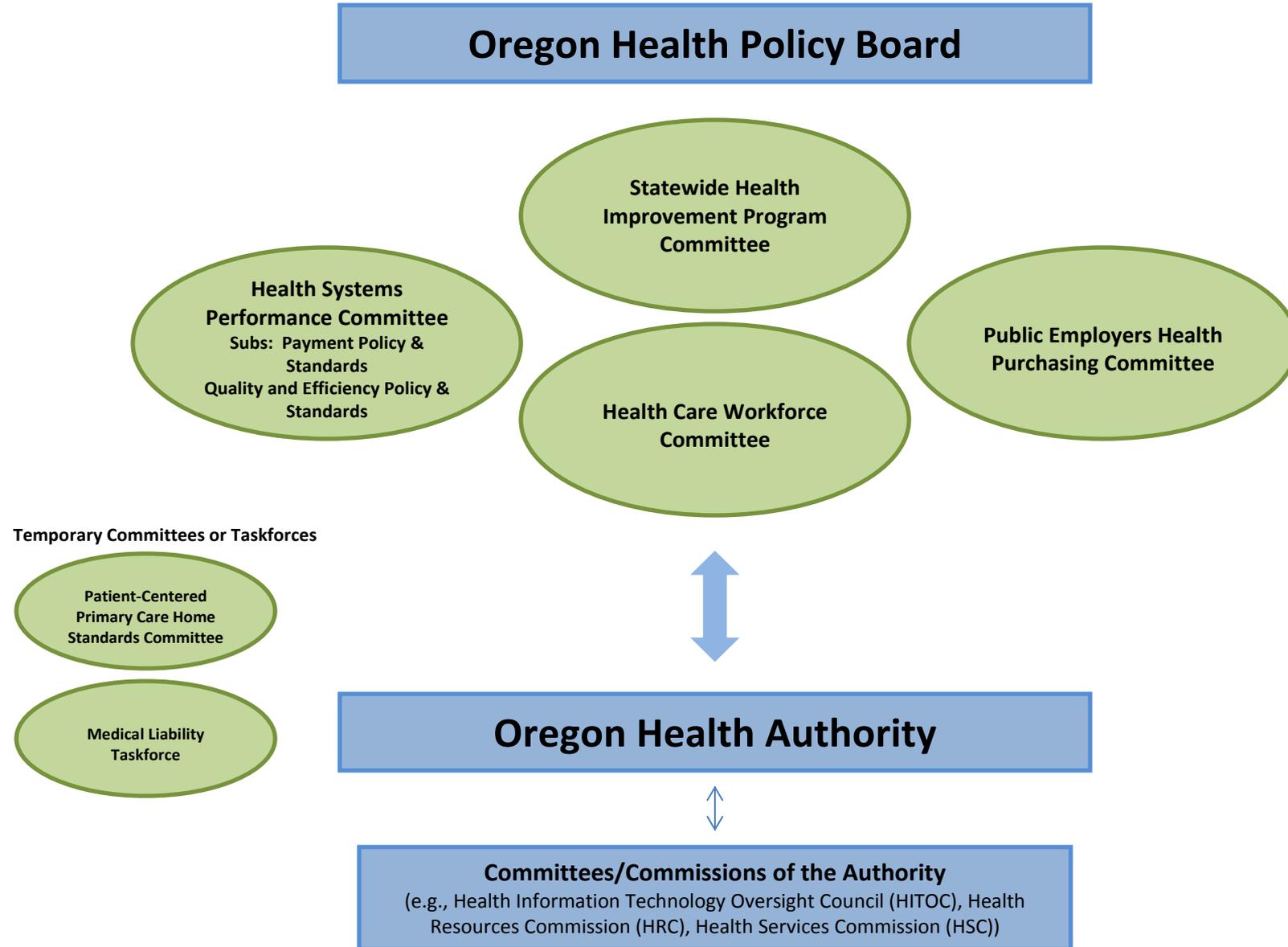
The development of an exchange poses several layers of issues. A series of what can be described as “functional” questions must be answered in the development of a plan. These include issues in the following areas:

- Exchange functions
 - Will the exchange provide information only, enrollment, benefit standardization?
- Health Plans, including:
 - What is a qualified plan?
 - How many plans will participate?
 - How many and what insurance products will be offered?
- Eligible individuals, including:
 - Who will be eligible to participate?
 - Will individuals accessing subsidies be required to use the exchange?
 - Where will non-eligible individuals get insurance?
- Businesses, including:
 - How will employers contribute to employees' coverage?
- Risk Adjustment
 - How to manage risk inside and outside of the exchange?
- Subsidies
- Regulation of plans inside the exchange
 - Are rating rules fine as they are or do they need some adjustment?

VI. Staff Resources

Barney Speight, Oregon Health Authority
Nora Leibowitz, Office for Oregon Health Policy and Research

Oregon Health Policy Board Committee Structure



**Oregon Health Policy Board
Decision Making
&
Policy Implementation/Improvement Cycle**

