Oregon Health Policy Board

AGENDA

June 4, 2013
Market Square Building
1515 SW 5th Avenue, 9th floor
1:00 to 4:00 p.m.

Live web streamed at: OHPB Live Web Streaming

#	Time	Item	Presenter	Action Item
1	1:00	Welcome, call to order and roll **Action item:** Consent agenda: 4/2/13 minutes 5/7/13 minutes	Eric Parsons, Chair	X
2	1:05	Director's report and legislative update	Bruce Goldberg	
3	1:20	Quarterly Report review	Tina Edlund	
4	1:45	Review: OHPB goals and progress	Tina Edlund	
5	2:00	OHPB Next Steps	Chair Bruce Goldberg	
	2:30	Break		
6	2:45	Cover Oregon: QHP Alignment with coordinated care model	Rocky King	
7	3:15	PEBB: Alignment with coordinated care model	Sean Kolmer	
8	3:45	Public testimony	Chair	
	4:00	Adjourn		

Next meeting:
July 2, 2013
8:30 a.m. to noon
Market Square Building
1515 SW 5th Avenue, 9th floor

DRAFT

Oregon Health Policy Board
DRAFT Minutes
April 2, 2013
1 p.m. to 4 p.m.
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, except Lillian Shirley and Nita Werner. Tina Edlund and Bruce Goldberg were present from the Oregon Health Authority (OHA). **Consent Agenda:** The minutes from the March 5, 2013 and meeting were unanimously approved.
Director's Report – Bruce Goldberg Bruce Goldberg gave a legislative update on the session thus far. Goldberg said liability reform, one of the OHA's legislative priorities, has been signed by the Governor. He said it is a real success in terms of moving forward in health system transformation. Goldberg said there is a bill that would create a Patient Engagement task force. The task force would present ideas and proposals during the February 2014 legislative session and would most likely engage the Board in developing those proposals. Goldberg also said CCO baseline quality data on quality metrics should be available by the end of April. He said beginning in July, OHA will start moving the payment mechanism from payment for volume, to payment for outcomes and performance.
Update on Transformation Center – Cathy Kaufmann Cathy Kaufmann gave a presentation about the Transformation Center and an update about the Center's progress. Kaufmann said that OHA established the Center to be a supportive partner in transformation and the spread of innovation. Kaufmann said the Transformation Center's goals are to partner with CCOs to increase the rate and spread of innovation needed to achieve the triple aim and spread elements of the CCO model to other players. Kaufmann gave of list of ways the Center will help good ideas travel faster: • Relative Advantage • Compatibility • Simplicity • Trialability • Observability • Reinvention • Active Learning Network • Champions of Change • Rapid Cycle Improvement She said the center will house Innovator Agents; learning collaboratives; data and analytics; technical assistance and infrastructure support; conferences and workshops, communications, outreach and

networking; the Council of Clinical Innovators; regional Health Equity Coalitions; and the promotion of PCPCH, use of NTHW and elements of CCO model.

Kaufmann said over the last month, Innovator Agents have had a significant amount of training in the agency, transformation and CCOs. Kaufmann said OHA has contracted with the Institute for Health Improvement to help train Innovator Agents and set up the Center's learning collaboratives. She said OHA wants the collaboratives to be very actionable, time-limited collaboratives that support the CCOs and help achieve real results.

The Transformation Center presentation can be viewed here.

Workforce Committee Report Back – Lisa Dodson

Lisa Dodson spoke about the most recent Workforce Committee Report, which includes revised recommendations requested by the Board.

Dodson said the Committee's top recommendations include:

- Implement flexible, functional, and outcomes-based reimbursement mechanisms, especially for primary care, widely and as soon as possible;
- Implement them new Medicaid loan repayment program for primary care providers
- Forecast short and longer-term demand for primary care practitioners, accounting for likely effects of new models of care; and
- Make better use of naturopaths as part of the primary care workforce by removing contracting, credentialing, coverage, and payment barriers.

Chair Eric Parsons asked OHA staff to look at key recommendations and help figure out barriers to success and possible resources.

Workforce Committee Recommendations can be viewed here, starting on page 27.

Reinsurance Report: ACA Impacts on Individual and Small Market – Barney Speight

Barney Speight gave a presentation about Impacts of the ACA on Individual and Small Group Markets, which included an overview of the current market.

Speight said ACA impacts on the individual market include the elimination of medical underwriting with guaranteed issue and renewability.

Standardized levels of coverage:

- Bronze: Covers 60% of expected costs for the average individual
- Silver: Covers 70% of expected costs for the average individual
- Gold: Covers 80% of expected costs for the average individual
- Platinum: Covers 90% of expected costs for the average individual

Speight said every carrier has to put all its individual business in a single risk pool, regardless of whether plans are offered inside or outside the Exchange. He said Premiums are adjusted for family size, geography, age and tobacco use.

Speight said there will be financial assistance for the cost of coverage. He said refundable, advanceable premium credits will be available to people between 100% and 400% of the Federal Poverty Level, who purchase coverage in the Exchange. Speight said there will also be cost-sharing subsidies for people under 250% of Federal Poverty Level.

Penalties for not having health insurance:

- 2014: The greater of: $95/adult and $47.40/child (up to $285 for a family) or 1.0% of family income
- 2015: The greater of: $325/adult and $162.50/child (up to $975 for a family) or 2.0% of family income

- 2016: The greater of: $695/adult and $347.50/child (up to $2,085 for a family) or 2.5% of family income

Speight also spoke about changes to the small group market. He said the new requirements include Essential Health Benefits, the same minimum actuarial values as the individual market, a prohibition of annual limits, limits on cost-sharing, and rating rules. Speight said one of the reasons that the Oregon exchange will be so fascinating is it will give employers and employees a whole new opportunity for choice.

The ACA Impacts on Individual and Small Market presentation can be viewed here, starting on page 53.

Public Testimony

The board did not hear any public testimony.

Adjourn

Next meeting:
May 7, 2013
8:30 a.m. to 12 p.m.
Market Square Building
1515 SW 5th Ave, 9th Floor
Portland, OR 97201

Oregon Health Policy Board
DRAFT Minutes
May 7 and 16, 2013
Webinar

Item
The May 7 Oregon Health Policy Board webinar can be viewed here. **Welcome and Call To Order** Vice-chair Lillian Shirley opened and conducted the meeting. Board members present: Vice-chair Lillian Shirley, Mike Bonetto, Carlos Crespo, Felisa Hagins, Carla McKelvey, and Nita Werner. Tina Edlund and Bruce Goldberg were present from the Oregon Health Authority (OHA). **Consent Agenda:** The accepting of the minutes from the April 2, 2013 meeting was postponed.
Director's Report and Legislative update – Bruce Goldberg Bruce Goldberg gave a legislative update. The Oregon Health Authority is actively working on five important policy bills. Four of them help implement the Affordable Care Act (two on the Medicaid side and two on the commercial side). Those four bills are through the house and into Ways and Means; they should be heard later this week. The fifth is a hospital assessment bill that helps fund the Oregon Health Plan. We anticipate that over the next month the legislative process will pick up a lot of steam both for health policy and budget issues. There should be much more to report on at the June board meeting. Within the agency, we have been working hard on completing the first Health System Transformation Quarterly Progress report. The board will be able to see that next week.
Oregon's rate review process – Laura Cali, Department of Consumer and Business Services Laura Cali, Chief Actuary & Manager of product regulation at the Oregon Insurance Division gave a presentation on Oregon's rate review process. The Oregon Insurance Division reviews all policy forms, plan designs and rates before plans become available on the market. The rate review process has become more robust and public over the last few years. The review of specific combinations of benefits and plan design is a new addition to the review process. Plan filings for this year were submitted by April 30 and final approval is expected in late June or early July. Public hearings on the rates will be held May 28 – June 7. Consumer-focused decision summaries will be posted in early July. All plans are reviewed for legal compliance, benefits and rates. Information from the submittals about rate information and benefits is used to populate Cover Oregon's insurance shopping experience. Some of the key aspects of the review process include: • Verifying that carriers quantify and support key assumptions to justify rates. • Ensuring plans include the minimum coverage and regulatory requirements. • Reviewing consistencies across plans in terms of assumptions and cost relative to new federal and state requirements. *Cali's* Oregon's rate review process *PowerPoint can be reviewed here. The video of the presentation can be found here, starting at the ten minute mark.*
Upcoming meetings Next week OHA staff will hold a webinar for the Oregon Health Policy Board and the public to review the first health system transformation quarterly report.

The June board meeting will include a discussion on creating an agenda for the board over the next few months.
The May 16 Oregon Health Policy Board Webinar on Health System Transformation Quarterly Report can be viewed here. The Oregon Health Policy Board held a special webinar to review the first health system transformation quarterly report. Oregon Health Authority director Bruce Goldberg, Tina Edlund, and Lori Coyner presented the report and highlighted some of its key components: • Coordinated care organization (CCO) metrics baselines and benchmarks. • Financial data • Key progress indicators of transformation • Promising practices from CCOs around the state.
Adjourn

Next meeting:
June 4, 2013
1:00 p.m. to 4:00 p.m.
Market Square Building
1515 SW 5th Ave, 9th Floor
Portland, OR 97201

Health System Transformation Baseline Metrics Update

June 4, 2013

Tina Edlund, Chief of Policy

Oregon Health Authority

Health System Transformation: Oregon's Commitment to CMS

- Reduce the annual increase in the cost of care (the cost curve) by 2 percentage points
- Ensure that quality of care improves
- Ensure that population health improves
- Establish a quality incentive pool that increases every year as a percentage of the global budget
- Commitment to measurement
- Public reporting of metrics by CCO

Oregon Health Authority

First Quarterly Progress Report

- First Health System Transformation Quarterly Progress Report, May 2013
  - Starting point for measuring access and quality of care
  - Transparent reporting
- Baseline data: snapshot of care provided in 2011
- Predecessor organizations, before CCOs began
- Report includes financial, utilization, access and quality metrics
- Shows individual CCO performance against benchmark values as well as statewide average

Oregon Health Authority

CCO Incentive Measures

- Annual assessment of CCO performance on 17 measures
- Will compare performance in CY 2013 to CY 2011 baseline
- Quality pool funds available to CCOs based on performance; up to 2% of their global budget in first year

State Performance Measures

- Annual assessment of statewide performance on CCO measures and an additional 16 metrics
- Financial penalties to the state if quality goals are not achieved.

Oregon Health Authority

Statewide Quality and Access Metrics

Report includes Oregon's statewide performance on 29 of 33 metrics, across 7 quality improvement focus areas:

- ✓ Improving behavioral and physical health coordination
- ✓ Improving perinatal and maternity care
- ✓ Reducing preventable re-hospitalizations
- ✓ Ensuring appropriate care is delivered in appropriate settings
- ✓ Reducing preventable and unnecessarily costly utilization by super-users
- ✓ Addressing discrete health issues (such as asthma, diabetes, high blood pressure)
- ✓ Improving primary care for all populations

Oregon Health Authority

CCO Incentive Measures

- Measures selected by the Metrics & Scoring Committee in October 2012, revised and approved by CMS in December 2012
- The report shows 11 of the 17 CCO incentive measures across the 7 quality improvement focus areas.
- Remaining 6 currently under review by CCOs

Oregon Health Authority

Metrics & Scoring Committee

- 2012 Senate Bill 1580 establishes committee
- Nine members serve two-year terms. Must include:
  - 3 members at large;
  - 3 members with expertise in health outcome measures;
  - 3 representatives of CCOs
- Committee uses public process to identify objective outcome and quality measures and set benchmarks.

Oregon Health Authority

Technical Advisory Group

- Group of technical and clinical experts from CCOs

- Ad hoc committee working to make recommendations to Metrics and Scoring Committee on detailed measure specifications

PERFORMANCE METRICS

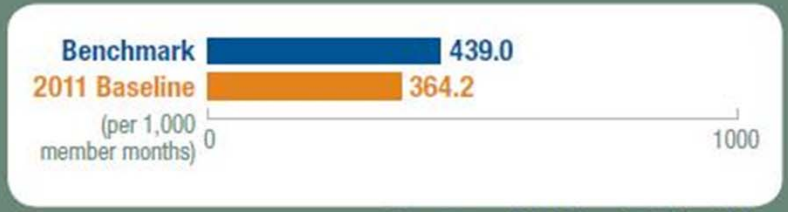
Statewide Metrics

Reducing preventable and unnecessarily costly utilization

Getting the right care at the right time and in the right setting is important for delivering high-quality, cost-effective care.

Ambulatory care: Outpatient utilization

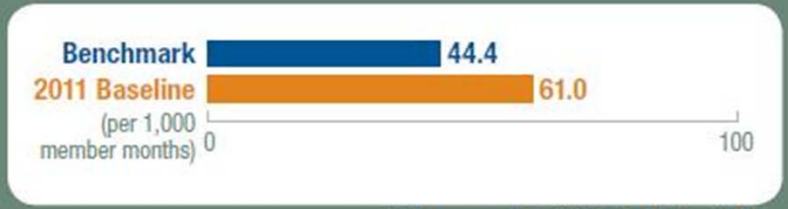
Rate of patient visits to a clinic or urgent care.
(CCO Incentive Measure)



Data source: Administrative (billing) claims
Benchmark source: 2011 National Medicaid 90th percentile

Ambulatory care: Emergency department utilization

Rate of patient visits to an emergency department.
(Lower scores are better.)
(CCO Incentive Measure)



Data source: Administrative (billing) claims
Benchmark source: 2011 National Medicaid 90th percentile

Plan all-cause readmission

Percentage of adult patients (ages 18 and older) who had a hospital stay and had to go back into the hospital again for any reason within 30 days of discharge.
(Lower scores are better.)

Data source: Administrative (billing) claims
Benchmark source: Average of 2012 Commercial and Medicare 75th percentiles

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

PERFORMANCE METRICS

CCO Baselines

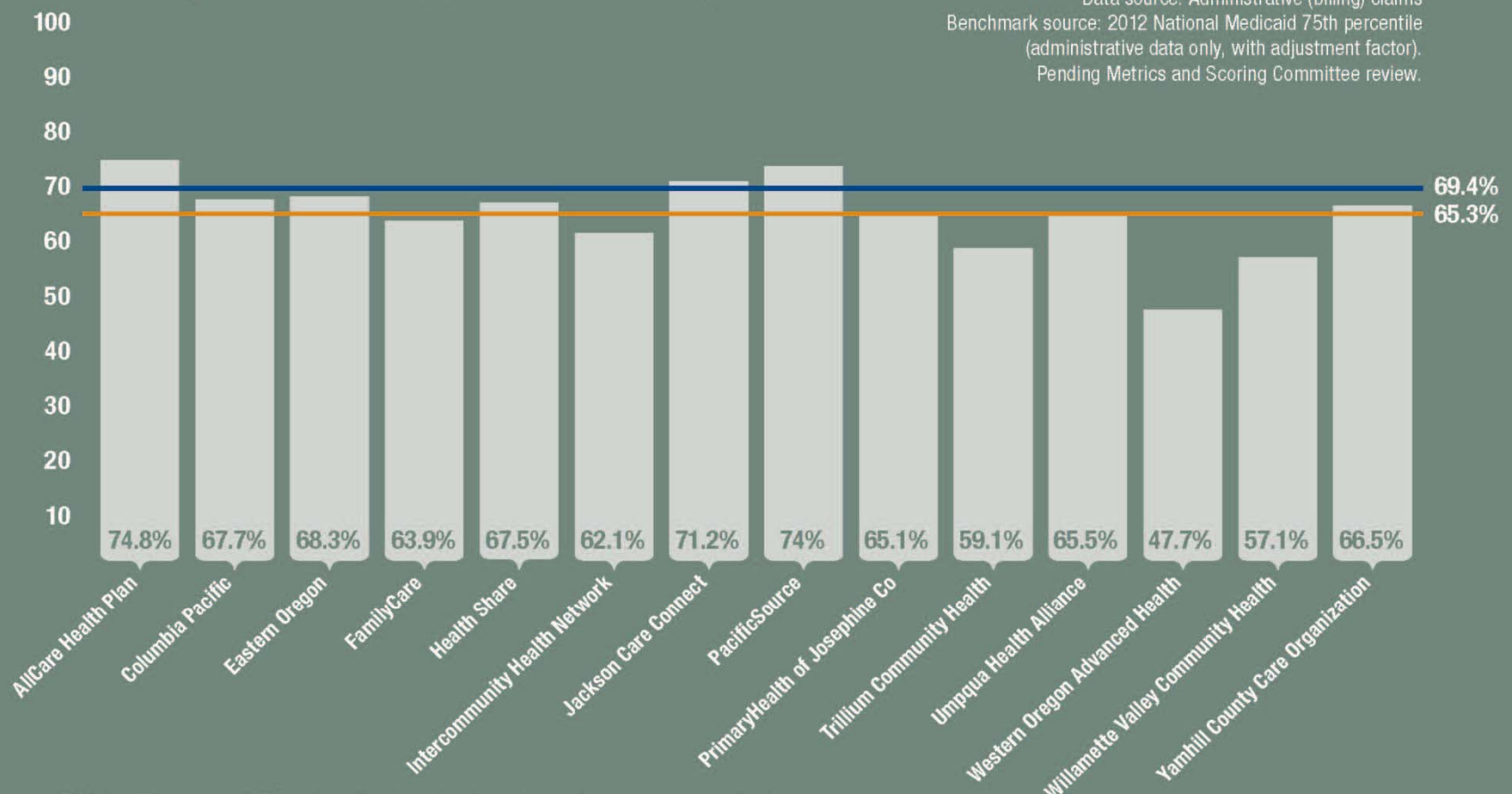
Timeliness of prenatal care

Care during a pregnancy (prenatal care) supports the delivery of a healthy baby and helps a woman prepare to become a mother. These data show the percentage of pregnant women who received a prenatal care visit within the first trimester (or within 42 days of CCO enrollment). (CCO Incentive Measure)

State Benchmark	69.4%
2011 State Baseline	65.3%

n = 15,128

Data source: Administrative (billing) claims
Benchmark source: 2012 National Medicaid 75th percentile (administrative data only, with adjustment factor).
Pending Metrics and Scoring Committee review.



2011 baselines are pre-CCO and are based on data from the predecessor care organization.

PERFORMANCE METRICS

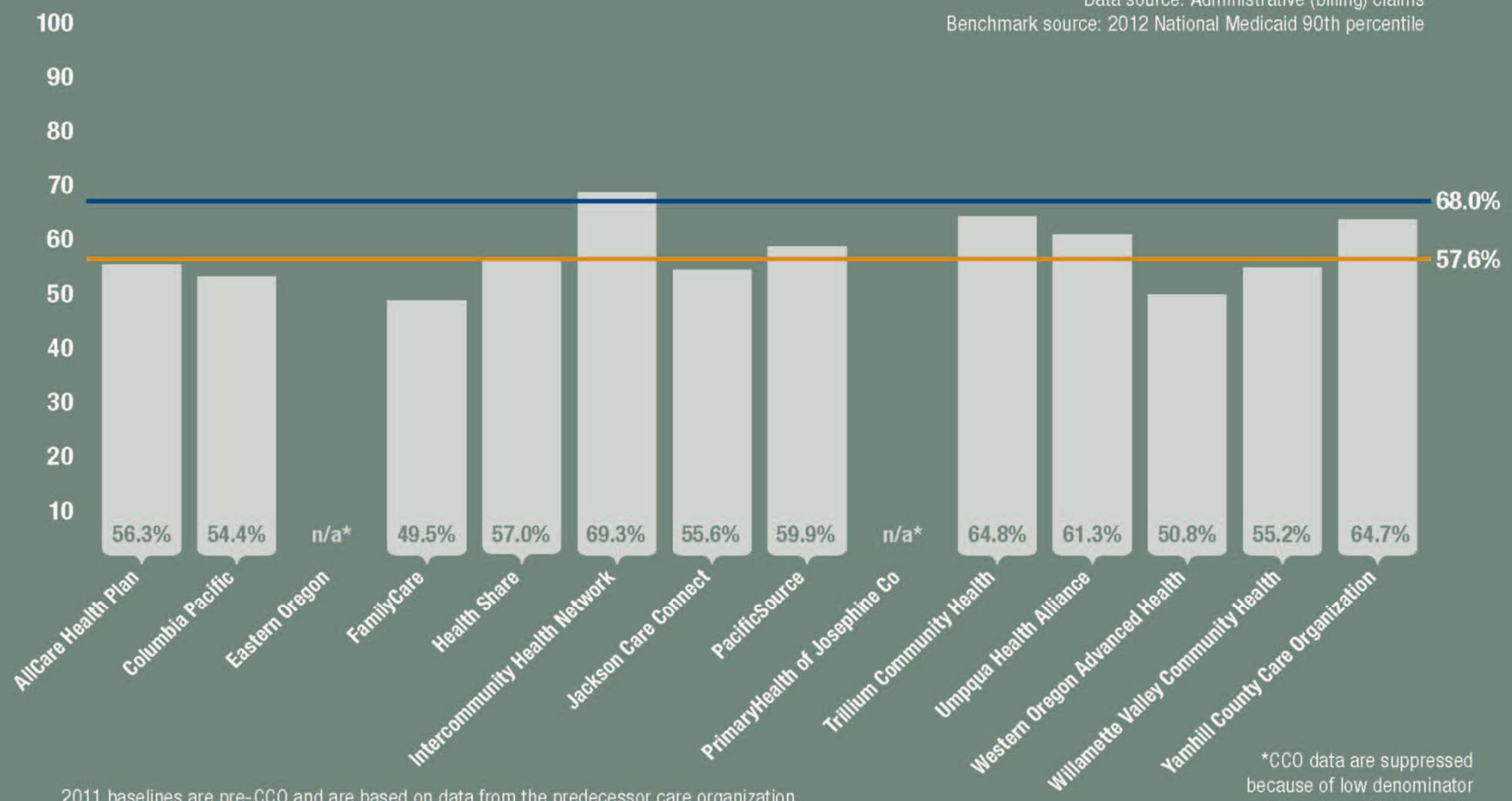
CCO Baselines

Follow-up after hospitalization for mental illness

Percentage of patients (ages 6 and older) who received appropriate follow-up care within 7 days of being discharged from the hospital for mental illness. (CCO Incentive Measure)

State Benchmark	68.0%
2011 State Baseline	57.6%
	n = 2,284

Data source: Administrative (billing) claims
Benchmark source: 2012 National Medicaid 90th percentile



2011 baselines are pre-CCO and are based on data from the predecessor care organization.

*CCO data are suppressed because of low denominator (fewer than 30 instances).

PERFORMANCE METRICS

CCO Baselines

Ambulatory care: Emergency department utilization

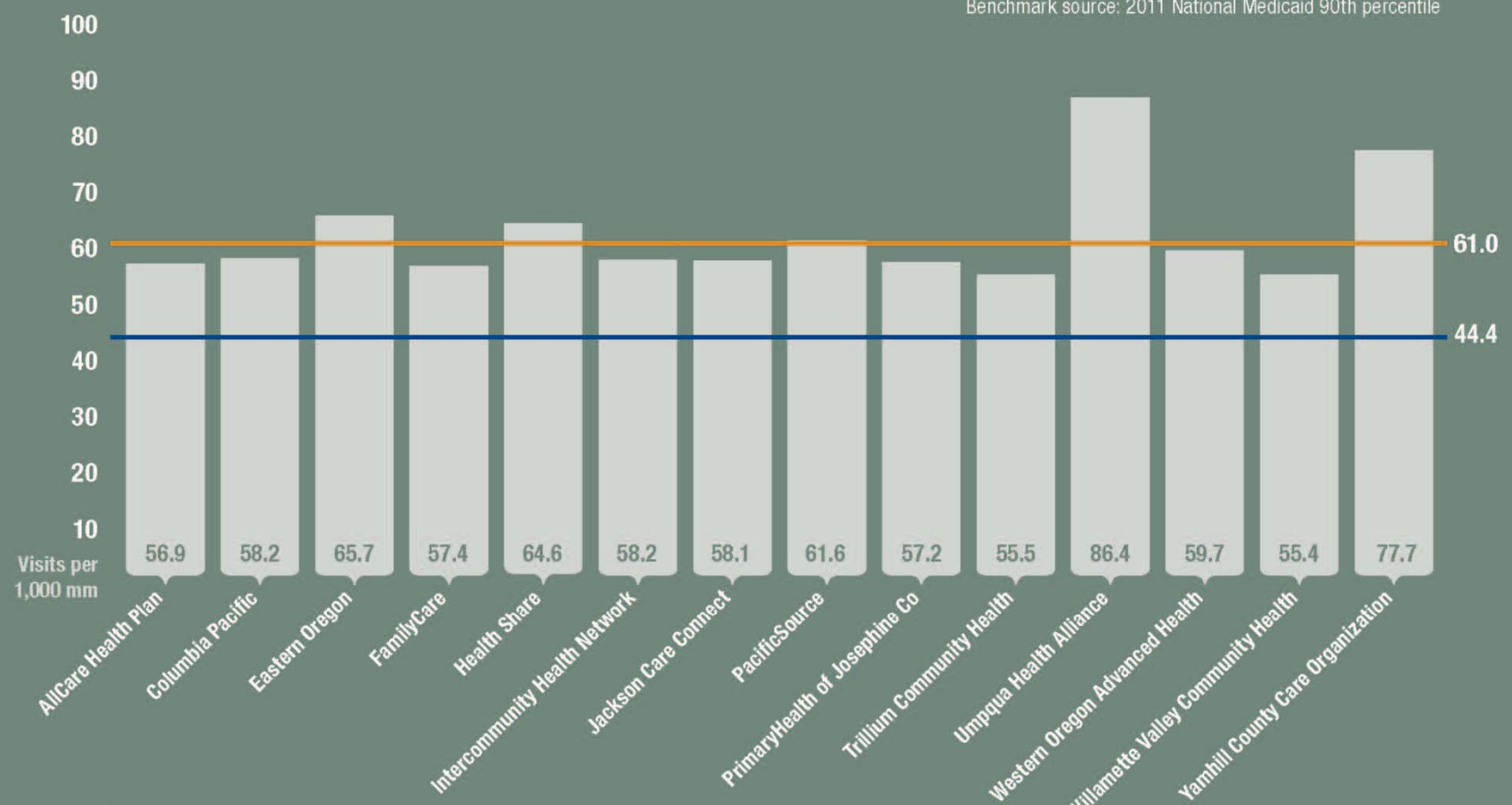
Rate of patient visits to an emergency department.

(CCO Incentive Measure)

State Benchmark	44.4/1,000 member months
2011 State Baseline	61.0/1,000 member months

(A lower score is better.)

Data source: Administrative (billing) claims
Benchmark source: 2011 National Medicaid 90th percentile



2011 baselines are pre-CCO and are based on data from the predecessor care organization.

PERFORMANCE METRICS

CCO Baselines

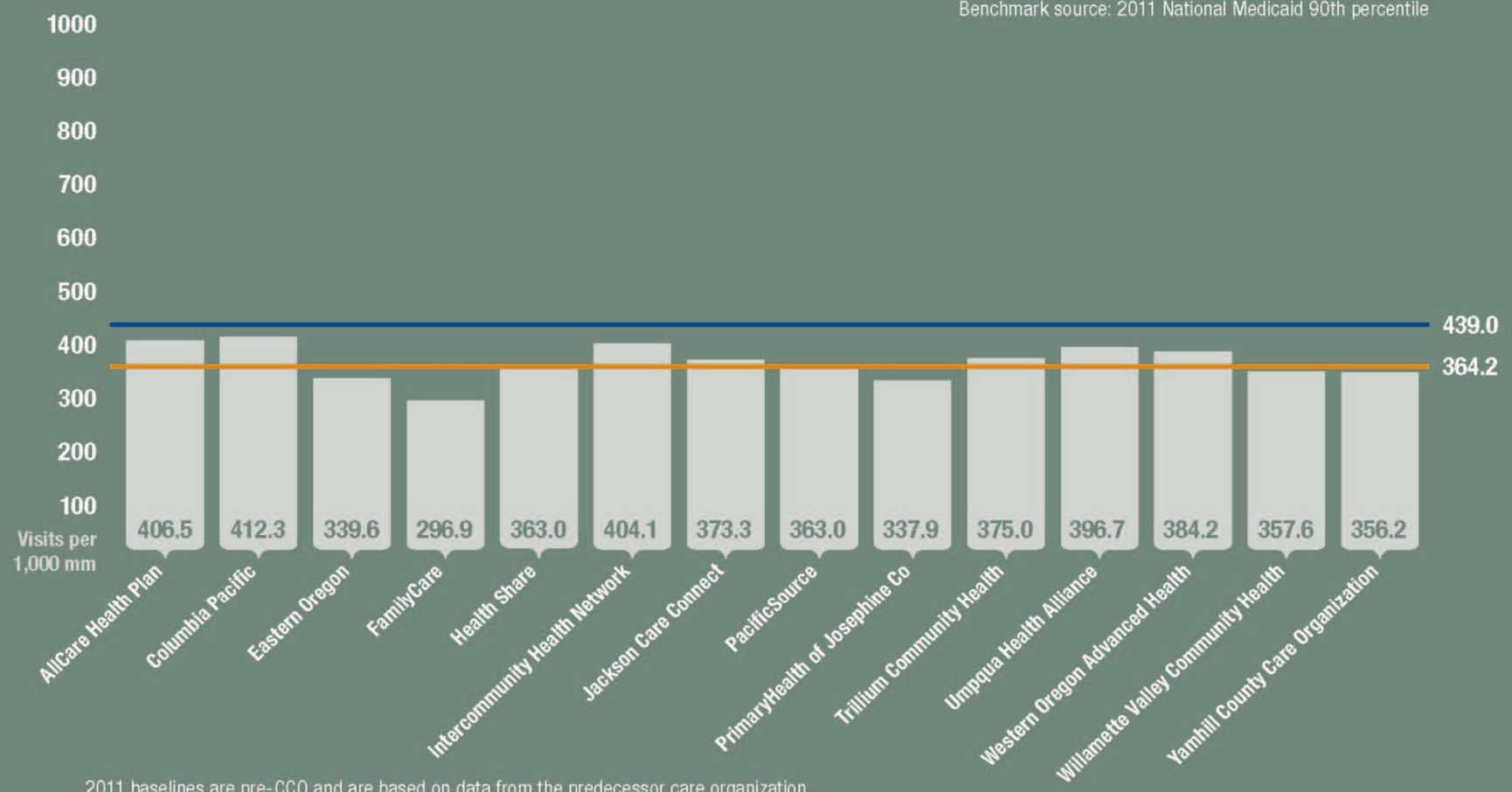
Ambulatory care: Outpatient utilization

Rate of patient visits to a clinic or urgent care.

(CCO Incentive Measure)

State Benchmark	439.0/1,000 member months
2011 State Baseline	364.2/1,000 member months

Data source: Administrative (billing) claims
Benchmark source: 2011 National Medicaid 90th percentile



2011 baselines are pre-CCO and are based on data from the predecessor care organization.

Bending the Cost Curve
Preliminary Financial Data

- Current report
  - Includes preliminary utilization and expenditure data for:
    - calendar year 2011, before CCOs were formed
    - 4th quarter 2012, the first quarter of CCO data
  - Includes data received and processed through April 26, 2013 so may be incomplete

- Future reports
  - Values will be recalculated and reported to reflect more complete data
  - Data will be tracked at both statewide and CCO levels
  - Financial benchmarks will be added as reference points to track the progress made in meeting Oregon's overarching goals

Oregon Health Authority

PRELIMINARY FINANCIAL DATA

Quarterly Data

UTILIZATION DATA

CATEGORIES	OREGON PRE-CCO BASELINE**	BENCHMARK	OCT-DEC 2012 PRELIMINARY DATA*
UTILIZATION DATA (ANNUALIZED / 1000 MEMBERS)			
Inpatient - Medical /Surgical Patient Days	252.6	In Development	218.3
Inpatient - Maternity Patient Days	73.8	In Development	60.0
Inpatient - Newborn Patient Days	88.8	In Development	66.7
Inpatient - Mental Health Patient Days	55.7	In Development	53.9
Outpatient - Primary Care Medical Visits (Includes Immun/Inject)	2,800.3	In Development	2,927.5
Outpatient - Specialty Care Visits	3,917.8	In Development	3,514.3
Outpatient - Mental Health Visits	912.6	In Development	953.2
Outpatient - Dental Visits (Preventive)	532.9	In Development	Data Pending
Outpatient - Emergency Department Visits	See emergency department utilization quality data on page 32.		
Outpatient - Pharmacy Prescriptions Filled	9,297.7	In Development	7,947.3
Outpatient - Labs and Radiology (Service Units)	4,739.3	In Development	4,300.0
Outpatient - Freestanding Ambulatory Surgical Center Procedures	24.6	In Development	20.1

May 2013

* Includes claim data received and processed through 4/26/13. At this point, there is no data on services that have happened, but have yet to be recorded or invoiced.
This initial dashboard is also incomplete due to lags in submitting data to OHA.
As a result, this data is very preliminary. The values will be recalculated and reported as additional data are made available.
This is the first step in collecting and sharing data, and future dashboards will be updated when more complete data is submitted.

** Oregon baseline measures are statewide values from CY 2011 and are based upon predecessor managed care organization (MCOs).

PRELIMINARY FINANCIAL DATA

Quarterly Data

COST DATA

CATEGORIES	OREGON PRE-CCO BASELINE**	BENCHMARK	OCT-DEC 2012 PRELIMINARY DATA*
	Cost PMPM	Cost PMPM	Cost PMPM
Inpatient - Medical / Surgical	$35.64	In Development	$36.98
Inpatient - Maternity	$7.28	In Development	$8.12
Inpatient - Newborn	$6.71	In Development	$6.02
Inpatient - Mental Health	$3.12	In Development	$3.06
Outpatient - Primary Care	$19.99	In Development	$20.61
Outpatient - Specialty Care	$24.88	In Development	$22.14
Outpatient - Mental Health	$18.86	In Development	$17.65
Outpatient - Dental	$9.52	In Development	Data Pending
Outpatient - Emergency Department	$8.73	In Development	$6.60
Outpatient - Pharmacy Prescriptions	$30.80	In Development	$27.91
Outpatient - Labs and Radiology	$19.25	In Development	$16.44
Outpatient - Freestanding Ambulatory Surgical Center Procedures	$1.52	In Development	$1.44
Outpatient - Health Related Services	$0.00	In Development	$0.00
Outpatient - Other Hospital Services	$32.24	In Development	$26.80

May 2013

PMPM- *Per Member Per Month*

* Includes claim data received and processed through 4/26/13. At this point, there is no data on services that have happened, but have yet to be recorded or invoiced.
This initial dashboard is also incomplete due to lags in submitting data to OHA.
As a result, this data is very preliminary. The values will be recalculated and reported as additional data are made available.
This is the first step in collecting and sharing data, and future dashboards will be updated when more complete data is submitted.

** Oregon baseline measures are statewide values from CY 2011 and are based upon predecessor managed care organization (MCOs).

Next Steps

- Next quarterly progress report: August 2013

- Add remaining state performance and CCO Incentive measures to next report.

Oregon Health Authority

Questions

For more information:

- OHA has posted the full Accountability Plan at www.health.oregon.gov
- Metrics & Scoring Committee www.oregon.gov/oha/pages/metrix.aspx/
- Measure Specifications + Methodology www.oregon.gov/oha/Pages/CCO-Baseline-Data.aspx
- Baseline Data and Report http://www.oregon.gov/oha/metrics/Pages/index.aspx

Contact

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Oregon Health Authority

Oregon's Action Plan for Health, 2010: Status of Action Items

Action	Status as of June 2013
Set a target for health care spending in Oregon	Through Oregon's 1115 waiver agreement with the Centers for Medicare and Medicaid Services (CMS), Coordinated Care Organizations (CCOs) will operate on a global budget that will increase at a fixed rate not tied to increases in medical costs. Oregon has committed to reducing the trend from 5.4% to 4.4% by July 2013 and to 3.4% by July 2014.
Align purchasing: • Standardize certain provider payments to Medicare methodology to set stage for future payment reform. • Focus on quality and cost improvement efforts to achieve critical momentum. • Introduce innovative payment methods that reward efficiency and outcomes.	Senate Bill 204 required the state to develop and implement standardized alternative payment methodologies for hospital services for all state purchased insurance (PEBB, OEBB, Medicaid). A work group met three times in late 2011 and made recommendations on standardized payments. The methodology has been implemented in most parts of the state. In February 2013, all CCOs submitted plans to OHA for implementing alternative payment methodologies in their delivery systems. These changes will take place during the next two years, beginning in July 2013. In addition, OHA is collaborating with CCOs to develop a plan by which CCOs can account for certain health-related, flexible services to avoid the need for higher cost medical services. CCOs will also partner with local Patient-Centered Primary Care Homes (PCPCH). Recognized primary care homes that applied receive additional Medicaid funding to support the coordinated and patient-centered care they offer certain Medicaid patients with chronic conditions such as diabetes and asthma. The current payments were made possible through an 8-quarter opportunity in the Affordable Care Act and will end in September 2013. CCO global budgets will increasingly shift from a per capita based payment to payment based on outcomes: 2% of the total budget will be paid on the basis of performance in the first year of Oregon's 1115 demonstration, with an agreement that the percentage will increase each remaining demonstration year. OHA created the Transformation Center in April 2013 to provide peer-to-peer learning opportunities to CCOs, focusing on best practices, including quality improvement and innovative payment methodologies to reward efficiency and outcomes.
Reduce administrative costs in health care	The Addictions and Mental Division and the Division of Medical Assistance Programs is identifying key functions, processes and skills of current administrative and program support and use the information to develop streamlined and standardized processes including tools for training, sharing resources and

Oregon's Action Plan for Health, 2010: Status of Action Items

Action	Status as of June 2013
	sustaining improvements. In February 2013, a stakeholder workgroup completed several revisions to the Integrated Services and Supports Rules (ISSR), which regulate addictions and mental health services and supports. To reduce administrative burdens and increase access to treatment, several requirements were eliminated or reduced. An overview of the revisions include a reduction in documentation to complete an Assessment and an Individual Service and Support Plan (ISSP), reduction of paperwork required at the start of services, elimination of barriers to access created by specific medical oversight requirements, and elimination of certain screenings and progress documentation. Additionally, rule language was changed to allow for documentation streamlining, significantly reducing time spent on paperwork. These revisions are the first step in an effort to improve behavioral health care by eliminating barriers to quality services, and promoting integration. In addition, each CCO has an assigned Innovator Agent who works closely with the CCO and OHA to break down bureaucratic barriers to innovation within OHA and to collaborate statewide on best practices and innovations.
Decrease obesity and tobacco use	Obesity and tobacco are identified as priorities in the Public Health strategic plan. The Public Health Division worked with stakeholders and partners to outline the evidence-based strategies and policies that will be the most effective in ending the tobacco use and obesity epidemics. OHA is continuing to make significant progress around tobacco, including moving toward tobacco-free state properties, reducing tobacco use among state employees through the health engagement model and cessation services, supporting tribal casinos in going smoke-free, and engaging in a national counter-marketing campaign to warn the public about the risks of tobacco use and promote the state quit line. Obesity and overweight continues to be a significant challenge for the State. In March 2013, the Public Health Division applied for a Federal grant that would fund a coordinated approach to chronic disease prevention. This grant will include funding for evidence-based obesity prevention. Evidence-based approaches to changing the social and physical environment, such as ensuring healthy food options and altering the information environment, continue to be the best way to prevent and reduce overweight and obesity.

Oregon's Action Plan for Health, 2010: Status of Action Items

Action	Status as of June 2013
	Public Health Division plans to work with the CCOs to encourage the adoption of evidence-based approaches to prevention and health promotion, and will provide technical assistance around CCO metrics related to tobacco use and obesity/overweight. The Public Health Division will continue to monitor tobacco use and obesity/overweight among all Oregonians to evaluate the effectiveness of our efforts.
Establish a mission-driven public corporation to serve as the legal entity for the Oregon Health Insurance Exchange	The Oregon Health Insurance Exchange Corporation – now called Cover Oregon – has taken significant steps in the past year to prepare for open enrollment in October 2013. Oregon was among the first six states to receive federal certification for its exchange, and Cover Oregon received $226 million in federal grant funding in early 2013 to complete development of its marketplace and sustain the business during its first year of operations. IT development continues at a rapid pace, and Cover Oregon expects to complete development of the eligibility and enrollment system in spring 2013. Cover Oregon already has begun user testing of a prototype with potential customers and plans to conduct a large amount of system testing in coming months. Cover Oregon solidified requirements for carriers who will sell Qualified Health Plans in the marketplace and established an initial set of quality measures. More than 20 carriers have been approved to offer medical and dental plans through Cover Oregon. Those carriers must submit their plans and rates to the Insurance Division for approval before they can be offered through Cover Oregon. The exchange officially rebranded itself as Cover Oregon in 2012 and launched a new website with consumer tools. This summer, Cover Oregon will launch a broad marketing campaign to reach Oregonians throughout the state. Cover Oregon also has started training insurance agents and community-based organizations, who will be key partners in educating Oregonians and small employers and helping them through the process of accessing health coverage. Help will also be available through Cover Oregon's Customer Service Center.

Oregon's Action Plan for Health, 2010: Status of Action Items

Action	Status as of June 2013
Promote local and regional accountability for health and health care	CCOs developed Transformation Plans, addressing eight critical components of health system reform. These components include strategies to: integrate mental health and addictions with physical health, payment reforms that result in improved health outcomes, the development and support of patient-centered medical homes, health information technology solutions to improve coordination of care, community health assessments and improvement plans that reflect local needs, and strategies to address health disparities. Each CCO has identified meaningful and measurable milestones and benchmarks. Innovator Agents have been assigned to partner with CCOs to assess, monitor progress, and identify best practices and innovative approaches to support CCOs in reaching their goals. In addition, each CCO has an assigned Innovator Agent who works closely with the CCO and OHA to break down bureaucratic barriers to innovation within OHA and to collaborate statewide on best practices and innovations.
Build the health care workforce • Use loan repayment to attract and retain primary care providers in rural and underserved areas • Standardize prerequisites for clinical training via a student "passport" • Extend requirement to participate in Oregon's health care workforce database to all health professional licensing boards.	SB 440, which created a $4M primary care provider loan repayment program was passed in both the House and Senate with broad bipartisan support and signed into law by the Governor on May 16th, 2013. The Health Authority will adopt administrative rules and launch the program as quickly as possible after the bill is signed. This program will complement ongoing work by the state's Primary Care Office (PCO) staff to maximize the number of recruitment incentives that can be awarded to Oregon clinicians and scholars through federal programs such as the National Health service Corps (NHSC). Also as part of the CMS agreement, the state also committed to training more Community Health Workers. Temporary rules were filed in February to establish curriculum guidelines and procedures for non-traditional health worker (NTHW) training programs to be approved by the Authority, as well as competency requirements for each NTHW type; a NTHW registry; and eligibility requirements and procedures for NTHW certification and provisional certification. In July 2012, the OHPB approved standard administrative requirements for student clinical placement that had been developed with significant stakeholder input. A Rules Advisory Committee (RAC) is currently working to translate the standards into rule language; the RAC's third meeting will take place on April 30. OHA anticipates that the rules will be in place by late summer, with an effective date of fall 2014 as recommended by stakeholders. As part of their approval, the OHPB also urged stakeholders to establish a centralized tracking system that would reduce paperwork exchange and duplicative work

Oregon's Action Plan for Health, 2010: Status of Action Items

Action	Status as of June 2013
	between schools, students, and clinical sites. The Health Authority recently released an RFI to gather information about the potential functions and costs of such a system and will work with stakeholders of financing and governance options. Currently, ten licensing boards are participating in the health care workforce database: seven as part of the original mandated group from HB 2009 and three voluntarily. HB 3650 (2011) directed OHA to work with all licensing boards to expand the database but did not make participation a requirement for licensure, nor did it allow the collection of fees from additional boards to support system operation.
Move to patient-centered primary care (PCPCH), first for OHA lives (Medicaid, state employees, educators) and then statewide	As of May 2013, over 380 practices statewide have been recognized by the OHA as Patient-Centered Primary Care Homes (PCPCH). This represents approximately half of the potentially eligible practices in Oregon and accounts for over 2,300 individual primary care providers. The Division of Medical Assistance Programs received approval from CMS in March 2012 to provide enhanced per-member-per-month payments to recognized PCPCH practices for Medicaid clients meeting certain criteria. These payments are available through September 2013. Beginning in January 2013, the Public Employees' Benefit Board (PEBB) provides an age-adjusted, per-member-per-month incentive payment to Tier 2 or Tier 3 recognized primary care homes in the PEBB Statewide plan, administered by Providence Health & Services. In addition, PEBB members in the PEBB Statewide plan have lower cost share for primary care services when they access care through a recognized primary care home – from 15 to 10 percent. Similar payment structures for OEBB lives are under discussion. On April 1, 2013 Aetna began providing per-member-per-month payments for their covered lives in recognized primary care homes, based on a practice's tier of PCPCH recognition. OHA, in partnership with the Northwest Health Foundation and the Oregon Healthcare Quality Corporation, launched the Patient-Centered Primary Care Institute in September 2012. The Institute provides technical assistance and resources through a variety of strategies to assist primary care practices with transformation and achieving the PCPCH standards of care. The Institute is also conducting its first

Oregon's Action Plan for Health, 2010: Status of Action Items

Action	Status as of June 2013
	Learning Collaborative with 25 practices from across Oregon. The 25 selected practices receive in-person and virtual technical assistance and quality improvement coaching. The Institute conducts monthly webinars on core transformation topics, and launched a comprehensive website of tools and resources to support primary care practices. The PCPCH Standards Advisory Committee held five public meetings from August through October 2012 to provide technical expertise and recommendations on refinement of the PCPCH model. The proposed revisions are designed to incrementally adapt the model to the changing health care needs across the state, align the model with the best evidence available, and improve the effectiveness of the standards and measures overall.
Introduce a value-based benefit design that removes barriers to preventive care.	The 20 value-based services representing preventive care and chronic disease management identified by the Health Services Commission continue to be used. The set has highest evidence of clinical and cost-effectiveness for which little or no cost-sharing should be required. A value-based benefit design prototype is available, using the Prioritized List of Health Services and the 20 sets of value-based services available with model pricing. It uses four tiers of cost-sharing which increase for services prioritized lower on the list. Some elements of the fourth tier have been used in PEBB's benefit design since 2012.OEBB has also considered the work in their benefit design
Expand the use of health information technology (HIT) and exchange (HIE)	Oregon's Health IT Extension Center (O-HITEC) measures progress in achieving electronic health record (EHR) adoption and meaningful use by Oregon providers in terms of three progressive Milestones for the federally-set target of 2,674 Priority Primary Care Providers (PPCPs). As of April 2013: • Milestone 1 (PPCP membership)- 3,236 or 121% of targeted 2,674 • Milestone 2 (Go Live) – 2,725 or 107% of targeted 2,674 • Milestone 3 (Meaningful Use) – 1,417 or 53% of targeted 2,674 Incentives for the adoption and meaningful use of EHRs are being paid through federally run Incentive Programs for Medicare, and by states for Medicaid. Oregon's Medicaid EHR Incentive Program launched in September 2011. As of April 23, 2013, that program has delivered the following incentive payments (federal dollars) to Oregon providers: • 1343 total eligible professionals have been paid $30,677,599, and • 49 total eligible hospitals have been paid $38,594,321.

Oregon's Action Plan for Health, 2010: Status of Action Items

Action	Status as of June 2013
	CareAccord statewide health information exchange (HIE) services launched in April 2012, making web-based, HIPAA-compliant Direct Secure Messaging services available to any provider, regardless of whether the provider has an EHR system or not. Phase One services are available at no cost, and the number of registered accounts exceeds 540 as of April 2013. Regional Health Information Organizations (RHIOs) continue to develop services that their local markets will support. OHA is exploring ways to connect CareAccord and RHIOs to increase providers' ability to exchange information. In addition, Oregon is a lead state in the National Association for Trusted Exchange (formerly the Western States Consortium) and has piloted the exchange of test messages between Oregon providers and California providers. A stakeholder engagement process is currently underway to identify top priorities for the next phase of HIE services. OHA expects to develop a framework for the Phase 2 HIE business plan over the summer, so we can apply for federal funding for the Medicaid-share of those services in Fall of this year.

Develop guidelines for clinical best practices	HERC is providing evidence-based guidance to public and private purchasers on coverage of health care services with high cost, high utilization and/or high variation in provider practice:
	
	• There have been three detailed guidelines approved by the Human Services Commission (HSC)/HERC so far:
	  o Evaluation and management of low back pain (includes pharmacologic and non-pharmacologic, non-invasive treatments)
	  o Advanced imaging for low back pain
	  o Percutaneous Interventions for Low Back Pain
	• 27 "Coverage Guidances" complete. On track to complete 3 updated coverage guidances and 9 additional coverage guidances by the end of 2013.
	• In addition to incorporating these coverage guidances into Prioritized List, PEBB and OEBB are using them to inform their coverage decisions. Efforts are planned through the CMMI grant to translate these guidances to further evidence-based practice.

Strengthen medical liability system	Senate Bill 1580 (2012) established the work group on Patient Safety and Defensive Medicine to recommend legislation introduced during the 2013 regular session. The resulting legislation introduced

Oregon's Action Plan for Health, 2010: Status of Action Items

Action	Status as of June 2013
• Remove barriers to full disclosure of adverse events by providers and facilities • Clarify that statements of regret or apology may not be used to prove negligence	and passed in 2013 (SB 483) allows providers and individuals to file notices of adverse events to the Patient Safety Commission (PSC), discuss the adverse event and resolutions, and use mediation if needed. It clarifies that expressions of regret or apology are inadmissible under ORS 677.082. The PSC will be responsible for analyzing the data in an effort to improve patient safety and staffing a 14 member Task Force on Resolution of Adverse Health Care Incidents that will oversee adverse event activities (e.g., regulations, forms, PSC performance, etc.). The Task Force is required to report to a committee of the Legislative Assembly by October 1, 2018 on whether any improvements to the process are necessary.
Performance measurement	Oregon's coordinated care organizations (CCOs) are charged with improving care, making quality care accessible and curbing the rising cost of health care. Well-designed measurements will help the state measure how well CCOs meet those goals. Through a public process in fall 2012, the Oregon Health Authority's Metrics and Scoring Committee developed 17 outcome and quality measures. Each year, OHA will award CCOs funds from a quality pool based on their performance on these 17 measures during the previous calendar year. OHA also agreed to report to the U.S. Centers for Medicare and Medicaid Services (CMS) on 16 additional state performance measures. These measures will allow OHA and CCOs to see where improvement is being made and where more work is needed. The measures will also be reported by race and ethnicity to ensure that Oregon and CCOs are striving to provide healthcare in an equitable way. The first quarterly progress report was published in May 2013.

"The Future"

Vision	Status as of June 2013
A coordinated and regionally integrated health system in which incentives are aligned toward quality care for every Oregonian.	There are 15 Coordinated Care Organizations established across Oregon, with 93% of all Medicaid clients currently enrolled. CCOs developed Transformation Plans, addressing eight critical components of health system reform. These components include strategies to: integrate mental health and addictions with physical health, payment reforms that result in improved health outcomes, the development and support of patient-centered medical homes, health information technology solutions to improve coordination of care,

Oregon's Action Plan for Health, 2010: Status of Action Items

Vision	Status as of June 2013
	community health assessments and improvement plans that reflect local needs, and strategies to address health disparities. Each CCO has identified meaningful and measurable milestones and benchmarks. Innovator Agents have been assigned to partner with CCOs to assess, monitor progress, and identify best practices and innovative approaches to support CCOs in reaching their goals.
A holistic approach that focuses on the patient, not the symptoms, and emphasizes preventive care and health lifestyles.	CCOs are responsible for treating patients in a holistic manner: They are responsible for a patient's physical, mental, and oral (starting in 2014) health care. Prevention on both a patient and community level is a key tool for CCOs in focusing on the holistic health of their patients. There are also over 380 practices statewide that have been recognized by the OHA as Patient-Centered Primary Care Homes (PCPCH). These PCPCHs must be accessible and accountable and offer comprehensive, continuous and coordinated care to patients and their families. Recognized primary care homes are eligible to receive payment incentives to support the quality, coordinated care they provide Oregonians. CCOs must also conduct regular Community Health Assessments (overseen by the CAC) to determine where the greatest needs for services are, what measures and programs can be implemented to provide better overall health, and where general improvements in the community's health and health systems could be made.
A community-based team of health care professionals, not just doctors, will help keep people healthy and treat them when they are sick	The Oregon Health Authority is working on identifying the number of non-traditional health workers across the state in order to better understand where need exists. Between January and April of 2013, OHA worked with the Oregon Employment Department and estimated that there are nearly 500 employed non-traditional health workers. People are working in this field statewide; however, Portland Metro and Willamette Valley organizations employ the majority, with nearly 75% of the total. New rules have established certification qualifications for funding non-traditional health workers through the Oregon Health Plan. Only those who have been certified by OHA after successful completion of an approved training program can be financed by Medicaid funds The Oregon Health Authority is currently working to establish rules for continuing education, age requirements, certification maintenance, and training program renewal. Permanent rules must be in

Oregon's Action Plan for Health, 2010: Status of Action Items

Vision	Status as of June 2013
	place by August 2, 2013.
Providers get paid for keeping people healthy.	CCOs are paid a global budget and will be responsible for maintaining the health of the entire population they serve. They will also be eligible to receive incentive payments for meeting certain benchmarks on measures that will create better health for a community. The goal is to eventually have all Medicaid members receive care through a CCO that is responsible for keeping the person healthy. Performance measurement will include measures of population health as well as health care and efficiency metrics.
Private, secure electronic medical records help providers see their patients' complete health picture and know what tests have already been done.	Oregon continues to exceed its goals for adoption and meaningful use of Electronic Health Records (see above section on expanding the use of HIT for more details). EHR incentives are paid through federally run incentive programs for Medicare and by states (using federal funds) for Medicaid. Oregon's Medicaid EHR Incentive Program launched in September 2011. The federal standards for meaningful use of EHRs are divided into stages, each encompassing increased requirements, thresholds and measurements. Stage 1 is focused on capturing data in a structured format to support interoperability, and stage 2 advances to greater focus on data exchange. Later stages will focus on advanced clinical processes and improved outcomes. We are exploring new ways to reach out to and assist providers who are not eligible for federal EHR incentives. For example, we are exploring possible methods to recognize providers who are not eligible for incentives but nonetheless adopt and meaningfully use EHRs.
A highly efficient health care system	<u>Efforts with CMS</u> OHA is working with CCOs and with representatives from the Centers for Medicare and Medicaid Services to find ways to reduce administrative red tape and burdens that weigh down the system by creating inefficiencies. <u>Administrative Simplification</u> The legislature passed SB 94 in 2011 which expanded some of the recommendations from the Administrative Simplification work group and allows DCBS to create uniform standards for administrative aspects of health insurance and care. OHA, through a partnership with the Oregon Health Leadership Council (OHLC), has been working to implement these recommendations as follows: • **Electronic Transactions** – The HLC has now completed companion guides on uniform standards for: o Eligibility Transactions (270/271) -(effective 2012, o Claims and Encounter Transactions (837) - effective 2013, and

Oregon's Action Plan for Health, 2010: Status of Action Items

Vision	Status as of June 2013
	o Health Care Electronic Funds Transfers (EFT) and Remittance Advice Transactions (835) – to be effective 2014 • **Credentialing** - A centralized portal for common credentialing has also been considered by the HLC. Efforts have been made to gain participation, including assessing vendor solutions to determine capabilities and conducting provider and health plan/hospital surveys. Unrelated to the OHLC work, pending legislation (SB 604) mandates the OHA to establish a centralized credentialing repository, but will allow it to be contracted out if determined necessary and/or efficient. Credentialing entities would be required to use the system and will likely be charge fees to do so. The bill has been referred to Ways and Means with a "do pass" recommendation. • **Prior Authorization** – The OHLC recently finished the development of prior authorization best practices and presented it to the Oregon Medical Association. <u>Administrative Burdens</u> OHA is also working to implement reductions to administrative burdens identified by stakeholders through Health Systems Transformation work. Specific work related to these burdens that are also part of SB 94 and SB 238 (2011), which required the Addictions and Mental Health Division to revise rules related to administrative burdens on providers, are being incorporated into streamlining work and efficiencies.
Together, clinical and public health providers will be accountable for the health of the whole community.	CCOs are required to collaborate with the community to develop a community health assessment that considers the health of the entire community. The Public Health Division of OHA is in the process of attaining national accreditation, and has developed a strategic plan, statewide community health assessment, and a statewide community health improvement plan focused on health outcomes. Local public health authorities are being supported by Public Health Division, as a part of a public health system transformation initiative, in their pursuit of accreditation. Oregon was one of six states to receive a grant from the Center for Medicare and Medicaid Innovation

Oregon's Action Plan for Health, 2010: Status of Action Items

Vision	Status as of June 2013
	(CMMI) for testing innovative approaches to improving health and lowering costs across the health care system. Through the CMMI initiative, the Public Health Division will award community prevention grants to Local Public Health Authorities (LPHA) and CCOs to implement primary and secondary evidence-based prevention strategies to address the leading causes of death. These grants will help reduce health care costs and improve health through collaboration between CCOs, LPHAs and other community-based organizations.
As more people get health insurance coverage, public health systems will devote more time and resources to maintaining healthy populations.	CCOs are required to collaborate with the community to develop a community health assessment that considers the health of the entire community. The Public Health Division of OHA is in the process of attaining national accreditation, and has developed a strategic plan, statewide community health assessment, and a statewide community health improvement plan focused on health outcomes. Oregon was one of six states to receive a grant from the Center for Medicare and Medicaid Innovation (CMMI) for testing innovative approaches to improving health and lowering costs across the health care system. Through the CMMI initiative, the Public Health Division will award community prevention grants to Local Public Health Authorities (LPHA) and CCOs to implement primary and secondary evidence-based prevention strategies to address the leading causes of death. These grants will help reduce health care costs and improve health through collaboration between CCOs, LPHAs and other community-based organizations.

Attributes of Coordinated Care Models*

1. **Best practices to manage and coordinate care**
   - Single point of accountability
   - Patient and family-centered care
   - Team-based care that across appropriate disciplines
   - Plans for managing care for 20 percent of population driving 80 percent of costs
   - Plans for prevention and wellness, including addressing disparities among population served.
   - Broad adoption and use of electronic health records

2. **Sharing responsibility for health**
   - Shared decision-making for care among patients and providers
   - Consumer / patient education and accountability strategies
   - Consumer / patient responsibility for personal health behaviors

3. **Measuring performance**
   - Demonstrated understanding of population served
   - Quality, cost and access metrics
   - Strategies for targets and improvement

4. **Paying for outcomes and health**
   - Payments aligned to outcomes not volume
   - Incentives for prevention and improved care of chronic illness

5. **Providing information**
   - Readily available, accurate, reliable and understandable cost and quality data
   - Price and value for payers, providers and patients

6. **Sustainable rate of growth**
   - Focused on preventing cost shift to employers, individuals and families
   - Reduced utilization and cost trend

*ACO, CCO, Systems of Care

COVER
OREGON

OREGON HEALTH POLICY BOARD PRESENTATION

ROCKY KING, COVER OREGON

NORA LEIBOWITZ, COVER OREGON (LIFE LINE)

JUNE 4, 2013

PRESENTATION OUTLINE

- Ready, Set … Go?
- Quality Scoring
- And Beyond
- Sleepless in Durham

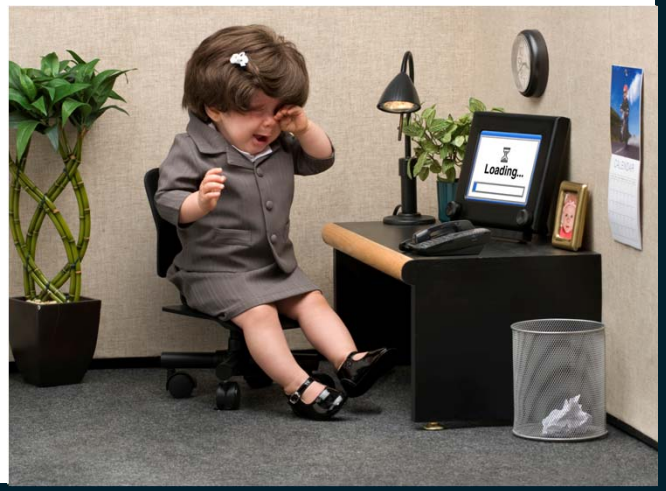
MISSION

Improving the health of all Oregonians by providing health coverage options, increasing access to information, and fostering quality and value in the health care system

COVER OREGON

QUICK UPDATE:

- Portal — Interfaces — Dashboards
- User Testing
- Customer Service Center
- Marketing and Outreach
- Agent and Community Partner Training
- Plan Management



INDIVIDUAL CARRIERS

1. **ATRIO Health Plans**
2. BridgeSpan Health Company
3. **Oregon's Health CO-OP**
4. **FamilyCare Health Plans**
5. **Freelancer's CO-OP (Health Republic)**
6. HealthNet
7. **Kaiser Permanente**
1. LifeWise Health Plan of Oregon
2. **MODA (ODS)**
3. **PacificSource Health Plans**
4. **Providence Health Plans**
5. **Trillium Community Health Plans**

SMALL EMPLOYER CARRIERS

1. ATRIO Health Plans
2. Oregon's Health CO-OP
3. Freelancer's CO-OP (Health Republic)
4. Kaiser Permanente
5. MODA (ODS)
6. PacificSource Health Plans
7. Providence Health Plans
8. Trillium Community Health Plans

PLAN CHOICE

Number of plans in individual market:	133
Number of plans in small group market:	77
Number of HSA-qualified plans (tentative):	29

CONSUMERS CAN SEARCH PLANS BY:

- Geography
- Price
- Provider
- Quality rating (13 metrics first year)
- Carrier
- Plan type (e.g., HMO, PPO)
- Deductible
- Out-of-pocket maximum
- Metal tier (bronze, silver, gold, platinum)

TIMELINE

- October 2013: Open enrollment
- January 2014: Coverage begins
- January 2016: Groups to 100 employees

QUALITY GRADING

QUALITY GRADING AT COVER OREGON

- Federal law requires quality measures at the plan level starting in 2016 plan year
- **Cover Oregon is providing consumers with carrier quality ratings starting in the 2013 open enrollment period**
- Goal: help consumers make “apples to apples” comparison on more than just cost
- Carrier-level grades in the first two years
- **Once data is available for new plans, will start to grade each QHP**
- Worked with Oregon Healthcare Quality Corporation, a recognized quality expert, to develop measures and scoring methodology

DEVELOPMENT OF QUALITY MEASURES

- Adopted 8 principles for measure selection
- Identified three sets of measures:
  - NCQA Exchange measures
  - CMS Medicare 5 Star
  - Oregon Health Plan (Medicaid) measures for Coordinated Care Organizations
- 13 measures in three areas: Preventative Care, Complex Care, Patient Experience

QUALITY GRADING: METHODOLOGY

- For each carrier, compare quality measures to three benchmarks:
  - Oregon average for the measures
  - National average for the measures
  - National 90th percentile for the measures

WHAT STARS MEAN

- Each carrier gets 1 to 4 stars on each measure based on how the measure compares to the benchmarks:
  - 4 stars: carrier measure exceeds three benchmarks
  - 3 stars: carrier measure exceeds two benchmarks
  - 2 stars: carrier measure exceeds one benchmark
  - 1 star: carrier does not exceed any benchmarks but qualifies for the exchange

GRADING: THIS YEAR, THE FUTURE

- **What Consumers Will See:**
  - Overall star score
  - Scores in three areas (Preventative Care, Complex Care, Patient Experience)
- **Next Steps**
  - Present plan-level ratings
  - Incorporate additional measures into plan ratings
  - Further align with statewide quality efforts
  - Use quality measures to drive plan improvement

AND BEYOND

5-YEAR PROJECT

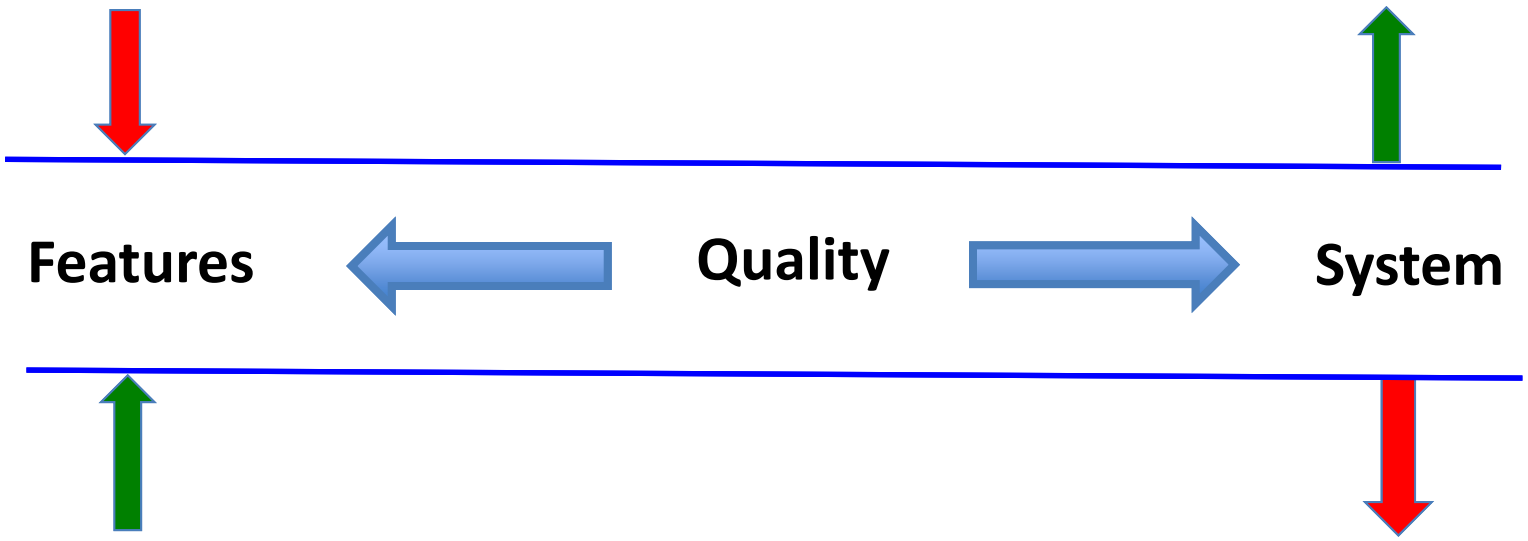
- Version Planning: 1.1 and beyond
  - Enhancements
  - Expansions (populations and products)
  - New requirements
- October 2014 — RFPs for 2016 Plan Year
- Focus on Health vs. Access
  - Expanded measure collection
  - Coordinated care models
- Alignment with PEBB, OEBB, CCOs and other large purchasers

SLEEPLESS IN DURHAM

MANAGING EXPECTATIONS

MANAGING EXPECTATIONS

User Experience



SLEEPLESS IN DURHAM

- Scope
- 13,000+ pages of regulations
- Medicaid and commercial coverage integration
- Testing (system, user, performance)
- Young and healthy
- Federal delay

THE ROAD AHEAD

BUT IT’S ABOUT PEOPLE

CoverOregon.com

PUBLIC EMPLOYEES'

PEBB

BENEFIT BOARD

HEALTHIER, TOGETHER

Looking Ahead to 2015

Ensuring better health and better care—at a price we can all afford.

Ashland, Oregon :: April 1, 2013

Oregon Health Authority

PEBB OVERVIEW

Who We Are and What We Do

MISSION

Public Employees' Benefit Board (PEBB)
negotiates with health plans
to deliver health benefits
for Oregon's state employees
and their families--130,000 people in total.

Our mission is better health and
better care at a price we can all afford.

PUBLIC EMPLOYEES'
PEBB
BENEFIT BOARD

Oregon Health Authority

PEBB MEMBERS: WHO WE ARE

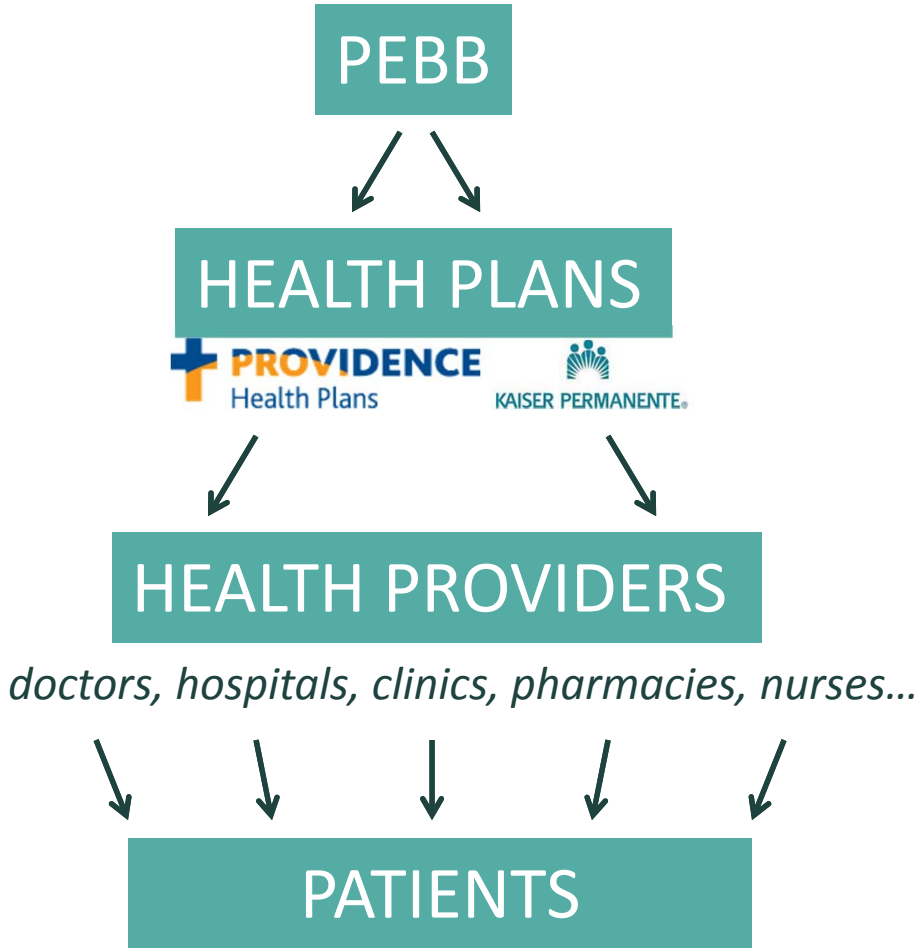
130,000

OREGON WORKERS &
THEIR FAMILIES

PUBLIC EMPLOYEES'
PEBB
BENEFIT BOARD

Oregon Health Authority

WHAT PEBB DOES:



PUBLIC EMPLOYEES' PEBB BENEFIT BOARD

Oregon Health Authority

PEBB DOES **NOT**…

- **Set its budget**. Dollars available for benefits are determined by the state legislature and collective bargaining.

- **Determine premium share (amount PEBB members pay each month)**. That's negotiated between state and labor through collective bargaining.

PUBLIC EMPLOYEES' PEBB BENEFIT BOARD

Oregon Health Authority

PUBLIC EMPLOYEES' PEBB BENEFIT BOARD

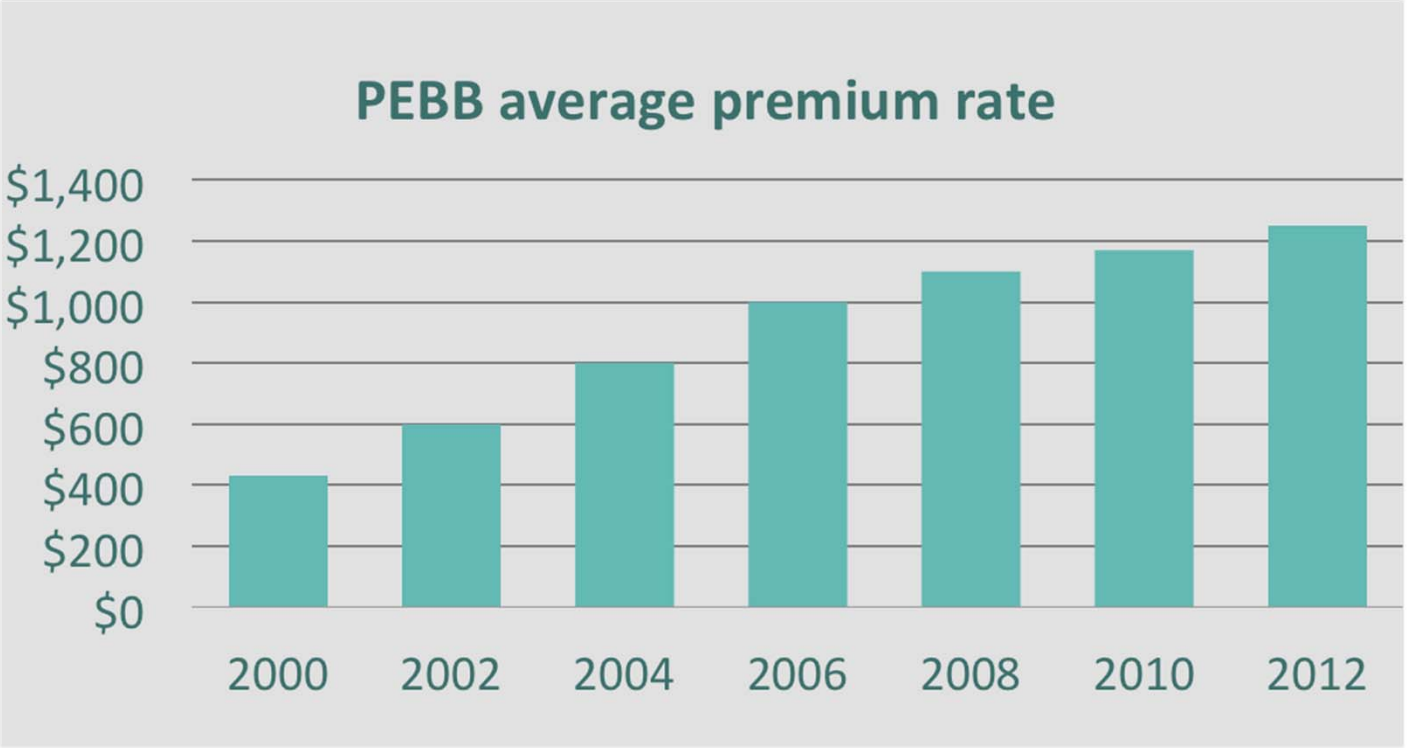
Oregon Health Authority

OUR CHALLENGES:

Managing Costs + Improving Health

OUR CHALLENGE: ↑ COSTS

Costs have **nearly tripled** in the past 12 years.



PUBLIC EMPLOYEES' PEBB BENEFIT BOARD

Oregon Health Authority

TRADITIONAL MEANS TO MANAGE COSTS

Increased member cost sharing

and

Reduced services

No improvement in health of PEBB Community

and

Doesn't lower the cost of health care

This is **not** sustainable; we all can't afford it.

PUBLIC EMPLOYEES' PEBB BENEFIT BOARD

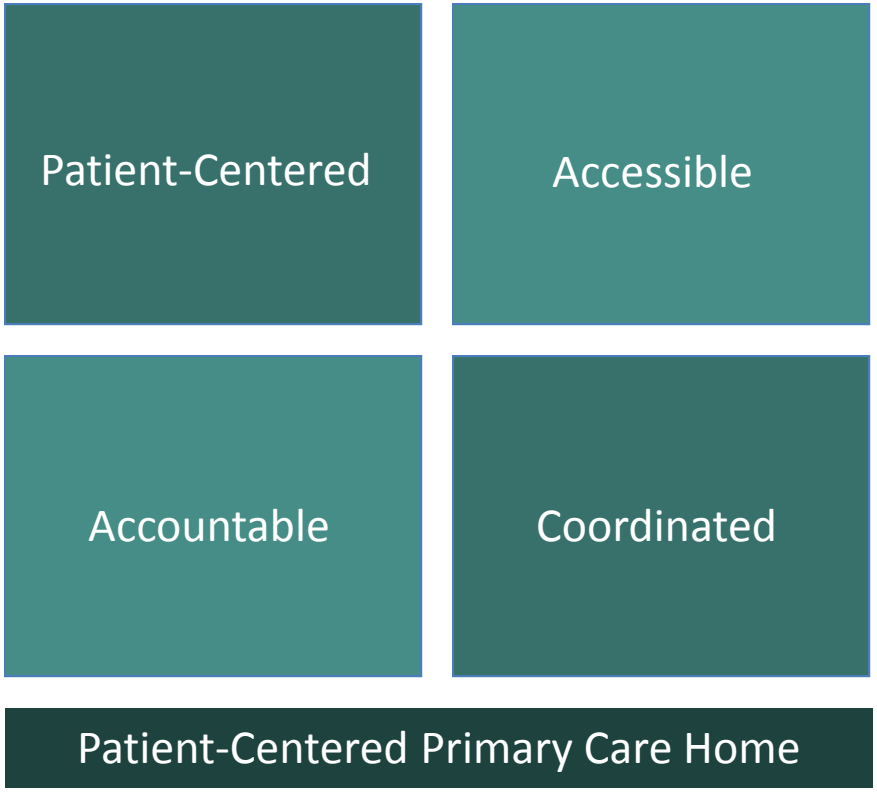
Oregon Health Authority

PEBB GOALS:

Improving Health + Managing Costs

PATIENT-CENTERED **PRIMARY CARE** HOME:

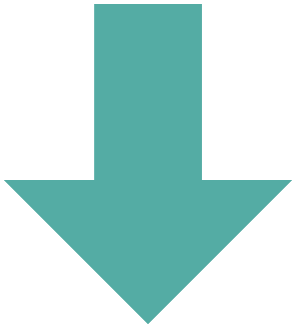
WHAT IS IT?



A PATIENT-CENTERED **APPROACH** TO CARE.

OTHER STRATEGIES TO IMPROVE HEALTH AND MANAGE COSTS

DESIGN BENEFITS BASED ON VALUE



Low or no cost to members for effective treatments *(chronic care visits, value-based drugs, substance abuse treatment, weight management, tobacco cessation)*

PUBLIC EMPLOYEES' PEBB BENEFIT BOARD

Oregon Health Authority

A LOOK FORWARD

WHAT'S NEXT?

Selecting Health Plan Partners for 2015

PUBLIC EMPLOYEES' PEBB BENEFIT BOARD

Oregon Health Authority

WHAT WE'RE GOING TO REQUIRE OF THE HEALTH PLANS

All health plans that want to contract with PEBB must be **coordinated** to:

- Meet certain high standards of quality
- Involve consumers and patients in their health
- Prioritize preventative care and other services with proven value
- Provide efficient, coordinated and patient-centered care
- Stay within a sustainable rate of growth

PUBLIC EMPLOYEES' PEBB BENEFIT BOARD

Oregon Health Authority

THANK YOU!

Healthier, Together!