

Oregon Health Policy Board

AGENDA

July 2, 2013

Market Square Building
1515 SW 5th Avenue, 9th floor
8:30 a.m. to noon

Live web streamed at: [OHPB Live Web Streaming](#)

#	Time	Item	Presenter	Action Item
1	8:30	Welcome, call to order and roll Action item: 6/4/13 minutes	Chair	X
2	8:35	Director's Report: Legislative update	Bruce Goldberg, OHA	
3	9:00	Medicaid Advisory Committee: Strategies on person- and family-centered engagement	Karen Gaffney, MAC co-chair Oliver Droppers, OHA	
	9:45	Break		
4	10:00	Work plan to address Governor's request: Rate review, transparency, accountability and cost shift	Jeff Scroggin, OHA	
5	10:20	Coordinated Care Model Alignment group: Draft charter and charge	Jeff Scroggin, OHA	X
6	10:40	Transparency and accountability & coverage and access framework discussion	Tina Edlund, OHA Jeff Scroggin, OHA	
7	11:45	Public Testimony	Chair	
	noon	Adjourn		

Next meeting:

August 6, 2013

1:00 to 4:00 p.m.

Market Square Building

1515 SW 5th Avenue, 9th floor

Oregon Health Policy Board

DRAFT Minutes

June 4, 2013

1 pm to 4 pm

Market Square Building
1515 SW 5th Ave, 9th Floor
Portland, OR 97201

Item

Welcome and Call To Order

Chair Eric Parsons called the Oregon Health Policy Board (OHPB) meeting to order. All Board members were present.

Tina Edlund and Bruce Goldberg were present from the Oregon Health Authority (OHA).

Consent Agenda:

The meeting minutes from April 2, 2013 were approved pending the addition of an agreement to follow up on the impacts of medical liability legislation.

The meeting minutes from May 7, 2013 were unanimously approved.

Director's Report and Legislative Update – Bruce Goldberg

Dr. Goldberg gave an update on current legislative activity:

- The liability reform legislation has passed.
- The four Affordable Care Act alignment bills are on their way toward passage. HB 2091 passed June 4, by a 29-0 vote, aligning the Healthy Kids program. There are three other bills to go: HB 3458, the state supplemental re-insurance bill as well as the two bills that align state law with new federal law, HBs 2240 and 2859. All the bills have passed through the House and are making their way through the Senate. The health plan budget is very close to passing.
- The provider assessment is tied into non health care related issues but we are hopeful the assessment will pass in the next few weeks.
- With the passage of SB 823 there is alignment and an investment will be seen in community addictions and mental health system which is the root cause issue around the health transformation system.

The Klamath Falls CCO will be up and running. A memorandum of understanding was recently signed and they will be up and operational as a CCO in August or September.

Quarterly Report Review – Tina Edlund

Tina Edlund presented the first quarterly report which was issued May 2013. The report provides status updates on the state's progress towards its goals of better health, better care and lower costs. OHA will publish quarterly reports showing performance data, financial data, and progress toward reaching benchmarks, beginning with the 2011 baseline data shown in the first report.

The next quarterly report will be released August, 2013.

View the Quarterly Report presentation [here](#), starting on page 7.

OHPB goals and progress – Tina Edlund

Edlund reviewed the goals that the board set for itself in its 2010 *Action Plan for Health* and gave an update on progress made in each of the following focus areas:

- Set a target for health care spending in Oregon
- Align purchasing
- Reduce administrative costs in health care

- Decrease obesity and tobacco use
- Establish a mission-driven public corporation to serve as the legal entity for the Oregon Health Insurance Exchange
- Promote local and regional accountability for health and health care
- Build the health care workforce
- Move to patient-centered primary care (PCPCH), first for OHA lives (Medicaid, state employees, educators) and then statewide
- Introduce a value-based benefit design that removes barriers to preventive care.
- Expand the use of health information technology (HIT) and exchange (HIE)
- Develop guidelines for clinical best practices
- Strengthen medical liability system

An updated status on the progress made toward those goals can be viewed in the OHPB Goals and Progress document [here](#), starting on page 25.

OHPB next steps

The Board discussed possible next steps for Governor Kitzhaber's request for recommendations to better align Affordable Care Act implementation activities and Oregon's current reform efforts.

Gov. Kitzhaber asked that the recommendations include:

- Strategies to mitigate cost shifting, decrease health insurance premiums and increase overall transparency and accountability;
- Opportunities to enhance the Oregon Insurance Division's rate review process;
- Alignment of care model attributes within PEBB and OEGB contracts;
- Alignment of care model attributes within Cover Oregon's qualified health plans.

The Board requested that OHA staff present a work plan at the next meeting that will address how to create an affordable, sustainable system.

Governor Kitzhaber's letter to the Oregon Health Policy Board can be viewed [here](#).

Cover Oregon– Rocky King and Nora Leibowitz

Rocky King, Cover Oregon director, and Nora Leibowitz provided an update on Cover Oregon. King took the board through Cover Oregon's web portal and demonstrated many of the features that will be available to consumers when the portal opens in October:

- When consumers are searching for health care plans, they will be able to search by several different criteria, such as geography, price and provider.
- Cover Oregon open enrollment begins October 2013. On January 1, 2014, coverage begins.
- Cover Oregon is providing consumers with carrier quality ratings starting in the 2013 open enrollment period. The goal is to help consumers make an equal comparison on more than just cost. This is a five year project; there will be enhancements, expansions and new requirements. In October 2014, request for proposals for 2016 plan year will be developed. There will be alignment with PEBB, OEGB, CCOs and other large purchasers.

View the Cover Oregon presentation [here](#), starting on page 38.

PEBB: Alignment with Coordinated Care Model – Sean Kolmer,

Sean Kolmer, PEBB Board Chair, gave an update on PEBB, including background on PEBB's mission and duties, and its alignment with the coordinated care model.

- PEBB board is governor appointed and senate confirmed.
- PEBB purchases care for 130,000 Oregonians statewide. PEBB's mission is better health and better care at a price we can all afford.

- PEBB is currently planning a request for proposals to go out in the fall. Selected plans would take effect January 2015. The objective is to bring the coordinated care model into PEBB. PEBB will be looking for plans that can provide coordinated care, meet high standards of quality, involve consumers and patients in health, prioritize preventative care and other services with proven value, provide efficient, patient-centered care and stay within a sustainable rate of growth.

The PEBB Alignment presentation can be viewed [here](#), starting on page 64.

Public Testimony

The Board heard testimony from one person:

Dean Robinson, Sanofi, said that he was impressed and encouraged by the Board's discussion. He said questions about the focus on quality as opposed to access were integral to the issues.

Adjourn

Next meeting:

July 2, 2013

8:30 a.m. to 12 p.m.

Market Square Building

1515 SW 5th Ave, 9th Floor

Portland, OR 97201

Enrolled House Bill 2859

Sponsored by COMMITTEE ON HEALTH CARE

CHAPTER

AN ACT

Relating to medical assistance; creating new provisions; amending ORS 1.198, 18.784, 18.838, 18.847, 25.381, 30.800, 93.967, 93.969, 97.939, 108.725, 109.811, 113.085, 113.086, 114.305, 114.515, 114.517, 115.125, 115.195, 125.170, 130.425, 166.715, 179.505, 183.458, 192.588, 293.231, 314.860, 409.010, 410.150, 410.490, 411.010, 411.070, 411.081, 411.087, 411.095, 411.119, 411.141, 411.159, 411.400, 411.402, 411.404, 411.406, 411.408, 411.435, 411.439, 411.443, 411.610, 411.620, 411.630, 411.632, 411.635, 411.640, 411.660, 411.670, 411.675, 411.690, 411.694, 411.703, 411.795, 411.802, 411.965, 411.967, 411.969, 411.970, 413.109, 413.175, 414.025, 414.041, 414.065, 414.095, 414.115, 414.231, 414.428, 414.534, 414.536, 414.706, 414.709, 414.727, 414.736, 414.740, 414.841, 414.842, 414.848, 414.862, 416.340, 416.350, 419B.373, 419C.550, 426.300, 435.215, 689.778 and 735.625 and section 6, chapter 290, Oregon Laws 1987, section 9, chapter 736, Oregon Laws 2003, section 20, chapter 595, Oregon Laws 2009, and section 1, chapter 867, Oregon Laws 2009; repealing ORS 411.431, 411.432, 414.707, 414.708, 414.750, 414.866, 414.868, 414.870 and 414.872; and declaring an emergency.

Be It Enacted by the People of the State of Oregon:

SECTION 1. (1) All applicants for and recipients of medical assistance, as defined in ORS 414.025, shall be treated in a courteous, fair and dignified manner by Oregon Health Authority employees.

(2) Any applicant or recipient who alleges discourteous, unfair or undignified treatment by an authority employee or alleges that an authority employee has provided incorrect or inadequate information regarding medical assistance programs may file a grievance with the authority. The authority shall publicize the grievance system in each office of the authority that is open to the public.

(3) The grievance shall be discussed first with the supervisor of the employee against whom the grievance is filed. If the grievance is not resolved, the applicant or recipient may discuss the grievance with the manager of the office.

(4) The authority shall compile a monthly report that summarizes each grievance filed against an authority employee and the action taken. The report shall identify each grievance by office and indicate the number of grievances filed against each authority employee. The report shall protect the anonymity of authority employees. The report shall be provided to the Medicaid Advisory Committee established under ORS 414.211.

NOTE: Section 2 was deleted by amendment. Subsequent sections were not renumbered.

SECTION 3. ORS 1.198 is amended to read:

1.198. (1) ORS 1.197 does not apply to liquidated and delinquent accounts that are:

(a) Prohibited by state or federal law or regulation from assignment or collection; or

(d) Provide health services described in ORS 414.025 [(8)] (7) to individuals: [*described in ORS 414.025 (3)(f)(B)*]

(A) Who are 18 years of age or older and for whom federal financial participation is available under Title XIX or XXI of the Social Security Act;

(B) Who, immediately prior to their 18th birthday, were in foster family homes or licensed child-caring agencies or institutions; and

(C) For whom a public agency of this state was assuming financial responsibility, in whole or in part.

(3) The authority shall develop a system for reimbursement by the authority to the Office of Private Health Partnerships out of the Health System Fund for costs associated with administering the private health option pursuant to ORS 414.826.

SECTION 98. ORS 411.431, 411.432, 414.707, 414.708, 414.750, 414.866, 414.868, 414.870 and 414.872 are repealed.

SECTION 99. ORS 411.159 is added to and made a part of ORS 410.595 to 410.625.

SECTION 100. (1) The Oregon Health Authority shall establish a program to provide grants to coordinated care organizations to fund pilot projects designed to improve patient engagement in and patient accountability for a patient's own health, disease prevention and wellness activities. To receive a grant through the program, a coordinated care organization must submit an application to the authority, no later than January 1, 2014, that includes:

(a) A proposal detailing the pilot project;

(b) An explanation of how the organization intends to promote patient responsibility and improve health care outcomes for patients through the pilot project;

(c) The incentives or penalties that the organization will utilize in the pilot project; and

(d) The goals of the pilot project and how the success of the pilot project will be measured.

(2) The Governor shall petition the federal government for waivers of any federal laws that prevent the implementation of the pilot projects.

SECTION 101. (1) The Task Force on Individual Responsibility and Health Engagement is established, consisting of 11 members appointed as follows:

(a) The President of the Senate shall appoint two members of the Senate, one of whom is a Democrat and one of whom is a Republican.

(b) The Speaker of the House of Representatives shall appoint two members of the House of Representatives, one of whom is a Democrat and one of whom is a Republican.

(c) The Governor shall appoint seven persons, at least two of whom are receiving medical assistance.

(2) Under the direction of the Governor, the task force shall develop recommendations for legislation that will establish mechanisms to meaningfully engage medical assistance recipients in their own health, disease prevention and wellness activities, in addition to the pilot projects authorized by section 100 of this 2013 Act. The task force shall prioritize recommendations that:

(a) Use incentives or disincentives;

(b) Encourage partnerships between medical assistance recipients and their health care providers;

(c) Are appropriate to the cultural and economic circumstances of medical assistance recipients;

(d) Can be implemented rapidly upon receipt of any necessary federal approval; and

(e) Represent best practices and are evidence-based with respect to medical assistance recipients.

(3) The task force may receive testimony or reports from persons or agencies that are nationally recognized experts in the field, as appropriate.

(4) A majority of the members of the task force constitutes a quorum for the transaction of business.

(5) Official action by the task force requires the approval of a majority of the members of the task force.

(6) The task force shall elect one of its members to serve as chairperson.

(7) If there is a vacancy for any cause, the appointing authority shall make an appointment to become immediately effective.

(8) The task force shall meet at times and places specified by the call of the chairperson or of a majority of the members of the task force.

(9) The task force may adopt rules necessary for the operation of the task force.

(10) The task force shall submit its recommendations, in the manner provided in ORS 192.245, to the appropriate interim committees of the Legislative Assembly no later than November 1, 2013.

(11) The Oregon Health Authority shall provide staff support to the task force.

(12) Members of the task force who are not members of the Legislative Assembly are not entitled to compensation, but may be reimbursed for actual and necessary travel and other expenses incurred by them in the performance of their official duties in the manner and amounts provided for in ORS 292.495.

(13) All agencies of state government, as defined in ORS 174.111, are directed to assist the task force in the performance of its duties and, to the extent permitted by laws relating to confidentiality, to furnish such information and advice as the members of the task force consider necessary to perform their duties.

SECTION 102. The costs of the pilot projects described in section 100 of this 2013 Act shall be paid from funds in the legislatively adopted budget that are allocated to the Oregon Health Authority to provide innovation grants to coordinated care organizations.

SECTION 103. Section 101 of this 2013 Act is repealed on the date of the convening of the 2014 regular session of the Legislative Assembly as specified in ORS 171.010.

SECTION 104. The Oregon Health Authority, the Department of Human Services and the Oregon Health Insurance Exchange Corporation may take any action prior to January 1, 2014, necessary to carry out sections 1 and 99 of this 2013 Act, the amendments to ORS 1.198, 18.784, 18.838, 18.847, 25.381, 30.800, 93.967, 93.969, 97.939, 108.725, 109.811, 113.085, 113.086, 114.305, 114.515, 114.517, 115.125, 115.195, 125.170, 130.425, 166.715, 179.505, 183.458, 192.588, 293.231, 314.860, 409.010, 410.150, 410.490, 411.010, 411.070, 411.081, 411.087, 411.095, 411.119, 411.141, 411.159, 411.400, 411.402, 411.404, 411.406, 411.408, 411.435, 411.439, 411.443, 411.610, 411.620, 411.630, 411.632, 411.635, 411.640, 411.660, 411.670, 411.675, 411.690, 411.694, 411.703, 411.795, 411.802, 411.965, 411.967, 411.969, 411.970, 413.109, 413.175, 414.025, 414.041, 414.065, 414.095, 414.115, 414.231, 414.428, 414.534, 414.536, 414.706, 414.709, 414.727, 414.736, 414.740, 414.841, 414.842, 414.848, 414.862, 416.340, 416.350, 419B.373, 419C.550, 426.300, 435.215, 689.778 and 735.625 and section 6, chapter 290, Oregon Laws 1987, section 9, chapter 736, Oregon Laws 2003, section 20, chapter 595, Oregon Laws 2009, and section 1, chapter 867, Oregon Laws 2009, by sections 3 to 97 of this 2013 Act and the repeal of ORS 411.431, 411.432, 414.707, 414.708, 414.750, 414.866, 414.868, 414.870 and 414.872 by section 98 of this 2013 Act on and after January 1, 2014.

SECTION 105. Sections 1 and 99 of this 2013 Act, the amendments to ORS 1.198, 18.784, 18.838, 18.847, 25.381, 30.800, 93.967, 93.969, 97.939, 108.725, 109.811, 113.085, 113.086, 114.305, 114.515, 114.517, 115.125, 115.195, 125.170, 130.425, 166.715, 179.505, 183.458, 192.588, 293.231, 314.860, 409.010, 410.150, 410.490, 411.010, 411.070, 411.081, 411.087, 411.095, 411.119, 411.141, 411.159, 411.400, 411.402, 411.404, 411.406, 411.408, 411.435, 411.439, 411.443, 411.610, 411.620, 411.630, 411.632, 411.635, 411.640, 411.660, 411.670, 411.675, 411.690, 411.694, 411.703, 411.795, 411.802, 411.965, 411.967, 411.969, 411.970, 413.109, 413.175, 414.025, 414.041, 414.065, 414.095, 414.115, 414.231, 414.428, 414.534, 414.536, 414.706, 414.709, 414.727, 414.736, 414.740, 414.841, 414.842, 414.848, 414.862, 416.340, 416.350, 419B.373, 419C.550, 426.300, 435.215, 689.778 and 735.625 and section 6, chapter 290, Oregon Laws 1987, section 9, chapter 736, Oregon Laws 2003, section 20, chapter 595, Oregon Laws 2009, and section 1, chapter 867, Oregon Laws 2009, by

sections 3 to 97 of this 2013 Act and the repeal of ORS 411.431, 411.432, 414.707, 414.708, 414.750, 414.866, 414.868, 414.870 and 414.872 by section 98 of this 2013 Act become operative January 1, 2014.

SECTION 106. This 2013 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2013 Act takes effect on its passage.

Passed by House May 28, 2013

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Ramona J. Line, Chief Clerk of House

.....
Tina Kotek, Speaker of House

Passed by Senate June 20, 2013

.....
Peter Courtney, President of Senate

Received by Governor:

.....M.,....., 2013

Approved:

.....M.,....., 2013

.....
John Kitzhaber, Governor

Filed in Office of Secretary of State:

.....M.,....., 2013

.....
Kate Brown, Secretary of State



**Office for
Oregon Health Policy and Research**

**Person- and Family-Centered Care and Engagement
Medicaid Advisory Committee
Full Report and Recommendations**

July 2013

**Oregon
Health
Authority**



Office for Oregon Health Policy and Research

John A. Kitzhaber, MD, Governor



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July 2, 2013

Chairs, Oregon Health Policy Board
Oregon Health Authority

Dear Chairs Parsons and Shirley and members of the Board:

The Medicaid Advisory Committee strongly believes that person- and family- centered engagement in health and health care serves as the most direct route to achieving Oregon's three-part aim for individuals served by the Oregon Health Plan (OHP). This conviction is reinforced by an increasing body of evidence that indicates individuals who are more engaged in their own health and health care experience better health outcomes, better experience of care, and incur lower medical costs. This is particularly the case when services and supports are tailored to their individual needs, goals, preferences, and circumstances with the input of the member and their families, in partnership with their health care team.

Recognizing the importance of OHP members' willingness and ability to engage in and manage their own health and health care, the Committee spent six months exploring a range of strategies to support this goal. The process comprised an extensive review of research and testimony from a diverse range of stakeholders and national experts on approaches and experiences from both commercial and state Medicaid programs. The Committee determined that strategies focused on cost-sharing, or the use of financial disincentives could have negative and unintended effects for OHP members. Furthermore, there is limited evidence that supports the use of financial incentives/disincentives in Medicaid, and is restricted by federal law.

The Committee opted to focus on a set of strategies and actions designed to coordinate, align and promote person- and family-centered activities statewide aimed at engaging OHP members in their health and health care. The goal is to further realize OHP members' full potential for improving and maintaining their health and for serving as active partners in a transformed health system that spans the Oregon Health Authority (OHA), Coordinated Care Organizations (CCOs), Patient-Centered Primary Care Homes (PCPCHs), other health care settings, and members' homes and communities.

Anchoring the Committee's work is the recognition that in order to think about health and health care differently policy makers, legislators, health care executives, providers, community leaders, and other key stakeholders participating in Oregon's historic Health System Transformation need to both think and talk about it differently. This entails continuing to shift away from the conventional medical model focused on disease treatment to thinking about, and caring for, the whole person, focusing on prevention and promoting health and wellness. For this reason, the Committee adopted preferred language, using the terms person (or individual) and family when talking about those who engage or are engaged in their health and health care.

The Committee also explicitly acknowledges that the prevailing nomenclature used in health care too often refers to individuals as patients instead of persons (i.e. individuals by categories as dual eligibles, patients, and consumers, rather than person). Examples include patient-engagement, patient-activation, and patient-centered care. In opting to move away from using the term "patient" and toward "person-centered" when possible, the Committee is also conscious of the undesirable and unintended connotations associated with the term patient. This subtle distinction recognizes that the term "patient" may connote passivity, as well as the historical patient-provider relationship, wherein a patient is one who relies on his or her providers to make health related decisions on his or her behalf. The Committee believes the preferred terminology, "person and family," transcends the varying roles and responsibilities individuals, their families, and representatives/advocates have regarding their health and well-being, and the characterization of those roles, which are often heavily influenced by their audience and context, are of particular importance for OHP members. This is an intentional effort to both encompass and respect an individual's needs, values, ability to engage, cultural traditions and family situation.

In closing, while concepts and strategies discussed in this report are applicable to a variety of populations, the Committee is charged with developing strategies for individuals enrolled as members in the Oregon Health Plan. The Committee believes the strategies put forward in this report, if implemented, will help further health system transformation in support of all Oregonians.

Sincerely,



Janet E. Patin, MD
Co-Chair, Medicaid Advisory Committee



Karen Gaffney, MS
Co-Chair, Medicaid Advisory Committee

Medicaid Advisory Committee Report

Submitted to Oregon Health Policy Board

July, 2013

Medicaid Advisory Committee Members

Janet Patin, MD – Co-Chair

Karen Gaffney, MS – Co-Chair

Romnee Auerbach, MS, ANP, PMHNP-BC

Lenore Bijan

Karen Berkowitz, JD

Rhonda Busek, MBA

Meghan Caughey, MA, MFA

Carol Criswell, BA

Leslie Sutton, JD

Dick Stenson, MHA, MBA, FACHE, FACMPE

Thomas Turek, MD

Staff

Oliver Droppers, MPH, Director, Oregon Medicaid Advisory Committee

Jeannette Nguyen-Johnson, MPH

If you would like additional copies of this report, or if you need this material in an alternate format, please call Lori Elliott at (503) 373-2275.

Executive Summary

The Oregon Medicaid Advisory Committee (MAC) believes that engaging a person and their family in their own health and health care is a critical aspect of achieving Oregon's three-part aim of:

- Improving the lifelong health of Oregonians;
- Increasing the quality, reliability, and availability of care for all Oregonians; and
- Lowering or containing the cost of care so it's affordable to everyone.

In an effort to build on the foundation of Oregon's health reform efforts, the Committee developed a set of strategies and key actions that will support Oregon Health Plan (OHP) members to become more engaged and informed decision-makers enhance their ability to manage their health and health care, and support individuals in becoming more active participants in Oregon's health system.* The strategies, critical to improving health outcomes among less advantaged Oregonians, are presented as a framework for enhancing policies and interventions aimed at supporting person and family engagement at all levels of Oregon's Health System Transformation.¹ The actions are designed specifically to address the diverse backgrounds and complex needs of current and future OHP members.

In developing the strategies, the Committee carefully reviewed and identified gaps as well as opportunities to build on existing activities already supported by OHA's Patient Centered Primary Care Home (PCPCH) Program, Coordinated Care Organizations (CCOs), and other key reform efforts. The Committee's full report includes background information, an overview of the committee process, key policy considerations, and supporting evidence for the proposed set of strategies and actions. The executive summary provides a synopsis of the key recommended strategies, rationale and actions for each strategy, and is intended to inform and guide Oregon's transformation to a high-performance health system.

Committee Process

The Committee began its work by examining strategies designed to encourage individuals to take ownership of their health and health care by promoting personal responsibility and quality- and cost-conscious decision-making. Starting with the commercial market, the Committee reviewed consumer-directed approaches that use mechanisms focused on benefit design and the use of financial levers to urge individuals to make more cost-sensitive decisions. A common form of this approach is a health savings account linked with a high

* Broadly inclusive of groups such as Oregon Health Plan members, their families and/or representatives, providers, practices, community clinics, hospitals, local health departments, the Oregon Health Authority and Department of Human Services, other culturally and linguistically diverse community members (such as race/ethnicity, Limited English Proficient individuals, people with disabilities, across the life-span, people with mental health and/or addictions issues, social services organizations, consumer advocacy groups, the community-at-large, etc.).

deductible health plan. Proponents of this approach believe that a consumer in control of, and at greater risk for, his or her health care costs will be better engaged, and may make more appropriate health and health care utilization decisions.²

Early in the Committee's work, however, the MAC recognized that even nominal cost-sharing including premiums and co-pays, can serve as a barrier to accessing necessary preventive and primary care services for low-income and other vulnerable populations. Cost-sharing can also result in unintended consequences such as increased use of the emergency department after delaying care.^{3,4} Furthermore, past experience in Oregon and in other states demonstrates that implementing cost-sharing in Medicaid is complex and administratively burdensome, wherein costs often outweigh anticipated state savings.⁵ Finally, federal law imposes strict cost-sharing limitations and benefit design requirements for all Medicaid populations. Thus, federal requirements currently restrict the use of such approaches in Oregon's current health care environment.⁶

Subsequently, the Committee reviewed available research and information from state Medicaid incentive programs that use a variety of approaches, including financial and non-financial incentives, to promote healthy behavior and appropriate utilization of health care among their members. Examples include Florida's Enhanced Benefits Reward\$ Program and Idaho's Preventive Health Assistance program. Early findings from these states indicate that program effectiveness would be improved by better addressing the *challenges* Medicaid members face to participating in such programs, such as lack of awareness and understanding of the program, and *barriers* to adopting healthy behaviors, such as limited transportation options to access both health care services and healthy activities. To date, there is limited evidence on the efficacy and cost-effectiveness of such approaches within state Medicaid programs.⁷

The Committee considered an growing body of evidence that shows individuals, who are more engaged in their own health and health care, experience better health outcomes and incur lower medical costs.^{8,9} Individuals that are more highly engaged and activated are less likely to have unmet medical needs; more likely to have regular check-ups, including screenings and immunizations; adhere to treatment and obtain regular chronic care services; and, engage in health behaviors such as eating a healthy diet, regular exercise, and avoid adverse behaviors such as smoking and illegal drug use.^{10,11,12} This is particularly the case when services and supports are tailored to their individual needs, goals, preferences, and circumstances.¹³ The Committee believes that innovative approaches, designed to improve individual engagement and accountability for one's own health in a person-and family-centered health system, will ultimately support the achievement of Oregon's three-part aim for all OHP members.

Recommendations

The recommended policy strategies seek to enhance alignment, coordination and create synergy among person- and family-centered efforts already underway through Oregon's Health System Transformation. The key is to effectively and equitably engage individuals and their families across all levels of the health system. Paramount to this is addressing the unique barriers and challenges experienced among OHP members. The continuum of person- and family-centered engagement in care is characterized across three levels: (1) direct patient care and partnership(s), (2) integration of patients' values in the design and governance of health care organizations, and (3) shared leadership and policy making that's responsive to patients' perspectives.¹⁴

The MAC envisions a number of key actors to help adopt and implement these strategies. Key partners include members of the OHP and their families and/or representatives; providers and practices, especially those in recognized, patient-centered primary care homes; the Patient-Centered Primary Care Institute (PCPCI); Coordinated Care Organizations (CCOs) and their community partners; the Oregon Health Authority and its Transformation Center, in addition partners such as Cover Oregon, health professional associations, and other stakeholders.

Strategy #1: OHP members provide information to providers and the OHA about how to effectively address barriers to individual and family engagement and improve the health system.

Rationale: To better understand how best to support individuals' efforts to participate in their health, there is a need to systematically and regularly collect information from OHP members on their level of engagement in their health and health care, their experience of care and satisfaction. This will identify specific opportunities, facilitators, and barriers for individuals to improve and maintain their health. The goal is to solicit information and understand members' barriers to accessing care, ability for self-management, and fostering shared responsibility for health.

- Action: Providers routinely and consistently engage OHP members and their families as key partners and participants in the health care process by providing timely, complete, unbiased and understandable information in accessible and appropriate formats on health conditions and treatment options, taking into account cultural, linguistic, and age appropriate factors.
- Action: Practices recognize and utilize members' experiences through outreach efforts including surveys, focus and advisory groups, and social media to guide practice level improvement.
- Action: OHP members and families directly partner with care teams, non-traditional health care workers, and community-based organizations to access and engage in community-based self-management programs.

- **Action:** OHA coordinates and aligns use of patient satisfaction and experience of care surveys statewide to address such things as purchasing strategies to assist practices and CCOs, preferred survey types (e.g. Picker, Press Ganey; HCAHPS, CG, & PCMH), use of benchmarks, survey timelines and redundancies with administration, and public reporting of information.

Strategy #2: Ensure ongoing education and training on evidence-based best practices for person- and family-centered engagement in health and health care.

Rationale: To fully support OHP members and their families in their own health and health care, practices and health care professionals, including community-based organizations, require education and sustained training in this arena. Such efforts should focus on effective use of techniques and best practices that create opportunities for individuals to make informed decisions and support health improvement of OHP members in their communities across Oregon.

- **Action:** Practices and providers receive regular and ongoing education and training from technical experts such as the Patient-Centered Primary Care Institute (PCPCI) and other learning forums on approaches to support person- and family-centered care. Examples include use of the Patient Activation Measure (PAM), shared decision-making and the use of decision aids, how to address low literacy and health literacy skills, and support for community-based self-management and wellness programs.
- **Action:** CCOs receive ongoing training and technical assistance from the OHA Transformation Center on how to work with practices to implement use of patient level data to inform practice and system level improvements.

Strategy #3: Leverage resources that support evidence-based best practices for person- and family-centered engagement and activation in health and health care.

Rationale: The Committee concluded that several evidence-based tools that would be helpful to sustain practice-level engagement efforts might not be affordable, individually, particularly for resource-limited small or rural practices.

- **Action:** PCPCI develop and disseminate practice-level tools for providers to routinely ask members and their families about their values, needs, knowledge, preferences and circumstances in culturally and linguistically appropriate ways. This will allow greater member feedback to be integrated into individually tailored and appropriate care plans.
- **Action:** OHA should work with CCOs and their delivery system partners to achieve economies of scale in order to make evidence-based tools more affordable and available to practices of all sizes throughout the state such as:
 - Patient Activation Measure (PAM)[†] or other evidence-based activation measurement tool(s), to assess the skills and readiness of the individuals for

[†] The Patient Activation Measure® (PAM®) assessment gauges the knowledge, skills and confidence essential to managing one's own health and health care.

engagement. Results can be used to determine the appropriate levels of intervention and allocation of resources. For example, a patient with complex and chronic health needs and low activation level may need the most intense interventions and resources versus someone with low acuity and a high level of activation.

- Shared Decision Making tools that are evidenced based, to engage individuals and their families about discrete health conditions and support medical decisions by providing information, helpful strategies, and other supports.
- Action: OHA works with community stakeholders to develop a sustainable system for evidence-based self-management program delivery and financing to ensure broader availability of community-based programs, such as Living Well with Chronic Conditions, across the state. The work should ensure linkages with PCPCHs and CCOs to the extent possible, working with the PCPCI and through the OHA Transformation Center to coordinate and align resources, provide targeted technical assistance and learning collaboratives.

Strategy #4: Create opportunities across all levels of the health system to support OHP members as integral partners in Oregon’s Health System Transformation.

Rationale: A comprehensive person- and family-centered transformed health system will need to encompass patients, families, their representatives, health professionals, and community partners working in active partnership at various levels across the system—direct care, organizational design and governance, and policy making—to improve members’ health and health care.

- Action: CCOs systematically and meaningfully engage representatives of diverse populations (including but not limited to cultural, language and age considerations) and community stakeholders to develop their community health assessments (CHAs) and community health improvement plans (CHIPs). For example, OHA should work closely with CCOs and their Community Advisory Councils to ensure the resources and support of person- and family-centered care strategies are available to foster the needs and primary goals of the members and community served by their CCO.
- Action: OHP members and their families serve as “equal and active partners” by fostering meaningfully and sustained participation in CCO advisory panels, provider/practice level advisory groups, and in local and state committees, councils, and boards, as OHP member advocates.

Strategy #5: Coordinate the adoption and spread of evidence-based best practices for person- and family-centered engagement in health and health care.

Rationale: Critical to this effort will be the promotion and alignment of multi-payer approaches to increase spread across provider practices and communities. OHA should work to ensure coordination and alignment of person- and family-centered models of care across the OHA, including CCOs, Public Employees’ Benefit Board (PEBB), Oregon Educators Benefit

Board (OEBC), the PCPCH Program, Cover Oregon and other payers. The goal is for OHA to leverage resources and activities statewide to disseminate best practices appropriate for OHP members and their families.

- Action: OHA should incentivize and disseminate the use of evidence-based best-practices for person- and family-care models of care that are sensitive to and account for the needs of diverse communities. This may be accomplished through the OHA Transformation Center coordinating with Innovator Agents, CCOs, regional learning collaboratives, and recognized PCPCHs to incentivize and disseminate the use of evidence-based best-practices for person- and family-care models of care that are sensitive to and account for the needs of diverse communities.
- Action: OHA works with CCOs to increase the number of recognized PCPCH practices; modify existing PCPCH Standards to support of more robust person- and family-centered care and engagement models; and consider alternative payment methodologies to incentivize practices with resources to adopt and sustain patient engagement activities.

[FULL REPORT]

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Introduction

As state policymakers, legislators, and health care leaders endeavor to improve a key determinant of health—the delivery system—individuals, families and communities must serve as key partners in reforming the system. By placing individuals, families and their communities at the center of health reform, efforts to increase access and quality, and to ensure that the health care system is held accountable, will be optimized. In Oregon, as new and innovative models of health care emerge, it will

“The most direct route to the Triple Aim is through implementation of patient and family-centered care in its fullest form.”

Don Berwick, former administrator for CMS

be important to design and test policy interventions that also influence factors beyond the delivery system, thus leveraging the critical work already led by CCOs. New policy approaches are needed to modify other determinants of health as an extension of broader health reform efforts, specifically addressing behavior and lifestyle determinants.¹⁵

Dozens of states are earnestly working to implement broad health reforms—addressing the financing, payment and delivery of health care services, both in Medicaid and the commercial marketplace—many of which are directly supported by the federal Affordable Care Act (ACA). Paramount to these reform efforts is the recognition by policy makers that an individual’s health status and well-being are determined to a large extent by factors outside of insurance coverage and access to high-quality health care services.

Increasingly understood is that the health of a community and its residents is determined by a number of factors including access to, and use of primary and preventive health care services. Altogether, health care accounts for approximately 10 percent of an individual’s health. ^{16,17,18} Therefore, comprehensive health reform efforts must also target broader social determinants of health such as education, housing and social cohesion, and personal behaviors such as diet, physical activity, tobacco use, substance abuse and addictions, approaches to safety, and coping strategies to stress. Combined, behavior and lifestyle account for over half the factors that influence one’s health status, including premature mortality.¹⁹

In the commercial market, health plans have begun to fold in efforts to address behavior, lifestyle, and person engagement through new wellness programs, such as Oregon’s Public Employee Benefit Board’s (PEBB) Health Engagement Model. Many such efforts tie financial penalties to non-participation in such programs. However, due to federal restrictions, these types of approaches cannot be fully replicated in state Medicaid programs. Nevertheless, opportunity remains in directing limited federal and state resources for Medicaid to support the design of new programs that target preventable and

healthy behaviors through novel interventions aimed at increasing individual responsibility and engagement of the individual in their own health and health care.

As Oregon works to transform its health system, an important factor in achieving the three-part aim is supporting providers along with individuals and their families to engage in improving and maintaining their health. The desired outcome is for individuals and families to adopt preventive and healthy behaviors, such as reducing tobacco use, modifying poor diet by increasing intake of nutritious foods, increasing physical activity, and reducing substance abuse. Oregon's transformed health system can benefit by encouraging and empowering individuals to take ownership of their health, particularly outside the clinical setting.

"Person-centeredness is needed if we are really going to improve health and if we want a partnership with the person whose health we are trying to improve."

Gary Christopherson, former CMS Senior Adviser

This report includes key background information, an overview of the committee process, review of the literature and evidence, key policy considerations, as well as the rationale and supporting evidence for the set of recommended strategies and actions.

Background

Oregon, along with other states can benefit by experimenting with interventions that seek to address behavioral and social circumstances by influencing and increasing participation of Medicaid beneficiaries in their own health care, make informed decisions as a member of their care team, increase efforts and support in disease management and wellness programs, and take part in preventive health behaviors. Over the long-term, these efforts may contribute to improved population health and curb the growth rate of health care expenditures.

States have begun to explore new opportunities to provide individuals with low-income and other vulnerable populations, access to resources and coverage of community-based services and supports. A good example in Oregon includes the use of non-traditional health workers (NTHWs), who are experts in providing culturally competent care and are uniquely placed to work with community members to identify and resolve their own most pressing health issues by addressing the social determinants of health; thus, contributing to reducing health inequities in Oregon. Accordingly, NTHWs can assist individuals in overcoming barriers to engaging and sustaining in preventive and healthy behaviors.

Among the more than 65 million individuals served by Medicaid, the notion of individual responsibility and the use of penalties or incentives to encourage healthy behaviors is

complex and not well understood.²⁰ There are several key policy considerations in trying to foster approaches designed to encourage individuals to take ownership of their health care by promoting personal responsibility and quality- and cost-conscious decision-making. Such considerations are of particular importance for those insured through Medicaid. For example, the use of incentive programs aimed at promoting healthy behavior and controlling costs must be designed so that the proposed interventions do not result in unintended consequences and inadvertently discriminate those covered by Medicaid. States have a responsibility to ensure and protect against policy interventions that insufficiently account for community-based and socioeconomic factors associated among low-income and other vulnerable population groups that affect an individual's ability to engage in healthy behaviors and disease management.

To learn from and build on the foundation of recent health reform efforts the Oregon Medicaid Advisory Committee (MAC) examined evidence and best practices around person- and family-centered care and engagement. The Committee spoke with experts both in Oregon and in other states to develop a set of strategies and key actions that will support OHP members to become informed decision-makers, enhance their ability to manage their health and health care, and support individuals in becoming more active participants in Oregon's health care system (* Please see *Appendix A* on page 18 for complete list of invited speakers).

What's the Issue?

The landmark Institute of Medicine report (2001), *Crossing the Quality Chasm: A New Health Systems for the 21st Century*, called for reforms to achieve a patient-centered health care system. The report described a future state in which the U.S. health care delivery system “is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions.”²¹ The “new chasm” is bridging the loci of health care services for individuals through person- and family-centered care by linking the delivery system to the community. The next major step in federal and state health reform is transitioning to a system of person- and family-centered care.

For decades, Oregon has been working towards comprehensive reform of its financing, payment, and delivery system, with notable accomplishments in its Medicaid program. From the creation of the Prioritized List of Health Services in 1988; expansion of the OHP to adults up to 100% of the federal poverty level (FPL) in 1994; the creation of the Oregon Health Authority, the Health Policy Board, and the Patient-Centered Primary Care Home Program in 2009; and most recently, Coordinated Care Organizations (CCOs)—Oregon is now committed to its three-part aim:

- Improving the lifelong health of Oregonians;
- Increasing the quality, reliability, and availability of care for all Oregonians; and
- Lowering or containing the cost of care so it's affordable to everyone.

Historically, individuals have not served as equal partners in health care or been involved in systems-level reforms.²² A key challenge is to redesign Oregon’s health care system, including Medicaid, with the individual as the nucleus in a transformed system. Fundamental to this is recognizing and valuing individuals not as patients, or recipients of care, but rather as “partners” across all levels of the health care system. This includes interactions with providers and care teams, at the practice-level, in hospitals, community-based organizations, in local and state directed programs, CCOs, and by public bodies that engage in regional and state directed policy development and oversight functions (i.e. governance). The new model must move beyond any restrictions or nominal representation in these redesigned structures and processes. In other words, individuals and families need opportunities for meaningful engagement and for their input to be encouraged and valued across the continuum.

“Recognize that we are the most important part of the care team, and that we are ultimately responsible for our overall health and wellness.”

Oregon Patient Centered Primary Care Home (PCPCH) Program
Core Attribute

Fortunately, Oregon is well positioned to identify additional opportunities to build on what has already been accomplished and continue to work towards the ultimate goal of better health, better care and lower costs for Oregonians. It will be important to leverage efforts already underway including:

- Health System Transformation Center: provision of technical assistance and other support to CCO and their provider networks to help them meet their incentive measures, that include patient satisfaction and contract requirements that must demonstrate progress in provider- and patient-engagement, in addition to other critical patient-and family-centered care areas.
- Patient-Centered Primary Care Institute (PCPCI): fostering medical home transformation. The Institute has hosted several webinars relating to person- and family-centered care and engagement, as well as the tremendous work being led CCOs and PCPCHs across the state.

The next building block of health reform can be achieved—person- and family-centered care—for members of by Oregon Health Plan (OHP). The redesign of Oregon’s health system emphasizes local accountability for health care and allocation of resources by each CCO. The next step is to address personal responsibility and engagement of the individual and their family. First, there are important challenges experienced by low-income populations, often covered by Medicaid that must be addressed prior to proposing policy recommendations.

Challenges Faced by Low-income, Vulnerable Populations

As states and policy makers consider policies aimed at improving individual engagement and influencing behavior modification, it is critical to account for the unique challenges low-income and other vulnerable populations experience with accessing, improving and maintaining their health and health care. Given limited financial resources, often poorer health status, complex health needs, and other barriers such as education and physical environment—strategies to engage low-income vulnerable populations including those in Medicaid in their health and health care—must take into careful consideration the unique challenges and barriers experienced by these populations.²³

Frequently experienced challenges Medicaid beneficiaries encounter, include but are not limited to:²⁴

- Limited education
- Limited literacy and health literacy
- Lack of resources
- Access to child care services
- Appropriate transportation
- Unhealthy physical environment
- Chronic stress
- Social exclusion/isolation
- Survival mentality
- Physical and mental capacity
- Health care professionals lack of cultural sensitivity toward low-income, diverse populations

Framework for Observations and Recommendations

The lexicon that encompasses person- and family-centered care is multidimensional, multi-layered, and expands across a continuum of engagement.²⁵ The term is also used synonymously with *patient engagement* and *patient activation*, which are related concepts but do not have an identical meaning. To help clarify the committee’s work, these concepts first need to be defined to avoid confusion and increase comprehension.

Person- and Family-Centered Care

Person- and family-centered care^c is an approach to the planning, delivery and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, individuals, families and communities. It redefines the relationships in health care by placing an emphasis on collaboration with individuals and families of all ages, at all levels of care, and in all settings—shifting from the traditional approach of “*doing to and for*” them to partnering “*with*” them.²⁶ It acknowledges that individuals and families are essential allies for quality and safety within any health care setting. Person-and family-centered care also acknowledges that emotional, social, and developmental supports are integral components of health care. It

^c The Committee adapted the term “patient- and family-centered care” to use the word “person” or in lieu of “patient,” in keeping with our approach of using person first language when possible and appropriate. The definition is from the Institute for Patient- and Family-Centered Care.

promotes the health and well-being of individuals and families and restores dignity and control to them.

Person and family-centered care offers a new framework for bringing about transformational change to health care by shaping policies, programs, facility design, provider and organizational culture, and staff day-to-day interactions.²⁷ It leads to better health outcomes, improved patient satisfaction, quality of care, improved allocation of resources, while reducing health care costs and disparities in health care.²⁸

“Research has shown that patient- and family-centered care that incorporates shared decision-making can reap potential healthcare savings of \$9 billion over 10 years.”

Commonwealth Fund 2013

The core concepts of person- and family-centered care are:

- *Respect and Dignity*: Health care providers invite, listen to and honor individual and family perspectives and choices. Individual and family knowledge, values, beliefs and cultural backgrounds are incorporated into the planning and delivery of care.
- *Information Sharing*: Health care providers communicate and share complete and unbiased information with individuals and families in ways that are affirming and useful. Individuals and families receive timely, complete, and accurate information in order to effectively participate in care and decision-making.
- *Participation*: Individuals and families are encouraged and supported in participating in care and decision-making at the level they choose.
- *Collaboration*: Individuals and families are also included on an institution-wide basis. Health care leaders collaborate with individuals and families in policy and program development, implementation, and evaluation; in health care facility design; and in professional education, as well as in the delivery of care.

Person- and family-centered care and cultural competence are inextricably linked. Respect for the beliefs, values, practices, preferences, needs and approaches to decision-making for individuals and families from diverse cultures and backgrounds are an essential aspect of person- and family-centered practice.²⁹

Individual Engagement and Activation

The term “patient engagement” encompasses patients, families, their representatives, and health professionals working in active partnership at various levels across the health care system—direct care, organizational design and governance, and policy-making—to improve health and health care.³⁰ Furthermore, engagement activities range along a continuum, from consultation to partnership with the willingness and ability of patients to engage being affected by multiple factors.³¹

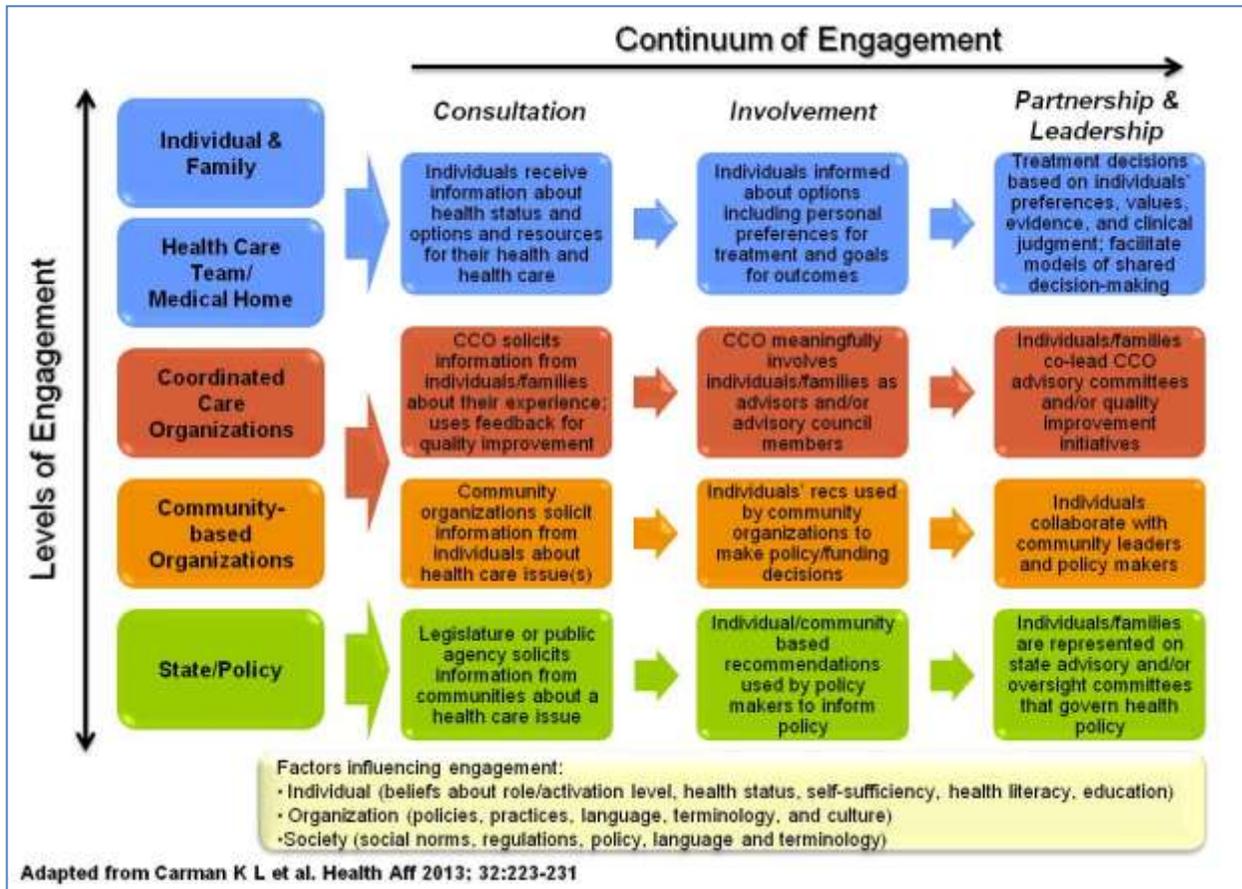
There is a growing body of research that indicates individuals who are more engaged, experience better health outcomes and help control health care costs.³² This is particularly the case when services and supports are person- and family-centered. Meaning they are respectful of and responsive to individual and family preferences, needs, and values, and ensuring that individual values guide all clinical decisions. Research consistently finds that those who are more activated are more likely to:³³

- Engage in preventive behaviors
- Engage in healthy behaviors
- Avoid health damaging-behaviors
- Engage in more disease specific self-management behaviors
- Engage in more health information seeking behaviors

Another important concept is patient activation, which refers to an individual's knowledge, skills, ability and willingness to manage his or her own health and health care.³⁴ Activation differs from compliance, where the emphasis is on getting individuals to follow medical advice. Individuals who are more activated have better health outcomes and experience of care. Activation is one aspect of an individual's capacity to engage in his or her own health. This term, however, does not address an individual's external context, nor does it focus on behavior.³⁵ [*Please see *Appendix B* on pg. 19 for additional information on evidence-based tools related to engagement, activation, and shared-decision making.]

The Committee adapted a multidimensional framework for patient engagement, developed by Carman et al. (2013), that reflects the Oregon context. See Figure 1 on the following page. Activities along the continuum of engagement remain the same, but the levels of engagement were modified to reflect the specific actors in Oregon's health care environment: individuals and their families; health care teams, including providers, front-office staff, non-traditional health workers, etc.; the medical home; CCOs; community-based organizations; and finally, state governance and policy.

Figure 1: Multidimensional Framework for Individual and Family Engagement



Committee Process and Rationale

Recognizing the importance of OHP members' willingness and ability to engage in, participate, and manage their own health and health care, the Committee spent six months (January-June 2013) exploring a range of strategies to support this goal. The process comprised of an extensive review of research and hearing from a diverse range of stakeholders and national experts on approaches and experiences from both commercial and state Medicaid programs. [*Please see *Appendix Aon* pg. 18 for a full list of invited experts that presented to the Committee.]

The Committee determined that strategies focused on cost-sharing or the use of financial incentives and disincentives could have negative or unintended effects for OHP members. Furthermore, there is limited evidence that supports the effectiveness of such approaches in Medicaid, which are restricted by federal law, and are summarized in the next section.

The proposed strategies, important to improving health outcomes among less advantaged Oregonians, are presented as a framework for enhancing policies and interventions aimed at supporting person- and family-engagement at all levels of Oregon's Health System Transformation.³⁶ The actions are designed, specifically, to address the diverse background and complex health care needs of current and future OHP members.

The committee's overall deliberation process and key steps are summarized as follows:

- Examined a broad range of strategies designed to encourage individuals to take ownership of their health and health care by promoting personal responsibility and quality- and cost-conscious decision-making.
- Recognized even nominal cost-sharing including premiums and co-pays can serve as a barrier to accessing necessary preventive and primary care services for low-income, vulnerable populations.
- Reviewed available research from state Medicaid incentive programs that use a variety of approaches, including financial and non-financial incentives, to promote healthy behavior and appropriate utilization of health care among their members.
- Concluded there is insufficient evidence on the efficacy and cost-effectiveness of incentive based approaches within state Medicaid programs.
- Focused on innovative approaches designed to improve individual engagement and accountability for one's own health, using person- and family-centered approaches to care and engagement.
- Adopted a set of strategies and actions to enhance alignment, coordination and create synergy among person- and family- centered care efforts already underway through Oregon's Health System Transformation.

Key Considerations: What's the Evidence?

The Committee gathered input from a diverse group of stakeholders and representatives from various agencies within the Oregon Health Authority that included Addictions and Mental Health Division, Division of Public Health, and the Office of Equity and Inclusion, local and national experts on patient engagement and activation, non-traditional and community-based health workers, providers, and officials with Florida's Medicaid Program. The committee was provided with peer-reviewed articles on national and state-level patient engagement activities, evidence-based strategies, and relevant literature highlighting available research. Information shared by the stakeholders as well as current research informed the set of strategies developed by the MAC for consideration by the Oregon Health Policy Board (OHPB).

Consumer-Directed Health Care and Cost-Sharing

The Committee began its work by examining strategies designed to encourage individuals to take ownership of their health and health care by promoting personal responsibility and quality- and cost-conscious decision-making. Starting with the commercial market, the Committee reviewed consumer-directed approaches that use mechanisms focused on benefit design and the use of financial levers to urge individuals to make more cost-sensitive decisions. A common form of this approach is a health savings account linked with a high deductible health plan. Proponents of this approach believe that a consumer in control of, and at greater risk for, his or her health care costs will be better engaged, and may make more appropriate health and health care utilization

decisions.³⁷ While such approaches originated in the commercial and Medicare market, state Medicaid programs have started to experiment with these approaches. [See next section for more information.]

Policy approaches reviewed by the Committee related to consumer-directed health care in the context of Medicaid programs include:³⁸

- Allocation of control over Medicaid funds to recipients – Medicaid recipients have greater exposure to the cost of their health care, which is believed to promote more cost-effective utilization decisions.
- Provision of financial and non-financial incentives for engaging individuals in healthy behaviors, chronic disease self-management programs, and cost-effective health care utilization.
- Requirements of beneficiaries to make financial contributions to care – require cost-sharing at nominal (\$3-5) or substantive levels.
- Removal of barriers to high value care – individuals receive more high value, appropriate health care.
- Provision of assistance with decision support – provide individuals in Medicaid support, information, education and advice, facilitating informed choices they make related to their health and health care and assisting them to implement healthy lifestyle choices.
- Offering incentives to individuals to use “Centers of Excellence” providers shown to provide quality care at reasonable cost.

Early in the Committee’s process, and informed by its previous work in developing the recommended Essential Health Benefit Benchmark Plan for Oregon’s Medicaid expansion population(s), the MAC understood that even nominal cost-sharing, including premiums and co-pays can serve as a barrier to accessing necessary preventive and primary care services for low-income, vulnerable populations. Furthermore, evidence indicates that nominal cost-sharing can lead to unintended consequences such as increased use of the emergency department after delaying care.^{39,40} Past experience in Oregon and in other states have demonstrated that implementing cost-sharing in Medicaid is complex and administratively burdensome, and costs can often outweigh anticipated state savings.⁴¹ Federal law also imposes strict cost-sharing limitations and benefit design requirements for all Medicaid populations. Thus, federal requirements currently restrict the use of certain consumer-directed health care approaches in Oregon’s current health care environment.⁴²

Medicaid Incentive Programs to Encourage Healthy Behavior

Subsequently, the Committee reviewed information from state Medicaid incentive programs that use a variety of approaches, including financial and non-financial incentives, to promote healthy behavior and appropriate utilization of health care among their members. Several state Medicaid programs are offering economic rewards (i.e. financial incentives) for healthy behavior based on the assumption that financial incentives will improve the health of individuals enrolled in Medicaid and help control health care costs. A key challenge is to incentivize individuals to modify unhealthy behaviors and maintain those modified behaviors over the long-term.

According to a 2011 report, commissioned by CMS, a panel of national experts recommended that states consider adopting a broad definition of “incentive” (p. 3). The notion of incentives in terms of person- and family-centered care should surpass providing financial incentives or money to Medicaid beneficiaries for certain health promotion behaviors.⁴³

According to the report, incentives can include but are not limited to:⁴⁴

- Waiving premiums, deductibles, coinsurance payments for participation in health improvement programs and activities or achieving certain positive health outcomes;
- Reimbursement for community-based programs designed to target behaviors of interest (e.g. paying for physical activity classes, completion of a certified smoking cessation program, or paying for Weight Watchers);
- Transportation to and from medical appointments; and
- Gasoline debit cards or phone cards.

The report also recommends that states consider a tiered incentive approach to participation in programs in an effort to sustain behavior changes over the long-term, especially in the areas of physical activity, nutrition, and smoking cessation. For example:

- Engaging in counseling aimed at teaching individuals how to quit smoking, attempts at behavior change (e.g., completing a smoking cessation program), actual behavior change (e.g., not smoking one week after completing the program), and finally achievement of health goals (e.g., remaining “quit” after 6 months).
- Rewarding appointments with providers to discuss health improvement goals, making attempts to improve behavior (e.g., becoming more physically active, eating a more nutritious diet), and finally attaining a behavior change goal (e.g., losing weight, lowering cholesterol levels).⁴⁵

When considering a broad definition of “incentive,” the report asserts a “penalty” or “stick” approach to incentives is counterproductive.⁴⁶ Based on review of available evidence, individuals, generally, respond better to a “rewards” program instead of a program perceived to be punitive in nature. Another policy issue is ensuring that any “incentive” program is responsive to the needs of a particular community including ensuring available resources and programs. The report concluded by raising the issue around individuals with co-morbidities who often have limited ability and resources to engage in health improvement programs outside the medical system.⁴⁷

The most frequently cited Medicaid incentive based programs are Florida’s Enhanced Benefits Reward\$ Program, Idaho’s Preventive Health Assistance program and West Virginia’s Mountain Health Choices Program. [*See *Appendix C* on pg. 21 for additional information on state Medicaid programs.]

Lessons learned by examining findings from these states indicate that program effectiveness would be improved by:

- Addressing lack of program awareness, perceived need for insurance, and misconceptions about program eligibility due to historic lack of eligibility for coverage, particularly among low-income adults, all served as barriers to enrollment.
- Educating Medicaid beneficiaries about new initiatives can be challenging due to the low literacy and health literacy levels of the population, and the difficulty of reaching them through traditional communication channels, such as phone, mail and email.^{48,49,50}
- Ensuring that the behaviors tracked are relevant. While it is easier to track wellness visits than lifestyle behavior changes, lifestyle behavior changes offer the greatest potential for Medicaid savings. States have yet to identify effective systems to track recipients' engagement in these behaviors and it is more administratively burdensome to do so.
- Addressing recipients' barriers to engaging in healthy behaviors by design programs to help beneficiaries overcome barriers, such as transportation or cost to participate in sports and exercise programs.

Current Experiments with Incentives for Medicaid Recipients

There is limited evidence to date on the impact and cost-effectiveness of such approaches within state Medicaid programs.⁵¹ This may change soon due to the Affordable Care Act's (ACA) section 4108 that provides an opportunity to test the effectiveness of incentives in engaging Medicaid enrollees in preventive health behavior and improving clinical outcomes. In September 2011, CMS awarded 10 states \$85 million over five years to design, implement, and evaluate Medicaid incentive programs. Key goals of the ACA's section 4108 include: increasing tobacco cessation, controlling or reducing weight, lowering cholesterol and blood pressure, and preventing the onset of diabetes or improving diabetes management. [*See *Appendix D* on pg. 25 for a complete list of the 10 grants including key characteristics.]

Based on a broad definition of "incentive" as described including provisions in the ACA designed to encourage behavior modification, states may also be interested in programs that aim to:

- Create healthier school environments, including increasing healthy food options, physical activity opportunities, promotion of health lifestyle, emotional wellness, prevention curricula, and activities to prevent chronic diseases;
- Create infrastructure to support active living and access to nutritious foods in a safe environment;
- Develop and promote programs to increase access to nutrition, physical activity and smoking cessation, enhance safety in a community;
- Assess and implement worksite wellness programs and incentives;
- Work to highlight health options at restaurants and other food venues;
- Address special population needs, including all age groups and individuals with disabilities, and individuals in urban and rural areas.

The federal opportunity highlights the importance of rigorous evaluation for each of the 2011 Medicaid incentive state programs. Early findings from these programs indicate that Medicaid incentive programs should be better designed so that enrollees can understand them and incentives are attractive enough to motivate participation. Ideally, each of the ten states will address central questions about the relationship between reward magnitude and effectiveness.⁵² Collectively, these efforts will help determine the degree to which incentive programs change health behavior, improve related health outcomes and are cost-effective within Medicaid programs. The Committee recommends tracking these efforts overtime to inform future work in Oregon that may consider the use incentives within OHP to improve health in a cost-effective manner.

Conclusion

Individuals who are more highly engaged and activated are less likely to have unmet medical needs; more likely to have regular check-ups, including screenings and immunizations; adhere to treatment and obtain regular chronic care; and, engage in health behaviors such as eating a healthy diet, regular exercise, and avoid adverse behaviors such as smoking and illegal drug use.^{53,54,55,56,57} This is particularly the case when services and supports are tailored to their individual needs, goals, preferences and circumstances.⁵⁸ The Committee believes that such innovative approaches, designed to improve individual engagement and accountability for one's own health in a person-and family-centered health system, will ultimately support the achievement of Oregon's three-part aim for all Oregonians.

Recommendations in Full

The recommended policy strategies seek to enhance alignment, coordination and create synergy among person- and family-centered efforts already underway through Oregon's Health System Transformation. The key is to effectively and equitably engage individuals and their families across all levels of the health system. Paramount to this is addressing the unique barriers and challenges experienced among OHP members. The continuum of person- and family-centered engagement in care is characterized across three levels: (1) direct patient care and partnership(s), (2) integration of patients' values in the design and governance of health care organizations, and (3) shared leadership and policy making that's responsive to patients' perspectives.⁵⁹

The MAC envisions a number of key actors that could help adopt and implement these strategies. Key partners include members of the OHP and their families and/or representatives; providers and practices, especially those in recognized, patient-centered primary care homes; the Patient-Centered Primary Care Institute (PCPCI); Coordinated Care Organizations (CCOs) and their community partners; the Oregon Health Authority and its Transformation Center, in addition partners such as Cover Oregon, health professional associations, and other stakeholders.

According to Carmen et al. (2013), it is difficult to "develop interventions at one level, such as direct care, when supports are needed at the levels of organization design and governance and of policy making to increase those interventions' effectiveness" (p. 227). The set of strategies and actions described below were developed based on available evidence and designed to target all three levels of the continuum. Ultimately, the strategies and actions recognize the new roles of health care professionals, policy makers, and individuals and families in working towards creating an accountable high-performance health system that *meaningfully* and *effectively* engages OHP members.

Strategy #1: OHP members provide information to providers and the OHA about how to effectively address barriers to individual and family engagement and improve the health system.

Rationale: To better understand how best to support individuals' efforts to participate in their health, there is a need to systematically and regularly collect information from OHP members on their level of engagement in their health and health care, their experience of care and satisfaction. This will identify specific opportunities, facilitators, and barriers for individuals to improve and maintain their health. The goal is to solicit information and understand members' barriers to accessing care, ability for self-management, and fostering shared responsibility for health.

- Action: Providers routinely and consistently engage OHP members and their families as key partners and participants in the health care process by providing timely, complete, unbiased and understandable information in accessible and

appropriate formats on health conditions and treatment options, taking into account cultural, linguistic, and age appropriate factors.

- Action: Practices recognize and utilize members' experiences through outreach efforts including surveys, focus and advisory groups, and social media to guide practice level improvement.
- Action: OHP members and families directly partner with care teams, non-traditional health care workers, and community-based organizations to access and engage in community-based self-management programs.
- Action: OHA coordinates and aligns use of patient satisfaction and experience of care surveys statewide to address such things as purchasing strategies to assist practices and CCOs, preferred survey types (e.g. Picker, Press Ganey; HCAHPS, CG, & PCMH), use of benchmarks, survey timelines and redundancies with administration, and public reporting of information.

Strategy #2: Ensure ongoing education and training on evidence-based best practices for person- and family-centered engagement in health and health care.

Rationale: To fully support OHP members and their families in their own health and health care, practices and health care professionals, including community-based organizations, require education and sustained training in this arena. Such efforts should focus on effective use of techniques and best practices that create opportunities for individuals to make informed decisions and support health improvement of OHP members in their communities across Oregon.

- Action: Practices and providers receive regular and ongoing education and training from technical experts such as the Patient-Centered Primary Care Institute (PCPCI) and other learning forums on approaches to support person- and family-centered care. Examples include use of the Patient Activation Measure (PAM), shared decision-making and the use of decision aids, how to address low literacy and health literacy skills, and support for community-based self-management and wellness programs.
- Action: CCOs receive ongoing training and technical assistance from the OHA Transformation Center on how to work with practices to implement use of patient level data to inform practice and system level improvements.

Strategy #3: Leverage resources that support evidence-based best practices for person- and family-centered engagement and activation in health and health care.

Rationale: The Committee concluded that several evidence-based tools that would be helpful to sustain practice-level engagement efforts might not be affordable, individually, particularly for resource-limited small or rural practices.

- Action: PCPCI develop and disseminate practice-level tools for providers to routinely ask members and their families about their values, needs, knowledge, preferences and circumstances in culturally and linguistically appropriate ways.

This will allow greater member feedback to be integrated into individually tailored and appropriate care plans.

- **Action:** OHA should work with CCOs and their delivery system partners to achieve economies of scale in order to make evidence-based tools more affordable and available to practices of all sizes throughout the state such as:
 - Patient Activation Measure (PAM)[§] or other evidence-based activation measurement tool(s), to assess the skills and readiness of the individuals for engagement. Results can be used to determine the appropriate levels of intervention and allocation of resources. For example, a patient with complex and chronic health needs and low activation level may need the most intense interventions and resources versus someone with low acuity and a high level of activation.
 - Shared Decision Making tools that are evidenced based, to engage individuals and their families about discrete health conditions and support medical decisions by providing information, helpful strategies, and other supports.
- **Action:** OHA works with community stakeholders to develop a sustainable system for evidence-based self-management program delivery and financing to ensure broader availability of community-based programs, such as Living Well with Chronic Conditions, across the state. The work should ensure linkages with PCPCHs and CCOs to the extent possible, working with the PCPCI and through the OHA Transformation Center to coordinate and align resources, provide targeted technical assistance and learning collaboratives.

Strategy #4: Create opportunities across all levels of the health system to support OHP members as integral partners in Oregon’s Health System Transformation.

Rationale: A comprehensive person- and family-centered transformed health system will need to encompass patients, families, their representatives, health professionals, and community partners working in active partnership at various levels across the system—direct care, organizational design and governance, and policy making—to improve members’ health and health care.

- **Action:** CCOs systematically and meaningfully engage representatives of diverse populations (including but not limited to cultural, language and age considerations) and community stakeholders to develop their community health assessments (CHAs) and community health improvement plans (CHIPs). For example, OHA should work closely with CCOs and their Community Advisory Councils to ensure the resources and support of person- and family-centered care strategies are available to foster the needs and primary goals of the members and community served by their CCO.
- **Action:** OHP members and their families serve as “equal and active partners” by fostering meaningfully and sustained participation in CCO advisory panels,

[§] The Patient Activation Measure® (PAM®) assessment gauges the knowledge, skills and confidence essential to managing one’s own health and health care.

provider/practice level advisory groups, and in local and state committees, councils, and boards, as OHP member advocates.

Strategy #5: Coordinate the adoption and spread of evidence-based best practices for person- and family-centered engagement in health and health care.

Rationale: Critical to this effort will be the promotion and alignment of multi-payer approaches to increase spread across provider practices and communities. OHA should work to ensure coordination and alignment of person- and family-centered models of care across the OHA, including CCOs, Public Employees' Benefit Board (PEBB), Oregon Educators Benefit Board (OEBB), the PCPCH Program, Cover Oregon and other payers. The goal is for OHA to leverage resources and activities statewide to disseminate best practices appropriate for OHP members and their families.

- Action: OHA should incentivize and disseminate the use of evidence-based best-practices for person- and family-care models of care that are sensitive to and account for the needs of diverse communities. This may be accomplished through the OHA Transformation Center coordinating with Innovator Agents, CCOs, regional learning collaboratives, and recognized PCPCHs to incentivize and disseminate the use of evidence-based best-practices for person- and family-care models of care that are sensitive to and account for the needs of diverse communities.
- Action: OHA works with CCOs to increase the number of recognized PCPCH practices; modify existing PCPCH Standards to support robust person- and family-centered care and engagement models; and consider alternative payment methodologies to incentivize practices with resources to adopt and sustain patient engagement activities.

Appendices

Appendix A: List of Invited Presenters and Experts

Cara Biddlecom, MPH, Public Health Division, OHA

Bill Bouska, Innovator Agent, OHA Transformation Center

Bryant Campbell, PEBB Member

R. Paul Duncan, PhD, Florida Medicaid Reform Evaluation Team

Danna Drum, Public Health Division, OHA

L.J. Fagnan, MD, Executive Director, Oregon Rural Practice-Based Research Network (ORPRN)

Judith H. Hibbard, DrPH, Institute for Policy Research and Innovation, University of Oregon

Mary Minniti, CPHQ, Program and Resource Specialist, Institute for Patient- and Family-Centered Care

Michael Morris, MS, Administrator, Addictions and Mental Health Division, OHA

Kelly Volkman, RN, MPH, Health Navigation Program Manager, Benton County Health Services

Julie Wu, Office of Equity and Inclusion, OHA

Appendix B: Evidence Based Tools

Tool	Description
Patient Activation Measure	<p>The Patient Activation Measure (PAM) is a tool for measuring the level of an individual’s capacity to manage his or her own health and health care. PAM is assessed through a series of answers to questions that gauge a person’s self-concept as a manager of his or her health and health care. The measure is scored on a 0-100 scale, and people are categorized into four levels of activation, with level 1 the least activated and level 4 the most activated. The score incorporates responses to 13 statements about beliefs, confidence in managing health related tasks, and self-assessed knowledge. The measure has been proven to be reliable and valid across different languages, cultures, demographic groups, and health statuses.^e</p> <p><i>For more information on activation and PAM see:</i> http://www.insigniahealth.com/solutions/patient-activation-measure</p>
Shared Decision-Making	<p>Shared decision-making occurs when provider and individuals exchange important information: providers help individuals understand medical evidence about the decisions they are facing, and individuals help providers understand their needs, values, and preferences concerning these decisions.^{f,g} Then, ideally after allowing time for reflection, individuals and providers decide together on a care plan consistent with medical science and personalized to each individual’s needs, values, and preferences.^h</p> <p><i>For more information on shared decision-making and decision aids see:</i> http://sdmtoolkit.org/</p>
Health Literacy	<p>Improving health outcomes relies on patients’ full engagement in prevention, decision-making, and self-management activities. Health literacy, or “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions”ⁱ is essential to those actions. However, relatively few Americans are proficient in understanding and acting on available health information.^j Health literacy has also been described as “a shared function of social and individual factors such as education, culture, and language. Additionally, health care providers need to have strong communication and assessment skills, as do the media, the marketplace, and government agencies—to provide health information in a manner appropriate to the</p>

^e Hibbard, J. and Greene, J. What the Evidence Shows About Patient Activation: Better Health Outcomes and Care Experiences; Fewer Data on Costs. *Health Affairs*, 32, No.2 (2013):207-214.

^f Fowler, F., Levin, C., and Sepucha, K. Informing And Involving Patients To Improve The Quality Of Medical Decisions. *Health Affairs*, Vol. 30, No. 4 (2011): 699–706.

^g Charles C., Gafni A., & Whelan T. Shared Decision-Making in The Medical Encounter: What Does It Mean? (Or It Takes At Least Two To Tango). *Soc Sci Med*, Vol. 44, No. 5 (1997):681–92.

^h Friedberg, M., et al. A Demonstration of Shared Decision-Making In Primary Care Highlights Barriers To Adoption And Potential Remedies. *Health Affairs*, Vol. 32, No. 2 (2013): 268-275.

ⁱ Ratzan, S. and Parker, R. Introduction. Selden, C., Zorn, M., Ratzan, S., Parker, R., Editors. In: National Libraries of Medicine Current Bibliographies in Medicine: Health Literacy. Vol. NLM No. CBM 2000-1. Bethesda, MD: National Institutes of Health, U.S. Department of Health and Human Services.

^j Kutner, M., Greenberg, E. Jin, Y., and Paulsen, C. The Health Literacy of America’s Adults: Results From The 2003 National Assessment Of Adult Literacy. Washington (DC): *National Center for Educational Statistics*; 2006 Sep.

Tool	Description
	<p>intended audience. The complexity of the health care system and the way patients experience it contribute to the difficulty of being health literate. Addressing health literacy is no less daunting than the task of addressing disparities.”^k</p> <p><i>For more information on health literacy see:</i> http://content.healthaffairs.org/content/32/2/357.abstract</p>
<p>Self-management</p>	<p>Self-management is a core requirement for person- and family-centered care. Individuals are empowered through education and information that help them to navigate the delivery system and seek appropriate and timely care.⁶⁰ The available evidence is relatively strong and suggests that expanding education and self-management support can be beneficial towards improving patient care outcomes and patient satisfaction at all levels of the delivery system.⁶¹ For example, self-management leads to improved health outcomes and reduced hospitalizations for patients with chronic disease; self-management also results in better adherence to medications and improved chronic disease control without incurring higher costs.¹</p> <p>The Oregon Health Authority and the Department of Human Services support several evidence-based self-management programs. The programs are also considered evidence-based by the US Centers for Disease Control and Prevention and/or the Administration on Aging. These programs provide individuals with the tools and connect them to resources to support self-and family-management or case management on a variety of issues such as nutrition, fitness, tobacco cessation, chronic health conditions, fall prevention, family violence, suicide prevention, and care transitions.</p> <p><i>For more information on community-based self-management programs see:</i> http://public.health.oregon.gov/PreventionWellness/SelfManagement/Pages/index.aspx</p>

^k IOM (Institute of Medicine). 2009. *Toward Health Equity and Patient-Centeredness: Integrating Health Literacy, Disparities Reduction, and Quality Improvement: Workshop Summary*. Washington, DC: The National Academies Press.

¹ Epstein, M. A Review of Self-Management Interventions Targeting Academic Outcomes for Students with Emotional and Behavioral Disorders. *Journal of Behavioral Education*, Vol. 14, No. 3 (2005): 203-221.

Appendix C: Medicaid Programs Designed to Increase Individual Engagement and Personal Responsibility

Characteristics of Healthy Indiana Plan (HIP)	
Characteristics	Details
Authority	<ul style="list-style-type: none"> State legislation; CMS 1115 Medicaid Demonstration Waiver (2008-2012)
Start date	<ul style="list-style-type: none"> January 1, 2008
Financing	<ul style="list-style-type: none"> Increased cigarette tax As a Medicaid waiver, the program is eligible for federal matching funds but must be budget neutral to the federal government.
Eligibility and Enrollment	<ul style="list-style-type: none"> Adults 19-64 years of age. Parents and caretaker relatives between 22%-200% FPL. Adults without children up to and including 200% FPL. Individuals above 200% FPL who are uninsured for six-months and do not have access to ESI are allowed to purchase the plan at full cost.⁶²
Goals	Put program enrollees in greater control of and at greater risk for his or her health care costs to promote engagement and more appropriate health and health care utilization decisions.
Coverage	<ul style="list-style-type: none"> Coverage for <u>preventive services</u> up to \$500 a year at no cost to participants. A <u>high deductible health plan</u> that covered state-specified benefits up to \$300,000 per year or \$1 million of lifetime expenses, with no cost-sharing after the \$1,100 deductible was met.^m A <u>POWER account</u> valued at \$1,100 to pay for the deductible, available in full to the member after his or her first contribution was made. A <u>POWER Account “Roll Over”</u> for HIP enrollees who met all of their preventive service requirements, the entire remaining balance of their POWER account rolled over to the following year, reducing the required contribution for that year. For enrollees who did not meet the preventive service requirements, only the individual’s portion, based on his or her percent contribution, rolled over.
Cost-sharing	<ul style="list-style-type: none"> <u>POWER Account Monthly Contributions</u> were made by enrollees on a sliding scale, from 2%-5% of income,ⁿ and could be reduced by payments from an enrollee’s employer.^o The State and the federal government subsidized the remaining amount at the state’s regular match rate. <u>Co-pays</u> of \$3-\$25 were required for all nonemergent use of the emergency department.^p
Results	Results from the first three years of the demonstration show HIP had served a total of 77,466 members; 87% of those eligible made monthly contributions to their POWER Account; established enrollees were more likely to use preventive services, compared to new enrollees: 69% compared to 28%; 94% of members said they were satisfied with HIP and 99% indicated they would re-enroll.
Comments	In order to meet the Affordable Care Act’s Medicaid expansion requirements, HIP would have to add vision, dental and maternity benefits. The enhanced HIP would cost 44% more than traditional Medicaid, totaling \$1.85 billion for 336,500 HIP enrollees during the first full year of the expansion. It is undetermined whether CMS will approve HIP as the coverage vehicle for Indiana’s Medicaid expansion populations in 2014.

^m HIP’s benefits differ from those offered through the Medicaid state plan as it does not provide coverage for maternity services, vision or dental services, and has annual and lifetime benefits.

ⁿ HIP policy requires that individuals make their monthly contributions within 60 days or face expulsion from the program for 12 months.

^o While these employers did not offer health insurance to their employees their contributions supported “the program’s goals to provide affordable consumer directed coverage.” Employers are also allowed to contribute up to 50% of the required contribution.

^p The copayment for caretakers is \$3 to \$25, depending on income, and is \$25 for non-caretakers regardless of income.

Appendix C: Medicaid Programs Designed to Increase Individual Engagement and Personal Responsibility

Characteristics of Florida's Enhanced Benefits Reward\$ Program	
Characteristics	Details
Authority	Florida's Agency for Health Care Administration's (AHCA), the agency responsible for the administration of its Medicaid program received approval to implement a CMS 1115 Research and Demonstration Waiver in Oct. 2005; the Legislature approved implementation of the waiver in Dec. 2005.
Start date	Began pilot program in Broward and Duval counties in September 2006; and expanded to Baker, Clay, and Nassau counties in September 2007.
Financing	AHCA assesses 2% of the monthly risk-adjusted capitated rate paid to each health maintenance organizations (HMOs) participating in the demonstration.
Eligibility and Enrollment	Medicaid beneficiaries in five pilot counties; required groups include disabled beneficiaries receiving Supplemental Security Income (SSI), parents, and children; other beneficiaries could participate on a voluntary basis. All Medicaid beneficiaries were automatically enrolled in the program and sent information after they chose a health plan.
Goals	Providing incentives (credits) for people to engage in healthy behavior
Target behavior	Receiving routine checkups, immunizations, and cancer screening; attending health appointments; adhering to medication regimens; and participating in programs for tobacco cessation, weight loss, diabetes
Incentive magnitude	\$7.50–\$25 per payment, \$125 per year maximum
Incentive type	<ul style="list-style-type: none"> • Credits are earned for specific health care utilization and wellness and prevention visits outside of a clinical setting • Credits are used to purchase approved health-related products and supplies at a Medicaid participating pharmacy (using Medicaid gold card or Medicaid ID number and government issued photo ID) • Credits may be carried over but if the enrollee loses Medicaid eligibility for one year, all credits are forfeited
Results	Since implementation of the program in Sept. 2006 through June 30, 2012, a total of 499,209 recipients have earned \$53.8M in credits; just over half redeemed; majority of credits earned were for childhood preventive care (45%) or adult/child office visits (25%), with <1% earned for participating in weight loss or tobacco cessation programs; lack of participation in programs that decrease chronic disease. ^q
Comments	Compliance, participation, success poorly defined; majority of credits (81%) earned by keeping routine physician visits and/or immunizations; < 1% earned for participating in a disease management program; none were earned for participating in other types of health improvement activities; analysis of program noted that most behaviors would have taken place in the absence of the program; ^r credit redemption rate of 50% suggests that credit amounts were too small and not salient to beneficiaries, or that participants had insufficient knowledge of program; qualitative interviews with health plans participating in the EBR program indicated that the program emphasized passive, more routine behaviors, rather than active behaviors requiring lifestyle changes. ^s

^q Florida Medicaid Reform: Year 6 Annual Report (July 1, 2011 – June 30, 2012). 1115 Research and Demonstration Waiver. Florida Agency for Health Care Administration.

^r Medicaid Reform: Beneficiaries Earn Enhanced Benefits Credits But Spend Only a Small Proportion. OPPAGA. July 2008.

^s Duncan, P. Florida's Enhanced Benefits Reward\$ Program. Presentation to the Oregon Medicaid Advisory Committee. January 23, 2013.

Appendix C: Medicaid Programs Designed to Increase Individual Engagement and Personal Responsibility

Characteristics of Idaho's Preventive Health Assistance (PHA) Benefits Program ^{t,u}		
Details		
Characteristics	Behavioral PHA	Wellness PHA
Authority	Two State Plan Amendments; authority granted under the Deficit Reduction Act of 2005	Amendment to the state's Children's Health Insurance Program
Start date	January 2007	
Financing	Unpublished	Unpublished
Eligibility and Enrollment	<p>Adult Medicaid beneficiaries are sent a health questionnaire at the time of initial Medicaid eligibility determination and annually thereafter; each beneficiary may only participate in one program at a time and may participate in the:</p> <ul style="list-style-type: none"> • Tobacco cessation program if questionnaire indicates the individual or their child wants to quit using tobacco; or the • Weight management program if questionnaire indicates the individual or their child (> age 5) has a Body Mass Index in the obese or underweight range, and wants to improve their health through weight management. 	Children in families with income between 134-185% FPL, who are also required to pay monthly premiums
Goals	Promoting healthy behavior	Promoting child wellness with financial premium support for child's CHIP coverage.
Target behavior	Weight management and tobacco cessation	Staying up-to-date on well-child visits
Incentive magnitude	\$200 maximum in vouchers per beneficiary	10 points per month maximum (equivalent to \$10)
Incentive type	Vouchers for weight management programs or tobacco cessation products	Points exactly offset the \$10/mo. premium for children between 134-149% FPL, and offset two-thirds of the \$15/mo. premium for children between 150-185% FPL
Results	Only 1,422 of the approximately 185,000 beneficiaries participated after 2 years	Significant increase in proportion of CHIP children up-to-date on well-child visits, compared to control
Comments	Limited impact on tobacco cessation and weight management; no data on success.	Children requiring only one annual visit had largest increase in adherence

^tGreene J. Using consumer incentives to increase well-child visits among low-income children. *Med Care Res Rev*, Vol. 68 No. 5. (2011): 579–93.

^u Idaho Department of Health and Welfare. Facts, figures, trends, 2008–2009. Available from: <http://healthandwelfare.idaho.gov/AboutUs/FactsFiguresTrends/tabid/1127/Default.aspx>

Characteristics of West Virginia’s Mountain Health Choices Program ^v	
Characteristics	Details
Authority	State Plan Amendment under the Deficit Reduction Act of 2005
Start date	May 2006
Financing	Regular FMAP
Eligibility and Enrollment	<p>Certain eligibility groups were moved to “Secretary approved” coverage. The affected groups were:</p> <ul style="list-style-type: none"> • Infants with incomes below 150% FPL, • Children age one to six with incomes below 133% FPL, • Children age six to nineteen with incomes below 100% FPL, • Working parents with incomes below 37% FPL, and • Non-working parents with incomes below 19% FPL. <p>To qualify for the enhanced plan, individuals have to sign a member responsibility agreement and enter into a health improvement contract with their physician that includes a wellness plan.</p>
Goals	Providing incentives for people to take more responsibility for their health with a choice between an “enhanced” or “basic” plan. The objective is to steer participants into the lower cost basic plan unless they adhere to behavioral commitments to improve health.
Target behavior	Signing a member responsibility agreement and developing a wellness plan with physician to enroll in enhanced plan, which offers beneficiaries more extensive coverage than the basic plan; adhering to member agreement to maintain coverage under enhanced plan.
Incentive magnitude	Maintaining access to enhanced plan
Incentive type	More extensive coverage, including unlimited prescriptions, tobacco cessation services, diabetes and weight management programs.
Results	Only 10% of eligible adults enrolled in enhanced plan; enhanced plan members were more likely than others to have more doctor visits and take their medications, and to have physicians involved in decision to enroll.
Comments	Criteria for determining adherence and continued eligibility were ambiguous; low-literacy patients at risk of being assigned to basic plan by default.

^v West Virginia Department of Health and Human Resources. Mountain Health Choices. Available from: <http://www.dhhr.wv.gov/bms/mhc/Pages/default.aspx>.

Appendix D: ACA Medicaid Incentives CDC Grants for States

Affordable Care Act: Medicaid Incentives for Prevention of Chronic Diseases Grants (10 states received 5-year grants in 2011)^w

State	Goal	Incentive	Evaluation
California	Tobacco cessation and diabetes management	\$10–20 per activity	Two evaluations: RCT and cost-effectiveness
Connecticut	Tobacco cessation	\$5–15 per activity	Evaluation of the effect of the incentives on smoking cessation rates, receipt of evidence-based smoking cessation treatments, health care use, cost savings, incremental cost-effectiveness
Hawaii	Diabetes prevention, detection, and management	\$20–25 per activity	Pre- versus post-intervention comparison; analysis using non-Medicaid patients with diabetes as control group
Minnesota	Increased weight loss and diabetes prevention, improved cardiovascular health, reduced health care spending	\$10–50 per activity	Prospective group RCT; evaluation of effectiveness of group versus individual incentives; cost-effectiveness evaluation
Montana	Increased weight loss, reduced lipid and blood pressure levels, diabetes prevention	\$320 maximum per Beneficiary	Crossover design will enable evaluation of process and health outcome measures in relation to incentives
New Hampshire	Increased exercise; improved nutrition; modification of risk factors for cardiovascular disease	Unknown	Evaluation using an Equipoise stratified randomization design; cost effectiveness evaluation
New York	Tobacco cessation, hypertension control, diabetes prevention, diabetes self-management	\$250 maximum per beneficiary	Four separate RCTs; evaluation of effectiveness of process versus outcome incentives in each RCT to be conducted by the University of Pennsylvania
Nevada	Increased weight loss, lowered cholesterol and blood pressure, diabetes prevention and management	Unknown	RCT, evaluation of effectiveness to be conducted by the University of Nevada, Reno
Texas	Improved health self management among Medicaid patients with SSI or a mental health or substance abuse diagnosis	\$1,150 maximum (flexible spending account) per beneficiary	Longitudinal RCT; cost-effectiveness evaluation to be conducted by the University of Florida
Wisconsin	Tobacco cessation (with focus on pregnant women)	\$595 maximum for pregnant women, \$350 maximum for other beneficiaries	RCT

NOTES: Incentive values based on publicly reported information. RCT is randomized controlled trial. SSI is Supplemental Security Income.

^w CMS.gov. MIPCD: the states awarded [Internet]. Baltimore (MD): Centers for Medicare and Medicaid Services. Available from: <http://innovation.cms.gov/initiatives/MIPCD/MIPCD-The-States-Awarded.html>.

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Strategies on Person- and Family-Centered Engagement

Recommendations from the
Oregon Medicaid Advisory Committee

July 2, 2013

Karen Gaffney, Committee Co-Chair
Oliver Droppers, Director of MAC, OHA

Committee Members

- Janet Patin, MD; Co-Chair
- Karen Gaffney, MS; Co-Chair
- Romnee Auerbach, MS, ANP, PMHNP-BC
- Lenore Bijan
- Karen Berkowitz, JD
- Rhonda Busek, MBA, OHA Ex-Officio
- Meghan Caughey, MA, MFA
- Carol Criswell, BA
- Leslie Sutton, JD
- Dick Stenson, MHA, MBA, FACHE, FACMPE
- Thomas Turek, MD

Presentation Overview

- Background and concepts
- Framework for observations & recommendations
- Examples of Medicaid incentive programs designed to encourage healthy behavior
- Committee findings: What's the evidence?
- Recommendations

Committee Background

- MAC recommended **Oregon Health Plan *Plus*** (*for non-pregnant adults) as the state’s Medicaid benchmark plan for expansion populations.
 - Issue of **individual responsibility** and **accountability for health and well-being** emerged as an important topic.
- Committee recommended future Oregon health policy should:

“Develop meaningful, evidence-based, and non-punitive strategies that address the issue of personal responsibility in lieu of cost-sharing that will support improvements in health and wellbeing, and promote fiscal sustainability of Oregon’s Medicaid program.”

What's the Issue?

“The most direct route to the Triple Aim is through the implementation of patient- and family-centered care in its fullest form.” –Don Berwick, former Administrator of CMS

- Evidence indicates individuals more engaged in their health and health care experience better health outcomes and incur lower medical costs.
 - Preventive behaviors
 - More disease specific self-management behaviors
 - Healthy behaviors
 - More health information seeking behaviors
 - Avoid health damaging-behaviors

Person- and Family-Centered Care

- People are treated with respect and dignity.
- Health providers constructively share complete/unbiased information with individuals & families.
- Collaboration & engagement among individuals, families and providers occurs at four levels: clinical encounter, practice/organizational level, community, and public policy.
- Individuals & families encouraged and supported to participate in care and decision-making at the level they choose.

Individual Engagement & Activation

- **Engagement** encompasses individuals, families, their representatives, and health professionals working in active partnership across the health system.
- **Engagement activities** range along a continuum, from consultation to partnership; the willingness and ability of individuals to engage affected by multiple factors.
- **Activation** refers to an individual's knowledge, skills, ability and willingness to manage his or her own health.

Committee Process

Goal: To further realize OHP members' full potential at improving and maintaining their health and serving as active partners in a transformed health system.

- January-May 2013: explored broad range of strategies designed to encourage individuals to take ownership of their health
- Adopted preferred language, “person and family”
- Shift away from conventional medical model focused on disease treatment to caring for the “whole person”
- Extensive review of research and testimony from diverse stakeholders and national experts

Challenges Faced by Individuals in Medicaid

- Limited education
- Limited literacy and health literacy
- Lack of resources
- Limited access to child care services
- Limited access to timely /appropriate transportation
- Unhealthy physical environment
- Chronic stress
- Social exclusion/isolation
- Physical and mental capacity
- Survival mentality
- Health care professionals lack of cultural sensitivity toward low-income and diverse populations

Potential Consumer-directed Approaches in Medicaid

- **Allocate control over some Medicaid funds to recipients**
- **Financial and non-financial incentives** to engage individuals in healthy behaviors, chronic disease self-management programs, and cost-effective health care utilization
- Require beneficiaries to make **financial contributions to care**
- Provide **decision support, information, education and advice**; facilitating informed choices individuals make related to their health and health care
- Provide incentives to individuals to use “**Centers of Excellence**” -- providers shown to provide quality care at reasonable cost

Cost-Sharing Considerations in Medicaid

- Informed by previous work developing the Medicaid EHB recommendation, the Committee:
 - Recognized even nominal cost-sharing can serve as a barrier to accessing necessary preventive and primary care services;
 - Evidence indicates nominal cost-sharing can lead to unintended consequences; and
 - Past experience in Oregon and other states demonstrates that implementing cost-sharing in Medicaid is complex and administratively burdensome.
- Federal limitations & ACA requirements imposed on Medicaid programs restrict use of consumer-directed approaches in Oregon.

Examples of Other States' Medicaid Incentive Programs

- Florida's Enhanced Benefits Reward\$ Program
 - Credits up to \$125 annually to purchase over the counter items
 - Credits earned for engaging in certain healthy activities
- Idaho's Preventive Health Assistance Program
 - Parents earn points when children are up-to-date on well child visits and immunizations; offset monthly premiums.
 - Enrollees interested in tobacco cessation or weight management receive up to \$200 towards an approved health program.
- West Virginia's Mountain Health Choices Program
 - Enrollees receive unlimited prescriptions, tobacco cessation services, diabetes and Weight management programs.

Committee Findings

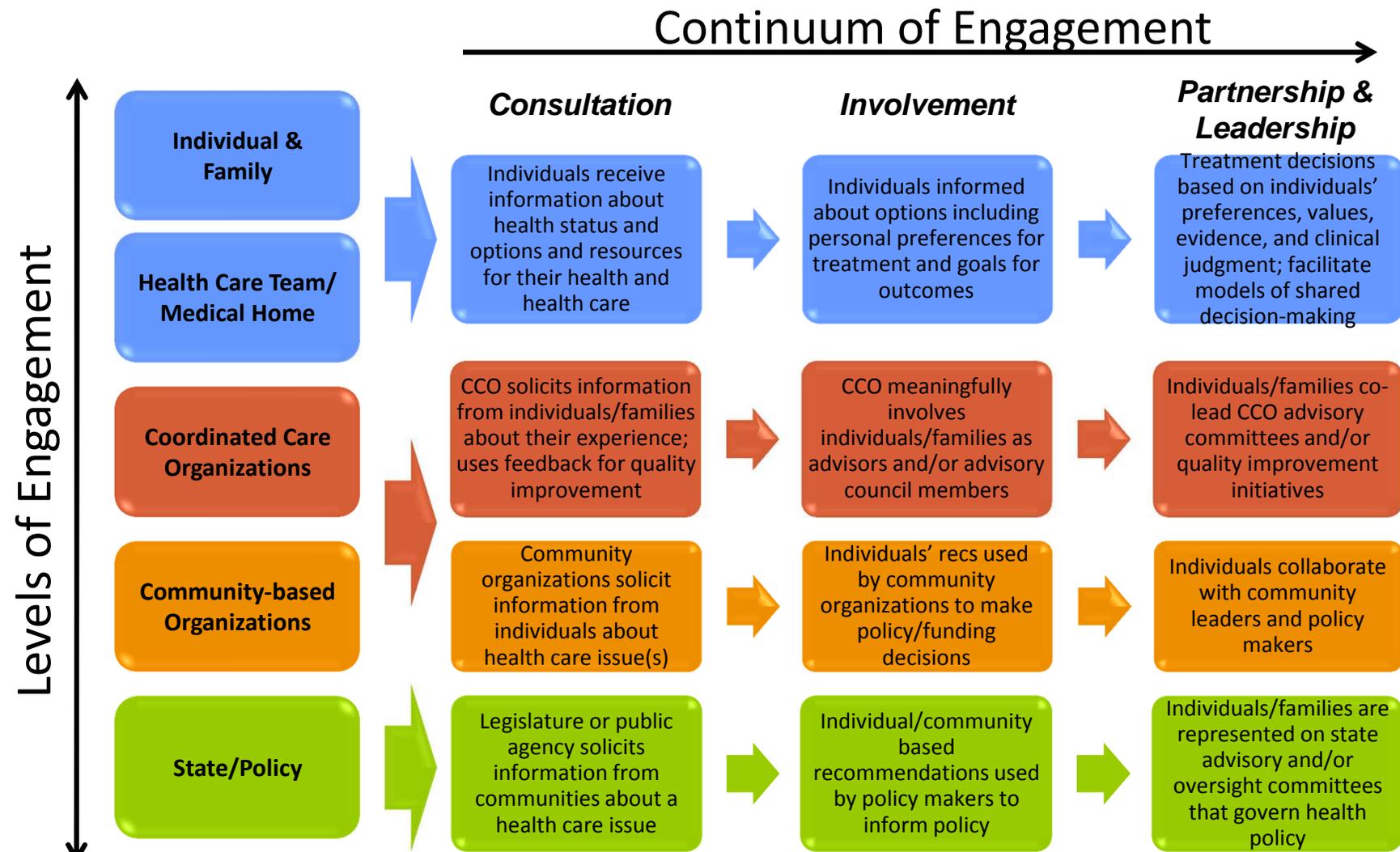
- Variety of financial and non-financial incentives to promote healthy behavior and appropriate utilization of health care.
- Limited evidence on efficacy & cost-effectiveness of financial incentives/disincentives within state Medicaid programs.
- Early findings from state Medicaid programs on use of financial incentives/disincentives - report negligible impact(s).
- “Penalty” or “stick” approach to incentives is counterproductive.
 - Use of financial disincentives may have negative and unintended effects for OHP members.
- Incentivizing individuals to modify unhealthy behaviors over the long-term is challenging
- Individuals with co-morbidities often have limited ability and resources to engage in health improvement programs

Committee's Recommended Strategies and Actions

MAC's Person- and Family-Centered Care and Engagement Framework

- Committee opted to focus on innovative approaches using person- and family-centered approaches for engagement.
- Strategies span the levels and continuum of engagement.
- Strategies and actions designed to enhance alignment, coordination and create synergy with efforts already underway through Oregon's Health System Transformation.
- Strategies and actions recognize the new roles of health care professionals, policy makers, and individuals and families in working towards creating an accountable high-performance health system.

A Multidimensional Framework for Individual And Family Engagement In Oregon



- Factors influencing engagement:
- Individual (beliefs about role/activation level, health status, self-sufficiency, health literacy, education)
 - Organization (policies, practices, language, terminology, and culture)
 - Society (social norms, regulations, policy, language and terminology)

Recommended Strategies

Strategy #1: OHP members provide information to providers and the OHA about how to effectively address barriers to individual and family engagement and improve the health system.

- Action: Providers routinely and consistently engage OHP members and their families as equal partners.
- Action: Practices recognize and utilize members' experiences to guide practice improvement.
- Action: OHP members directly partner with care teams, non-traditional health care workers, and community-based organizations.
- Action: OHA coordinates and aligns use of patient satisfaction and experience of care surveys statewide.

Recommended Strategies (cont.)

Strategy #2: Ensure ongoing education and training on evidence-based best practices for person- and family-centered engagement in health and health care.

- Action: Practices and providers receive regular and ongoing education and training from technical experts to support person- and family-centered care.
- Action: CCOs receive ongoing training and technical assistance from the OHA Transformation Center on how to work with practices to implement use of patient level data to inform practice and system level improvements.

Recommended Strategies (cont.)

Strategy #3: Leverage resources that support evidence-based best practices for person- and family- centered engagement and activation in health and health care.

- Action: PCPCI develop and disseminate practice-level tools for providers to routinely ask members and families about their values, needs, knowledge, preferences and circumstances.
- Action: OHA work with CCOs and delivery system partners to achieve economies of scale to make evidence-based tools more affordable and available to all practices.
- Action: OHA works with community stakeholders to develop a sustainable system for evidence-based self-management program delivery and financing; ensure broader availability of community-based programs.

Recommended Strategies (cont.)

Strategy #4: Create opportunities across all levels of the health system to support OHP members as integral partners in Oregon's Health System Transformation.

- Action: CCOs systematically and meaningfully engage representatives of diverse populations and community stakeholders to develop /inform community health assessments (CHAs) and community health improvement plans (CHIPs).
- Action: OHP members and their families serve as “equal and active partners” by fostering meaningfully and sustained participation in CCO advisory panels, provider/practice level advisory groups, and in local and state committees, councils, and boards.

Recommended Strategies (cont.)

Strategy #5: Coordinate the adoption and spread of evidence-based best practices for person- and family-centered engagement in health and health care.

- Action: OHA should incentivize and disseminate the use of evidence-based best-practices for person- and family-care models of care that are sensitive to and account for the needs of diverse communities.
- Action: OHA works with CCOs to increase the number of recognized PCPCH practices; modify existing PCPCH standards to encourage and enhance support of more robust person- and family-centered care and engagement models;.

Report Appendices

- Examples of evidence-based tools
- Descriptions of state incentive Medicaid programs
- Summary of ACA Medicaid incentive grants
- [Full report](#)

Questions & Comments

Medicaid Advisory Committee

MAC.info@state.or.us



JOHN A. KITZHABER, MD
Governor

June 3, 2013

Oregon Health Policy Board
Chair Eric Parsons
Vice-Chair Lillian Shirley

Dear Chair Parsons and Vice-Chair Shirley:

As you and the Board are well aware, beginning in 2014, the Affordable Care Act (ACA) will significantly expand coverage to thousands of currently uninsured Oregonians and alter the regulations governing the individual and small group markets. While the ACA makes historic, nationwide changes in coverage expansion and the regulation of the individual and small group markets, I believe there is an immediate need to focus on how to better align ACA implementation activities with our current reform efforts. I want to ensure that our triple aim goals of lower costs, better care and better health across all markets are achieved. To that end, concurrent with the ACA, we have an opportunity to create an environment for the commercial marketplace in Oregon that moves toward one characterized by models of coordinated care and growth rates of total health care expenditures that are reasonable and predictable.

For this to occur, I am asking that by the end of this year, the Oregon Health Policy Board take on the task of recommending to me and the Legislature, possible statutory and regulatory changes necessary to ensure our triple aim goals are met. I would anticipate that such recommendations would include, but not be limited to:

- strategies to mitigate cost shifting, decrease health insurance premiums and increase overall transparency and accountability;
- opportunities to enhance the Oregon Insurance Division's rate review process;
- alignment of care model attributes within PEBB and OEBC contracts;
- alignment of care model attributes within Cover Oregon's qualified health plans.

Thanks to all of your hard work and leadership over the past several years, Oregon has made significant progress in reforming its health care delivery system. Across the state, communities have begun transforming to deliver more effective, efficient care. Critical partnerships are developing to reward quality care, promote prevention and wellness and manage chronic diseases and are building new networks, products and contracting models.

Oregon Health Policy Board
June 3, 2013
Page Two

We have an amazing opportunity to leverage all of your great work with the implementation of the ACA and I look forward to working with you to achieve further success.

Sincerely,

A handwritten signature in black ink, appearing to read "John A. Kitzhaber". The signature is fluid and cursive, with the first name "John" being the most prominent.

John A. Kitzhaber, M.D.
Governor

MJB/smg



**Draft Oregon Health Policy Board work plan proposal for
Healthcare cost sustainability recommendations for action
June, 2013**

Overall Objectives:

Make recommendations to Governor Kitzhaber and the Oregon Legislature to achieve better alignment between Oregon's current reform and the ACA. Recommendations should support total health expenditures that are reasonable and predictable:

- **Cost Shift Containment and Lower Premium Prices:** Recommend strategies to mitigate the cost shift and decrease health insurance premiums.
 - **Rate Review Reform:** Explore and recommend opportunities to enhance the Oregon Insurance Division's (OID) rate review process.
 - **Transparency & Accountability:** Recommend strategies to increase overall transparency and accountability.
- **Coordinated Care Alignment work group:** Recommend strategies that move PEBB, OEBC, Cover Oregon and the commercial marketplace toward one characterized by models of coordinated care.

Deliverables:

OHPB healthcare cost sustainability recommendations for action: Recommendations to Governor Kitzhaber and the Oregon Legislature by Dec. 31, 2013, which include potential statutory and regulatory changes.

Timeline:

July 2013 OHPB meeting:

1. Presentation of draft work plan
2. Presentation of draft charter & charge for coordinated care alignment workgroup
3. Presentation of MAC recommendations, RE: Medicaid personal responsibility
4. Discussion, RE: transparency and accountability framework

August 2013 OHPB meeting:

1. Alignment work group status update
2. Education, presentation and discussion: rate review enhancement and strategies
 - a. Options, other state experience and current status in Oregon (*consultant to present, consultant TBD*)
 - i. Coverage and access
 - ii. Transparency and accountability
 - iii. Affordability standards
 - b. Affordability standards for insurers
 - i. Hospital contracting requirements
 - ii. Public testimony

OHA staff August meeting deliverables:

1. RFP process completed and consultant hired

2. Work with consultant and DCBS to prepare presentation and discussion, RE: rate review (transparency, accountability, cost containment and lower premium price)
 - a. “Bucket” assignments & policy options

September 2013 OHPB Meeting:

1. Review and discussion continuation from August meeting
2. Rate review: Transparency, Accountability and Coverage and Access strategies and potential straw model presentation
3. Alignment work group first report out of options & Board discussion

October 2013 OHPB Meeting:

- OHA Staff synthesis and review of August and September meeting with narrowing of recommendations and outline of legislative or regulatory changes needed.
- Straw person review
- OHA staff synthesis of Alignment Work group discussions and recommendations
- OHPB discussion and recommendations

November 2013 OHPB Meeting:

- OHA Presentation: Draft report on strategies and recommended legislative and/or regulatory changes. For rate review, transparency and contract alignment.

December 2013 OHPB Meeting:

- Final recommendations/presentation; Board refers final report to governor and legislature

Background:

Executive Context:

From Governor’s Letter dated 3 June 2013:

I believe there is an immediate need to focus on how to better align ACA implementation activities with our current reform efforts. I want to ensure that our triple aim goals of lower costs, better care and better health across all markets are achieved. To that end, concurrent with the ACA, we have an opportunity to create an environment for the commercial marketplace in Oregon that moves toward one characterized by models of coordinated care and growth rates of total healthcare expenditures that are reasonable predictable. For this to occur, I am asking that by the end of this year the OHPB take on the task of recommending to me and the Legislature, possible statutory and regulatory changes necessary to ensure our triple aim goals are met. I would anticipate that such recommendations would include but not be limited to:

- strategies to mitigate cost shifting, decrease health insurance premiums and increase overall transparency and accountability;
- opportunities to enhance the Oregon Insurance Division’s rate review process.

OHPB Context:

Oregon Health Fund Board 2008 [here](#).

OHPB Action Plan for Health 2010 [here](#).

OHPB Report Leadership and Staffing:

	OHA	DCBS
Sponsors:	Bruce Goldberg	
Key Leadership:	Tina Edlund, OHA	Laura Cali
Other Leadership:	Kelly Ballas	
Lead staff:	Jeff Scroggin, Jeanene Smith, Lisa Angus	
Staff: policy analysis work	OHA staff: <ul style="list-style-type: none">• Director's Office	
Staff: financial analysis work	Health Analytics/Actuarial Services Unit:	
Administrative support	TBD	
Communications	Patty Wentz	
Technical Assistance, subject matter expertise, other external support	RWJF, Consultants TBD	
Facilitator	Diana Bianco	

Oregon Health Policy Board Coordinated Care Model Alignment Work Group Charter

Approved by OHPB on 2 July 2013

I. Authority

The Oregon Health Authority (OHA), under Governor Kitzhaber's June 2013 letter to the Oregon Health Policy Board (Board), is establishing a public process to inform healthcare cost containment strategies and recommend delivery system alignment actions.

The goal is a sustainable, affordable, coordinated and high quality health care delivery system.

The Oregon Health Plan (OHP), Oregon's coordinated care delivery model, delivers care through a fixed global budget and maintains costs at a sustainable level. Under this model healthcare is coordinated across the delivery spectrum through locally accountable Coordinated Care Organizations (CCOs). Flexibility to innovate, alternative payment methodologies, and shared responsibility among local providers, patients and health plans are other key aspects of the model. CCOs are charged with delivering healthy outcomes and their ability to meet this charge is measured quarterly through performance data.

As the policy-making and oversight body for OHA, the Board establishes the Coordinated Care Model Alignment Work Group to provide input on potential regulatory delivery system alignment improvements. The Work Group will be guided by Governor Kitzhaber's June 2013 letter to the Board, the Board's 2010 report *Oregon's Action Plan for Health*, and by Oregon's health system transformation goals:

- improving the lifelong health of all Oregonians;
- improving the quality, availability and reliability of care for all Oregonians, and;
- lowering or containing the cost of health care so that it is affordable for everyone.

This charter shall expire on November 31, 2013 or when the Board determines that the charter has been fulfilled, whichever is sooner.

II. Scope

The Coordinated Care Model Alignment Workgroup is charged with providing draft recommendations and implementation actions for the consideration of the Oregon Health Policy Board.

Purchasers to be covered in recommendations include but are not limited to:

- PEBB (to include currently underway RFP process for 2015 services)
- OEBC
- Cover Oregon
- Other public and private organizations

OHA staff will provide workgroup members materials in advance of scheduled meetings in order to ensure adequate review time and meaningful input.

The work group will not be asked to approve the final Board recommendations to the Legislature.

III. Deliverables

The workgroup will submit recommendations in a report to the Board before November 1, 2013.

IV. Timing/Schedule

The Workgroup will complete its work by November 2013; it will meet monthly at a location to be determined. The workgroup will meet at the discretion of the Board.

V. Staff Resources

Chairs: TBD

Staff: TBD, Jeff Scroggin

VI. Work Group Membership

Workgroup members are appointed by and will serve at the pleasure of the Board chair. The workgroup will have a chair that will represent the group and present at Board meetings.

Membership: TBD

OHPB Framework for:

Transparency, Accountability, Coverage and Access

Background: Gov. Kitzhaber, in a letter dated June 3, 2013, charged the Oregon Health Policy Board with, “focus(ing) on how to better align ACA implementation activities with Oregon’s current reform efforts”. The Governor requests specific recommendations to enhance the rate review process and increase transparency and accountability. These recommendations are expected to encompass strategies which mitigate cost shifting and decrease premiums. Recommendations are expected to encompass statutory and regulatory change.

This document serves to provide a possible starting point for policy indicators recommended for measurement which demonstrate Oregon’s progress in accomplishing the Governor’s charge while informing potential course corrections. Indicators are potential metrics for data analysis and measurement by OHA. Indicators are noted by policy area measured.

Coverage & Access:

- Individual & Small Group Market:
 - number of uninsured over time
 - number of individuals paying tax penalty for no coverage
- Small Group Market:
 - number of small employers that move to SHOP
 - number of small employers that go direct with carriers for coverage
 - number of small employers that drop coverage and allow employees to move to the individual Exchange
 - trend to part time employees (under 30 hours)
- Consumers:
 - consumer satisfaction with access to primary care providers
 - utilization of service across provider types by geo by payer

Transparency & Accountability:

- Individual, Large and Small Group Market:
 - number of employers offering coverage
 - changes in who is bearing the cost of coverage (by employer, by individual and by government)
 - transparency on the drivers of health care costs as it relates to health insurance premiums (i.e. costs, utilization, new technology).
- Small Group Market:
 - change in growth of employers less than 50 FT employees.
- Providers:
 - provider charity care and bad debt
 - number of bankruptcies due to health care costs

- providers capacity to accept new patients across payers
- Consumers:
 - analyze/compare all metrics equitably and across geographic areas

Oregon Health Fund Board 2008 Recommendations

* *italics indicates legislation was enacted*

- Additional public reporting of hospital, provider, and health plan quality and financial data by insurers and TPAs
- Report contract rates paid to providers and report on the percentage increases in such rates in local markets by facility and other provider groupings
- *Require health insurers and TPAs to report their membership by defined blocks of business and zip code, report on changes in the number of insured residents by local markets*
- *Require the collections of data on race, ethnicity and primary language by all health care providers and health plans to be included in APAC submissions*
- *Authorize reporting of proposed capital expenditures*
- Public reporting of the average admin expense on a pmpm basis, total premiums earned, and the percent growth in admin as a percentage of premium by hospitals and providers
- Public reporting of paid amounts
- Public reporting of quality data
- Uniform contracting strategies
- Strengthen public employers uniform purchasing strategies
- Control increases in administrative spending
- Control provider increases
 - Reference pricing