

Oregon Health Policy Board

AGENDA (REVISED)

October 1, 2013

Market Square Building
1515 SW 5th Avenue, 9th floor
1:00 p.m. to 5:00 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: 9/10/13 minutes	Chair	X
2	1:05	Director's Report	Bruce Goldberg, OHA	
3	1:10	HIT-HIE update	Susan Otter, OHA	
4	1:15	Update on PEBB Request for Proposal and coordinated care model alignment work group	Sean Kolmer, Governor's Office	
5	1:20	DRAFT measurement framework and All Payer All Claims data	Gretchen Morley, OHA	
6	1:50	Feasibility and effectiveness of cost containment strategies	David Cusano, Senior Research Fellow, Georgetown University Health Policy Institute	
	2:20	Break		
7	2:30	1 st DRAFT Straw model proposal and discussion	Diana Bianco	
8	3:45	Invited testimony	TBD	
9	4:30	Public testimony	Chair	
10	5:00	Adjourn	Chair	

Next meeting:

November 5, 2013

8:30 a.m. to noon

Hood River Inn

1108 E Marina Dr.

Hood River, OR 97031

Oregon Health Policy Board
DRAFT Minutes
September 10, 2013
8:30 a.m. to 12:30 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.

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

Chair Parsons announced he will be stepping down as Chair of the Oregon Health Policy Board after the January, 2014 meeting.

Consent Agenda:

The meeting minutes from August 6, 2013 and the Updated Work Force Committee Charter were unanimously approved.

View the Oregon Health Policy Board Health Care Workforce Committee Charter [here](#), starting on page 5. Chair Parson's resignation letter can be viewed [here](#)

Director's Report – Bruce Goldberg

Dr. Goldberg discussed the triple aim concept and the ACA implementation with short term issues of enrollment and information technology infrastructure and how they continue to be a main focus. Approval was received from the Federal Government for current qualified adult participants in the SNAP program to be fast-tracked, where it's not necessary to apply through Cover Oregon to be enrolled in the health plan, only a completed fast-track from needs to be submitted to enroll. This will help with streamlining the system and allows health plans to know of eligibility in advance.

CCO's are up and running with the sixteenth CCO in Klamath Falls now operating.

ELC-OHPB Joint Subcommittee: Straw person proposal – Pam Curtis, Director, Center for Evidence Based Policy, OHSU; Chair, Early Learning Council; Dana Hargunani, Child Health Director, OHA, Staff, ELC Joint Sub-Committee

The early years for young children are the place the foundation is set for life-long learning and life-long health. A joint sub-committee was formed, ELC-OHPB, and identified the following set of principles which guided their work:

- *As shared as possible* (community culture and change; accountability; outcomes; coordination)
- *As simple as possible* (family experience; build on existing resources; common forms)
- *As straightforward as possible* (clear communication; family-centered; customer-driven)
- *As soon as possible* (urgency to address transformation opportunities, improve outcomes)

The Collective Impact approach was taken, recognizing that no single entity or organization has sufficient power or resources to solve complex social problems alone.

The straw proposal recommends a state level collective impact approach across health, early learning and human services to enable and best support collective impact activities at the local level.

Straw Framework: “5 conditions of collective impact” for success

- Common agenda
- Shared measurement systems
- Mutually reinforcing activities
- Continuous communication
- Backbone organization

Summary of straw proposal recommendations:

- Adopt this collective impact framework to guide the joint work of the Early Learning Council and Oregon Health Policy Board.
- Designate kindergarten readiness as the common agenda for the Oregon Health Policy Board and Early Learning Council with a focus on equity.
- Adopt kindergarten readiness as a shared outcome with the included implementation timeline.
- Establish shared incentives linked to joint outcomes.
- Adopt the Child and Family Well-being measurement strategy and identify a technical advisory committee to support implementation.
- Identify additional resources to ensure capacity for cross-system learning and health information exchange dedicated to care coordination.
- Adopt and implement a statewide system of developmental screening including identified core components.
- Renew the Joint ELC/OHPB Subcommittee Charter with new deliverables focused on a shared measurement strategy, care coordination, information exchange and shared incentives.
- Designate the Transformation Center as the backbone structure for fostering shared learning and alignment at the local level.
- Implement shared communication strategies that facilitate local, cross-system learning between health and education.

The Joint ELC/OHPB Subcommittee: Strawperson Proposal can be found [here](#) starting on page 9
View the Stanford Social Innovation Review, Collective Impact [here](#), starting on page 21

Coordinated Care Model Alignment Workgroup Update – Sean Kolmer, Governor’s Office, Chair of PEBC, Chair of CCM Workgroup

Sean discussed how the CCO formation development is only the beginning and the next step is to align it with public employees, teachers and Cover Oregon. The CCM is trying to provide a framework around how this alignment takes place by looking at the coordinated care model attributes and principles and ensuring all targets and missions for all organizations are met. Sean discussed transparent data and how the CCM members will ensure alignment amongst all the organizations. The next meeting for the CMM workgroup is September 26. A draft set of recommendations will be available for review at the November OHPB meeting.

View the OHPB Coordinated Care Model Alignment Work Group Charter [here](#), starting on page 28

Rate review, transparency and affordability standards: insurance industry perspective – Leanne Gassaway, Vice President, State Affairs, America’s Health Insurance Plans (AHIP)

Leanne’s presentation consisted of trying to reach a couple of goals, including looking at transparency and affordability in two ways: understanding the audience and what affordability really means, and broadening the understanding beyond healthcare premiums.

Key discussion points discussed today:

- Overview of the rate review process and what it entails today
- Highlight cost-drivers and what is driving the healthcare dollar from a system perspective, not just premium
- Outline some basis of transparency programs that are already happening and how they can be better utilized and put into a master plan
- Offer thoughts in a consolidated way

View *Leanne Gassaway's AHIP presentation* [here](#)

Rate review, transparency and affordability standards: lessons learned in other states – Chris Koller, President, Milbank Memorial Fund

Chris Koller provided background and context of the Rhode Island Office of Health Insurance Commissioner. There were five areas of focus for today's discussion:

- Conditions of Work
- Evolution of Oversight
- Development of Priorities
- Affordability Standards
- Transparency: Work of various states

Chris Koller's presentation regarding Rhode Island's Affordability Standards: Aligning for Transformation can be viewed [here](#)

View the *Affordability Standards Report, Michael Bailit*, [here](#)

Board discussion on rate review, transparency and affordability standards – Diana Bianco, Artemis Consulting

Diana Bianco will be working with the Board as a proposal is developed in response to the letter from the Governor. Today's discussion will focus on the direction the Board will recommend with discussion surrounding the Health Policy Board Draft Elements for Potential Straw Model Development and Discussion document, distributed at today's meeting.

Diana facilitated a discussion between the Board members regarding the potential elements which fall into four broad categories:

- Accountability & Measurement
- Cost Containment
- Transparency
- Quality Improvement

Next month, questions from today's discussion along with further research pertaining to existing levers, ease of implementation and effectiveness will be addressed.

The OHPB Elements for Potential Straw Model Development and Discussion handout used to facilitate today's discussion can be viewed [here](#)

Public Testimony

Public testimony was heard from 5 individuals.

Tom McGinnis, Owner, Chucky Cheese, SE Portland

Mr. McGinnis employs 36 employees and in running his business is concerned about three things, cost, coverage and predictability. As a business owner, he is coping with the ACA, new business, mandates and new public exchanges. With all of the new changes in the coming year he's asking the Board to slow down and allow businesses to adjust to these changes. Oregon's premium regulation process is very

open and he would like to see it given time to work before we try to complicate it. Rhode Island is microscopic compared to Oregon and has one insurance carrier as compared to Portland's highly competitive market. In Oregon, the Rhode Island model is a solution looking for a problem. Mr. McGinnis also touched on the uninsured and how that doesn't seem to be a solvable problem. Small businesses are being crushed by taxes and are either being forced to move or forced out of business. Please weigh the benefits of public policy, regulation and cost increases against the damage they can inflict.

Jesse O'Brien, Healthcare advocate with OSPIRG.

OSPIRG has had a close relationship with Oregon Health Insurance Rate Review process and Jesse discussed and distributed a report that was released last spring regarding Health Insurance Rate Review in Oregon.

John Mullen, Oregon Law Center

The Oregon Law Center works on behalf of low income people. Mr. Mullen provided an update on the Basic Health Program, which is available under the Affordable Care Act. The basic Health Program who recently met Aug. 23 will send out draft rules this month and continues to address how the BHP will adapt to the changes from the ACA.

Larry Kirsch, IMR Health Economics

Larry expressed two problems he sees regarding rate review. Right now rate review is being looked at as it stands now and historically and it hasn't been doing everything it could do. Rate review could be used for evidence based medicine and be applied to all carriers, products and programs. Mr. Kirsch asked the Board to consider how they could use rate review in a creative sense to go after bending the cost curve.

Adjourn

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November 5, 2013

8:30 a.m. to noon

Hood River Inn

1108 E Marina Dr.

Hood River, OR. 97031

Oregon's Health Information Technology (HIT)/Health Information Exchange (HIE) Planning to Support Health Systems Transformation

Oregon Health Policy Board, October 1, 2013

Susan Otter, State Coordinator for Health Information Technology, susan.otter@state.or.us

Background:

- Oregon's HIT Oversight Council (HITOC) set initial strategic and operational plan in 2010
 - Anticipated the need to “monitor and adapt” state HIT/HIE strategies to reflect changing federal and state landscape
 - Major changes since then:
 - State health systems transformation efforts and CCOs
 - Federal standards for electronic health records
 - National standards building for exchange of information
- Oregon established a statewide health information exchange program, CareAccord, in 2012.
First service – Direct Secure Messaging
 - HIPAA-compliant way to encrypt and send any attachment of protected information electronically, for example, screening results, shared care plans, patient histories, and more sophisticated attachments such as x-rays and echocardiograms.
 - Augments local capabilities to view or share information (where they exist) by bringing new members to the electronic care coordination circle, such as LTC, early learning providers, and emergency medical services.
 - Statewide connection of Direct secure messaging service providers (HISPs) will allow providers to meet federal requirements and connect from their EHRs to any other Direct user in the state.
 - As EHRs evolve in 2014 to meet federal Meaningful Use requirements, Direct secure messaging will be a core service within each EHR and national standards will support interoperability between Direct secure messaging providers (HISPs).

Current Planning and Development work

Objectives:

- Implementation of foundational/high value near-term HIT/HIE statewide services
- Multi-year business plan framework for the critical HIE/HIT infrastructure that ensures Oregonians have access to “HIT-enabled” health care:
 - Care delivery and care coordination is informed by meaningful, reliable and actionable patient information
 - Aggregated data inform the management, quality and effectiveness of health care
 - Business plan framework will include recommendations on the role of statewide services, governance structure, finance plan and technology requirements for statewide HIT/HIE services

Timeline:

- Spring/Summer 2013: Listening sessions with key stakeholders
- August/Sept. 2013: Identification of key near-term statewide HIT/HIE resources
- Sept-December: Oregon HIT/HIE Business Plan framework development: HIT Task Force
- 2014: HIT/HIE development and implementation planning
- 2014-2015: HITOC policy work/oversight
- 2014-2015: Implementation of key near-term statewide HIT/HIE services

HIT Task Force and Listening Sessions: HIT/HIE Problems to Address to Support Health Systems Transformation

- Gaps in meaningful, timely, actionable patient information for care team at the point of care
 - High cost and high risk populations lack “whole person” coordinated care that includes sharing information across physical, behavioral, dental and other care settings
 - Poor communication across transitions of care leads to wasteful spending and poor patient experiences and outcomes
 - Providers often rely on a patient’s memory to inform their care
 - Current system includes redundancies and lack common understanding of which information is meaningful for different care coordination scenarios
- Gaps in ability to collect, aggregate use and disseminate aggregated data (including clinical information. Providers, health systems, health plans and CCOs:
 - Do not have the ability to identify, monitor and improve the quality of care and identify and manage their patients/populations effectively and transform care delivery
 - Need to address new payment models that are based on buying health rather than visits and provide incentives/disincentives to improve and transform care
- Gaps in patient access to their clinical information
 - Patients don’t have access to and engagement with their complete health record, including treatments and goals, in order to more effectively engage in their health care

State Near-term Foundational/Value-add Services (2013-2015)

6 Near-Term Statewide HIT/HIE Elements

- Building blocks to facilitate exchange and analytics:
 - State-level provider directory and
 - Incremental development of a state-level patient index
- High value services around expensive transitions of care:
 - Statewide hospital notifications to providers, health plans, CCOs, health systems when their patients are seen in ED/inpatient
- Electronic connectivity of all members of the care team across organizational and technological boundaries:
 - Statewide Direct secure messaging to augment local capabilities, add new members of the care team, and support statewide connections between providers from within their electronic health record.
- Reliable, actionable information from aggregation of clinical quality data:
 - Statewide clinical *metrics* registry to support quality reporting and quality improvement efforts, and enhance existing capabilities (population management, analytics, targeting of care coordination resources)
- Meaningful use of HIT and ensuring the quality of health information captured by providers in their EHRs:
 - Technical assistance to providers to help providers meet Meaningful Use requirements and ensure clinical metrics data are complete and credible

MEMORANDUM

To: Oregon Health Policy Board

**From: Joel Ario, Manatt Health Solutions
David Cusano, Georgetown Health Policy Institute**

Date: September 26, 2013

Re: Feasibility and Effectiveness of Cost Containment Strategies

During the Oregon Health Policy Board meeting held on September 10, 2013, the Board members discussed 10 draft elements for potential straw model development. The purpose of this memorandum is to provide an analysis of the effectiveness and feasibility of the 10 elements, plus one additional element that was raised at the meeting.

A. Accountability & Measurement

1. Utilize All-Payer All-Claims (APAC) database to enhance transparency to stakeholders and the public through a “dashboard” with 10-12 key measures that provide an overall perspective on the impact of Oregon’s reforms and the Patient Protection and Affordable Care Act (ACA). Oregon could use its APAC database to identify cost shift and allow for future potential cost shift mitigation strategies and goals and track utilization metrics (e.g. ER utilization, readmission rates) in the individual and small group markets.

Effectiveness and feasibility: A number of States utilize an APAC database to develop a baseline capacity to measure utilization and outcomes.¹ Therefore, Oregon’s use of its APAC database for this purpose would be feasible and in line with the practice of other States. Most APAC databases are relatively new, so their effectiveness as a measurement tool that is capable of providing apples to apples comparisons is not fully established, but Oregon’s APAC database does appear to have the potential to be an effective accountability and measurement tool. A measurement framework built around Oregon’s APAC database would allow Oregon to accurately and effectively measure identified outcomes and set specific goals around them.

B. Cost Containment

2. Decrease the total cost of care by increasing emphasis on evidence-based primary care.

¹ See <http://www.apcdouncil.org/state/map>

3. Identify key outcomes and develop benchmarks that can be used to measure progress toward achieving those outcomes through PCPCH and/or other health home model expansion.

Effectiveness and feasibility: Primary care services include preventive care and chronic disease management and both are hallmarks of Oregon’s current reform strategy. Studies suggest that preventive care² and chronic disease management services³ may result in a healthier population and a decrease in overall utilization. Therefore, an increased emphasis on primary care could prove to be an effective cost containment strategy.

Focusing resources on primary care would also be feasible because Oregon has already taken several important steps toward supporting the patient-centered primary care home (PCPCH) model. PCPCH adoption is currently a metric in the Medicaid market and will be included in the soon to be released Public Employees’ Benefit Board (PEBB) request for proposals. Further, the Oregon Health Authority (OHA) and the Oregon Health Leadership Council (OHLC) have convened a series of meetings to develop a consensus-based strategy to support primary care homes in Oregon. The PCPCH program could serve as a model for increased emphasis on primary and chronic care services in the commercial market as it has with CCOs.

4. Promote wellness incentives and expand to individual market.

Effectiveness and feasibility: The promotion of wellness incentives is an important initiative, and has shown impressive results in the large group market, where insurers and the human resource departments of large employers work together to promote wellness programs. However, there are not clear models for how to effectively promote wellness programs in the small group and individual

² See, e.g., Andrea Klemes, DO, et. al., “Personalized Preventive Care Leads to Significant Reductions in Hospital Utilization,” American Journal of Managed Care, December 18, 2012. Stating that:

The MDVIP model of personalized preventive care allows the physician to take a more proactive, rather than reactive, approach; we believe this increased physician interaction is the reason for the lower hospital utilization and ultimately lower healthcare costs seen here.

Found at: <http://www.ajmc.com/publications/issue/2012/2012-12-vol18-n12/Personalized-Preventive-Care-Leads-to-Significant-Reductions-in-Hospital-Utilization#sthash.0gmVVacD.dpuf>

³ See, e.g., Niall Brennan, et. al., “Improving Quality and Value in the U.S. Health Care System,” Brookings Institute, August 2009. Stating that:

A large body of evidence shows that [disease management] can improve quality of care. Evidence on the impact of [disease management] programs on overall health care costs varies depending on the targeted condition, the populations included, and the types of interventions used. While some programs have not proven cost-effective, other interventions have the potential to improve quality and reduce costs (page 10).

Found at: <http://www.brookings.edu/research/reports/2009/08/21-bpc-qualityreport>

markets where there is no analog to the human resource department to ensure follow through. Given the importance of behavioral changes to improving health outcomes, there is every reason for Oregon to participate in experiments to expand wellness programs to the individual market, but the feasibility and effectiveness of such experiments is an open question.

5. Identify potentially unnecessary regulatory burdens and streamline and simplify rate review process through administrative simplification mechanisms.

Effectiveness and feasibility: Oregon has been a leader in regulatory streamlining and it makes eminent sense for the Insurance Division to be looking for opportunities to tie into other reporting elements and eliminate redundant processes and requirements as new more effective strategies are adopted. This will not support cost containment directly, but will free up regulatory and insurer resources for effective and feasible cost containment strategies.

6. Growth rates of total cost of care expenditures that are reasonable and predictable (moving toward a fixed rate of growth strategy).

Effectiveness and feasibility: The concept of maintaining healthcare costs at a sustainable fixed rate of growth is a centerpiece of Oregon's Health System Transformation and a key principle in Oregon's Coordinated Care Model. The strategy presents challenges for the commercial marketplace, though Massachusetts has enacted legislation charging the Massachusetts Health Policy Commission with establishing an annual cost growth benchmark and monitoring progress through annual cost trends hearings.⁴ Health care entities that exceed the benchmark may be required to file and implement performance improvement plans. While the feasibility of this strategy has not been established, its potential effectiveness suggests that Oregon would be well served to explore whether there are feasible short term approaches that could measure and benchmark growth in the total cost of care. The challenge is identifying what to measure. A long term approach to consider could be developing guidelines for measuring the growth of total cost of care and evaluating how various levers for cost containment may be best utilized. To that end Oregon could be well served to establish a coordinated strategy with stakeholder input to determine the most effective, feasible and relevant related metrics. The concept has a high potential for effectiveness and given Oregon's history in healthcare innovation it's appropriate to consider varying mechanisms for making the concept more feasible.

C. Transparency

7. Enhanced communication tools for consumers (e.g., rate comparison charts, pre-service pricing disclosure).

⁴ See M.G.L. ch. 224, found at: <https://malegislature.gov/Laws/SessionLaws/Acts/2012/Chapter224>

Effectiveness and feasibility: Oregon is a leader among the States in terms of the information available to consumers. However, studies have indicated that consumers may have difficulties with understanding complex data.⁵ Therefore, health plans should continue to improve the information that is available and identify opportunities to distill that information into a format that is easily digestible for consumers.

8. Enhanced bad debt/charity care analysis and timely reporting.

Effectiveness and feasibility: The coverage provisions of the ACA will result in less uncompensated care in hospitals. Oregon could use the data obtained from its community benefit reports to effectively measure the impact of access to coverage on hospital revenues, bad debt and charity care. This data should be used within the measurement framework described in element #1 above. Using community benefit reports in this manner would be feasible to implement because these reports are publicly available today.

9. Enhanced disclosure of hospital and/or provider pricing.

Effectiveness and feasibility: The ACA requires disclosure of much new data, but it does not directly address provider pricing because the issues are tricky. A comparison of hospital and physician pricing can be difficult, and there is a fine line between using pricing data to promote competition versus engage in cost fixing. The commercial marketplace will continue to experiment with new pricing models and some of those will involve more transparency, but it is not clear that mandated disclosure is the most effective approach. In past experience, it also has proven time consuming to work out the details of disclosures. One approach could be to continue monitoring these pricing issues through the APAC.

D. Quality Improvement

10. Promote alternative payment methodologies (APMs) and collect relevant data to support APM development.

Effectiveness and feasibility: APMs are a fast-evolving concept, as public programs and the commercial marketplace experiment with new forms of risk sharing, from pay for performance to bundled payments to shared savings. There

⁵ See, e.g., Alla Keselman et al, “Developing Informatics Tools and Strategies for Consumer-centered Health Communication,” *Journal of the American Medical Informatics Association*, Vol. 15, Issue 4, 2008, pp. 473–483. Stating that:

[H]ealth literacy has emerged as a more fundamental barrier to providing Internet and other health resources to medically underserved and other audiences... About 50% of U.S. adults do not possess adequate health literacy skills required for many health communication and management tasks.

Found at: <http://171.67.114.118/content/15/4/473.full>

are not yet definitive studies on the effectiveness of particular APMs, and there will continue to be broad innovation with APMs, which may lead to better evidence about effective new payment methodologies.

11. Incent or set goals to promote value-based benefit designs.

Effectiveness and feasibility: Similar to APMs, value-based benefit designs (“VBDs”) are a fast evolving concept, with the ACA requiring first dollar coverage of preventive benefits and commercial insurers experimenting with new benefit designs. There are not yet definitive studies on the effectiveness of particular VBDs, and there will continue to be broad innovation with VBDs, which may lead to better evidence on what are the most effective new benefit designs.

OHPB Straw Model #1: Aligning ACA implementation with Health System Transformation

Governor's Charge:

1. Spread Triple Aim (Better Health, Better Health Care, and Lower Cost) goals across all markets; provide recommendations to that end to the Governor and Legislature, by the end of the year, possibly statutory and regulatory.
2. Make recommendations to:
 - a. move marketplace toward one characterized by-
 - i. models of coordinated care,
 - ii. growth rates of total health care that are reasonable and predictable
 - b. mitigate cost shift, decrease premiums, increase transparency and accountability
 - c. enhance Oregon Insurance Division (OID) rate review process
 - d. align care model attributes within Public Employees Benefit Board (PEBB), Oregon Educators Benefit Board (OEBB) and Cover Oregon Qualified Health Plans (QHPs)

OHPB Principles for Governor's Letter Response:

1. Leverage coordinated care model
2. Enhance transparency
3. Promote accountability
4. Focus on outcomes
5. Actuarially-based and hold carriers accountable for quality improvement and cost containment

Coordinated Care Model Principles:

1. Do what works. Use best practices.
2. Have shared responsibility for health among providers, individuals and health plans.
3. Measure performance.
4. Pay for outcomes and health.
5. Provide information so that patients and providers know price and quality.
6. Maintain costs at a sustainable fixed rate of growth.

Straw Model Component #1: Transparency- Develop measurement framework for ACA implementation and Oregon health system transformation

Implementation Lever: All Payer All Claims (APAC) Database, potential OHA rulemaking ORS 442

Related Levers: Oregon Health Insurance Survey (OHIS), Cover Oregon, Oregon Hospital Discharge Data, Databank and Hospital Community Benefit Reporting, Oregon Insurance Division, Oregon Department of Revenue, etc.

Coordinated Care Model Principles: Measure performance; provide information so that price and quality information is transparent and understandable to purchasers, providers and individual consumers.

Alignment: Potential to extend Coordinated Care Organization measures to broader markets, set benchmarks and provide performance incentives around key measurements which drive down the total cost of care and meet the triple aim.

Outcomes:

1. 2014- OHA uses APAC and other data sources to create a measurement framework and enhance transparency through a public facing dashboard which includes measures of utilization, cost and quality reported at the payer and plan level at various levels of aggregation (e.g., line of business, plan, provider, and geographic area).
2. 2014/5- OHA's measurement framework is publicly available and contains validated data with multiple tiers of information to include but not limited to information related to provider level health care entities, measures of utilization, cost and quality by entity, market segment data, access, utilization, coverage, quality, demographics, geographic differentials, bad debt, charity care, and health equity.
3. 2014- OHA creates a *technical* advisory group to provide input on APAC and other related data sources, identify additional data collection needs, identify redundancies, advise measure specification, and inform data validation processes required to support a meaningful and useful measurement framework and dashboard. The group does not derive metrics; it advises how they may be best utilized and makes related recommendations. The group reports to the OHPB and is appointed by the Commissioner of OID and Director of OHA and shall serve at the pleasure of those respective offices. The group consists of but is not limited to stakeholders and technical experts from health plans, Cover Oregon, PEBB and OEBB.

Straw Model Component #2: Sustainable fixed rate of growth concept

Implementation Lever: Transparency through measurement framework (APAC, etc.), OID rate review and rulemaking, OHA rule making, statutory changes

Coordinated Care Model Principles: Maintain costs at a sustainable fixed rate of growth; pay for outcomes and health; measure performance; have shared responsibility for health among providers, consumers, and health plans

Alignment: A sustainable fixed rate of growth is a core Coordinated Care Model principle.

Outcomes:

1. 2014- OHA & OID develop a timeline and process to formulate and/or endorse a “Sustainable rate of growth (SRG)” methodology. SRG is used to set baseline data and reflect the total cost of care and related costs.
 - a. OID compares rate requests with SRG in rate review process, but the comparison is “informal” and there is no additional regulation or change in determining reasonability of rate requests. Recommended methodology and rate review comparison process forwarded to 2014 Legislature and Governor’s office.
2. 2014/15- OHA & OID explore and make recommendations to the 2015 Legislature and Governor’s office around the benefit of developing benchmarks and goals for rate requests in relation to SRG. Potential mechanisms for exploration include, but are not limited to:
 - a. SRG is placed in rate review process for formal consideration when evaluating rate requests
 - i. Expedited rate reviews for rates which meet federal standards for effective rate review, are determined to be actuarially based, are below SRG and meet health outcome and access goals as established through Cover Oregon metrics and/or the measurement framework
 - ii. OHA, OID and Cover Oregon explore public facing identifiers, e.g. “merit badge” on the exchange, which recognize health plans which are consistently below SRG and meet health outcome and access goals established through Cover Oregon metrics and/or the measurement framework
 - iii. Filings above SRG go through a more rigorous cost containment and rate review analysis during rate review process. OID & OHA make further accountability recommendations.
3. 2014/15- OHA explores the benefit of potential cross-references between plans and health care entities, benchmarks and mechanisms which hold health care entities identified through measurement framework above SRG accountable. Recommendations to 2015 Legislature and Governor’s Office
4. 2014- OHA & OID develop recommendations for a timeline and plan to incent and support multiyear rate filings which are “reasonable and predictable” and make related recommendations to 2015 Legislature and Governor’s Office

Straw Model Component #3: Expand and improve primary & preventive care infrastructure

Implementation Lever: Oregon Insurance Division rulemaking ORS 743, rate review process, potential statutory changes, TBD

Coordinated Care Model Principles: Do what works; use best practices. Pay for outcomes and health.

Alignment: Potential for alignment with Oregon's focus in addressing chronic care, primary care and preventive care

Outcomes:

1. 2014- OID adds definitions to reasonability through rulemaking to include a provision emphasizing adoption of process and/or achievement related outcomes related to evidence based primary, chronic and preventive care. Rules promote outcomes to include but not limited to the adoption of Oregon's Patient Centered Primary Care Home (PCPCH) standards and health plans have flexibility to achieve outcomes. As determined by the OID Commissioner, failure to meet benchmarks or outcomes may be taken into account in the rate review process.

Straw Model Component #4: Administrative simplification & meaningful communication tools

Implementation Lever: OID rulemaking; OHA rulemaking; others to be identified

Coordinated Care Model Principles: Provide information so that patients and providers know price and quality. Pay for outcomes and health. Do what works; use best practices.

Outcomes:

1. 2014- OID identifies opportunities for administrative simplification mechanisms in rate review process as a result of OHPB's recommended actions, Oregon's reforms, and ACA implementation and develops plans to implement those mechanisms. OID reports results and process to the 2014 and 2015 OHPB.
 - a. 2014-OHA & OID identify opportunities captured in the measurement framework to support OID rate review administrative simplification.
2. 2014- OHA initiates a "standardization initiative" to identify potential standardization recommendations which further enable the triple aim and reduce administrative barriers. The initiative includes but is not limited to recommendations to decrease duplication and inefficiencies in reporting requirements at the plan and provider level. OHA reports results to 2014 and 2015 OHPB.
3. 2014- OID engages in stakeholder-driven public process to identify implement enhanced meaningful communications tools that work for health plans and consumers. OID reports results to the 2014 OHPB.

Straw Model Component #5: Coordinated Care Model (CCM) alignment in PEBB, OEBC and Cover Oregon

Implementation Lever: Purchasing

Coordinated Care Model Principles: all coordinated care model principles

Outcomes:

1. 2013- OHPB includes in report to Governor and Legislature details on PEBB, OEBC, and Cover Oregon CCM alignment mechanisms, which may include:
 - a. Shared timeline detailing Request for Proposal (RFP) for (PEBB and OEBC) and Request for Applications (RFA) (Cover Oregon) process, including opportunities to implement CCM principles
 - b. Purchaser-specific, refined CCM principles for adoption in health plans offered through PEBB, OEBC, and Qualified Health Plans in Cover Oregon
 - c. Potential opportunities for joint strategic planning, shared learning and organizational alignment related to the adoption and implementation of coordinated care model attributes in PEBB, OEBC, and Cover Oregon
2. 2014- OHA, with input from OIC and Cover Oregon, make recommendations to the Legislature and Governor to ensure alignment of Cover Oregon quality metrics and CCM principles through OIC definitions in rate review to ensure the same principles and standards are upheld in and outside the exchange.



Transparency for Better Care, Health Outcomes and Lower Costs

Written remarks by AARP Oregon State Director Jerry Cohen, J.D., M.P.A. to the Oregon Health Policy Board

October 1, 2013

AARP is a membership organization for persons age 50+ dedicated to helping all enjoy the best life as we age while shaping societal attitudes to value all as we age. In Oregon, we have over ½ million members and half are under age 65. We accomplish this mission through education and information, advocacy, community service and providing value and best practices through the marketplace.

AARP Oregon greatly appreciates the opportunity to testify before the Oregon Health Policy Board today. Oregon is a national leader in state health reform efforts and has been at the forefront in engaging community stakeholders in these efforts, as evidenced by the Oregon Health Policy Board and this Committee meeting here today.

In a recent letter, Governor Kitzhaber charged the Board with seeking ways to extend the Triple Aim goals of health care reform -- better care, better health and lower costs – to ensure that the commercial marketplace also aligns with these state reform goals. We strongly support the achievement of the Triple Aim across the Oregon health care sector and are pleased to comment on strategies to achieve this important alignment.

AARP believes that all individuals have a right to high-quality health care and that transparency is key to achieving improved performance. Toward that end, information about the performance of health care plans and providers should be collected, analyzed and made publicly available and easily accessible to all health care stakeholders, particularly consumers. We, therefore, strongly support efforts to require public reporting of key quality health care measures that are evidenced based and have a known relationship to outcomes. The Oregon Health Authority has made great strides in making this information on Medicaid Coordinated Care Organizations available and similar transparency must be brought to the commercial market place. Such public reporting of information on commercial health plans and providers of all types will help consumers make good choices and help ensure that all plans, whether in the public or private marketplace, focus on quality.

In selecting the required measures for public reporting, AARP Oregon would recommend that measures be standardized across all Oregon payers and that the state rely, to the extent possible, on nationally recognized benchmark indicators, e.g. NCQA Health Effectiveness Data Information Set (HEDIS). This will help keep efforts focused on key areas of improvement, allow for better comparisons across health plans, and also reduce administrative burden on health plans and providers. The Oregon Health

Authority Measurement Framework used to evaluate CCOs with more than 80 measures of cost, quality, access, patient experience, and health status across delivery settings and populations is a good place to start. We would recommend that a subset of these measures be selected, with input from consumers and other health care stakeholders, for reporting by the commercial plans. AARP would likewise urge that metrics of particular importance in evaluating the performance of plans in providing care to the senior (i.e., Medigap and Medicare Advantage) population be included in this subset.

One of the levers that Oregon can employ to accomplish better transparency and public reporting on performance is through use of the rate setting process. Recent reforms in Oregon have led to increased transparency and consumer input, and resulted in significant premium savings to Oregonians. AARP Oregon supports efforts to bring quality metrics into the equation by requiring that commercial plans report on these quality metrics as part of their rate filings and that this information is made publicly available. In addition, we are supportive, over time, of making plans' performance on these key metrics one of the factors that the Oregon Insurance Division should consider during deliberation on prospective rate increases. At the same time, other factors such as the population served, capital reserves and service area, among others need to be considered in approving rate increases to ensure plan solvency and protect enrollee access to health coverage.

When including quality measures as a factor for consideration in rate review, the playing field must be level in that the measures have to be standardized to effectively evaluate performance and whenever possible, should also include provider level quality data to ensure provider cooperation with quality improvement and cost containment efforts.

AARP supports aligning payment methods and incentives to support delivery system reform and quality outcomes rather than volume of services across payers. To the extent possible, quality information should be paired with cost of care to allow for determinations of efficiency and effectiveness of these new payment methodologies and the models of care they support. Efforts to encourage bundling and other new payment methodologies must have sufficient protections to ensure that consumers receive appropriate quality care.

AARP Oregon fully supports efforts of the Oregon Health Authority and the Health Policy Board to continue reforms designed to provide more coordinated care to Oregonians and achieve the Triple Aim of reduced costs, better care, and improved health outcomes. These reforms should likewise be extended to the commercial marketplace to ensure that all Oregonians, including our seniors, are able to similarly benefit. Increased transparency and reporting on standardized metrics by the commercial plans represents a first step in this direction and the rate setting process is a mechanism that can be employed to achieve this improved alignment with the Triple Aim.