Oregon Health Policy Board

AGENDA *(revised 4/1/10)*

April 13, 2010
St. Charles Medical Center, Bend
Conference Room A&B
8:00 am to 12:30 pm
OHPB Live Web Streaming

#	Estimated Time	Item	Presenter	Action Item
1	8:00	Welcome and call to order Consent agenda: • Minutes from March 9, 2010 meeting • Addition to *Incentives and Outcomes Committee*: Dan Clay representing Taft-Hartley Trust • Addition to *Health Care Workforce Committee*: Paula Crone, DO, Executive Associate Dean of the new College of Osteopathic Medicine (COMP-NW)	Chair Eric Parsons	X
2	8:05	Director's Report	Bruce Goldberg	
3	8:15	Behavioral health integration & health reform	Richard Harris	
4	8:30	Central Oregon Regional Efforts • HealthMatters of Central Oregon o Multi-share program o Care coordination pathways • Physician Hospital Alignment for Central Oregon • Behavioral Health Integration Project • Regional Health Authority	Mike Bonetto Alisha Hopper Mike Boileau, MD Scott Johnson Tammy Baney	
	9:50	Break		
5	10:00	OHA Primary Care Pilots	Jeanene Smith	
6	10:30	Federal Reform: The interaction of federal and state health reform and impact on the OHPB Work Plan.	Amy Fauver Tina Edlund	X
7	12:00	Public Testimony		
	12:30	Adjourn		

Next meeting:
May 11, 2010
1 pm to 5 pm
Market Square Building
1515 SW 5th Avenue (Between Market and Clay), 9th floor

Questions can be submitted to the Board during the meeting at ohpb.info@state.or.us.

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Oregon Health Policy Board

AGENDA

March 9, 2010
Market Square Building
1515 SW 5th Avenue, 9th floor
1pm to 5pm

Item
Welcome and call to order Vice Chair Lillian Shirley called the Oregon Health Policy Board (OHPB) meeting to order. All Board members were present with the exception of Eric Parsons. Eileen Brady attended via conference call. Oregon Health Authority (OHA) staff members present were Bruce Goldberg and Tina Edlund. **Consent agenda:** ***Minutes from Feb. 9, 2010 meeting*** The February 9, 2010 minutes were reviewed. No changes were noted. Final minutes will be posted to the web. ***Legislative Concepts*** Draft OHA 2011 Legislative concept placeholders were reviewed. This is an informational document because we are early in the process. This report shows the placeholders that will be fleshed out in next couple of weeks. **Next Board Meeting in Bend** During each biennium the Board must hold a meeting in every congressional district. The April 13 meeting is being held in Bend because delivery system innovations being made in Central Oregon are directly relevant to the work of the Board.
Director's Report Dr. Goldberg presented the Director's Report. The report outlines current Healthy Kids Plan enrollment, program expansion, marketing, outreach and OHP Standards updates. The report touched on transition to/formation of OHA, legislative session updates, as well as progress in the Health Care Workforce Committee, State Health Improvement Program Committee, Public employers Health Purchasing Committee and the Health Incentives and Outcomes Committees. Budget reports will be provided to the Board on a bi-monthly basis. Dr. Goldberg also provided an update on Health Care Performance.
Confirm membership for Medical Liability Taskforce The Medical Liability Taskforce membership list was confirmed last month, but the Board recognized the need for more business stakeholder involvement. Chuck Hofmann nominated Mark Stevenson to the taskforce. Chuck Hofmann also suggested that co-chairs lead the committee rather than a single chair. Board members agreed to the change. Chuck nominated J

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Michael Alexander and Joe Siemienczuk to serve as co-chairs. The motion was moved and carried by unanimous voice vote.

Add following names to the Health Incentives and Outcomes Committee
Bill Murray, Doctors of Oregon Coast Southern (DOCS) and Jim Russel, Manager, Employee Benefits & Business Development were added to the Health Incentives and Outcomes Committee.

February Legislative Session – President Obama's Reform Proposal
Amy Fauver provided an update on February 2010 legislative session and President Obama's Reform proposal. Legislative session convened on February 1 and ended February 25. OHA tracked over 100 bills. One quarter of those bills dealt with health care issues. Ms. Fauver's handout lists key bills related to health care in Oregon.

Communications and Outreach Plan
Patty Wentz and Jeremy Vandehey reported on the communications and outreach plan. The plan outlined communications and engagement goals, the purpose of the plan and the timelines to achieve success. The Board emphasized that its current work is not a strategic planning effort. The Board's role is to come up with implementation recommendations to be taken to the legislature. The Board will be involved in meeting with stakeholders.

Patient Centered Primary Care Home Standards and Next Steps
Jeanene Smith provided an overview of HB 2009 final report of the Patient Centered Primary Care Home Standards (PCPCH) Committee and the next steps. This report provides the framework for common measurement approaches from a provider perspective. The Board will use the information as a foundation for collaboration with the Health Leadership Taskforce. It creates a common vision. The goal is to create a common unified and standard definition.

Break

Board Discussion: Confirm Oregon Health Policy Board's alignment with Health Fund Board's staged approach. Make adjustments as necessary

Tina Edlund outlined the Oregon Health Fund Board (OHFB) reform strategies and implementation progress using crosswalk of OHFB included in the packet materials and asked the Board if this approach is something the Board wants staff to continue using.
The Board stressed the importance of cost containment and feels it should be moved to the forefront of the blueprint. The OHFB's analysis of cost containment needs to be reviewed again.

Cost containment should translate into affordability to the consumer. Staff should price each proposal brought forward to the Board.

Board Discussion:
Gretchen Morley provided an outline of the Blueprint for Comprehensive Health Reform and asked the Board to provide further direction and suggestions. The OHFB report will serve as a resource and starts the process. The Board needs to identify the frequency in which it wants staff to bring information forward. All Board members are on Committees as liaisons. The

Board's role is to bring the questions forward. The backbone is the Triple Aim. OHPR provided some briefings on the overview of the finance committee. The Board suggested that OHPR could give an overview of that committee's work again. The Board also asked for a brief overview from the finance committee. Bruce added that staff has been requested to do some modeling and the information will be ready for the Board in a few weeks. That work could be done before the April board meeting. If it is we will send it out to the Board when it is complete. OHPR will present options on how to raise funds if there are no federal funds.
Public Comments ***How does preventive oral health and dental care will work into this?*** The goal is overall health. The work of OHPB and OHA is about health and comprehensive health, which includes oral health. ***Bob Brown*** suggested outreach to legislators and would like the Board to comment on how to reach out to legislators. The Board has been waiting for special session to end and will ask staff for input to establish relationships with legislators. The Board noted that legislators conduct town hall meetings so OHPB will make an effort to talk about the importance of health care during those meetings. Dr. Goldberg advised the Board that staff have attended a number of town halls and meetings with legislators over the last couple of months. It is a part of OHA's strategy to talk about the work of the Board and where it is going with health reform. OHA will be discussing health care issues. Whenever Board members meet with legislators, they should contact Jeremy Vandehey so he can track that information.
Adjourn 4:05 p.m.

<u>Next meeting:</u>
April 13th, 2010
8:30 am to 12:30 pm
Bend

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Monthly Report to
Oregon Health Policy Board
April 13, 2010

Bruce Goldberg, M.D.

I. PROGRAM AND KEY ISSUE UPDATES

Healthy Kids Plan

Enrollment

- Approximately 3,000 kids were enrolled in February for a total of 38,000 enrolled since inception. Still tracking just slightly ahead of our enrollment targets. Approximately 500 children have been enrolled in the new KidsConnect program since it came on line last month.

Outreach

- There are now over 100 organizations in the state working to help with outreach, enrollment and application assistance, and 750 individuals who have been trained to help with that effort.

OHP Standard

- Enrollment in OHP Standard is 25,195.

- As of Friday, March 26, 94,121 people had signed up for the OHP Standard reservation list since it opened in November 2009.

- DHS has completed four random drawings:

Month of random selection	Number of names drawn
October 2009	2,000 (opt-in list only)
January 2010	2,000
February 2010	2,000
March 2010	6,000

  - The next two drawings will be:

    - April 5, 2010 -- 8,000 names
    - May 3, 2010 -- 10,000 names
      Note: A significant percentage of those individuals selected to apply end up not qualifying for the program.

- The department continues to conduct a statewide campaign to encourage and assist more uninsured adults in Oregon to sign up, with the help of community partner organizations throughout the state and a grant from the federal Health Services and Resources Administration (HRSA). Outreach efforts have included:

  - There have been four press releases.
  - More than 350,000 large-size postcards went out in early March to all DHS clients who do not have medical assistance and to households in zip codes with average household incomes under $45,000.
  - Letters have gone out to providers and schools to help reach out to low income families.
  - Flyers and brochures have gone out to more than 2,500 community organizations and groups who have agreed to help reach out to low income families.
  - We are developing on-screen public service announcements for movie theatres and local cable access television stations.

- DMAP and OHPR are collaborating under the HRSA grant to establish a program to provide enhanced outreach to hard-to-reach populations and to provide those selected from the list with help in getting their application completed and submitted.

- The biennial goal is to have an enrollment of 60,000 people in the OHP Standard program by June 30, 2011.

Transition to/Formation of OHA

Activities remain on track.

POLST Update (Physician Ordered Life Sustaining Treatment)

A detailed dashboard of the registry metrics accompanies this report as a separate attachment, in summary:

As of March 31 the Oregon POLST Registry has:

1. Received 15,374 POLST forms (excludes duplicates).
2. Since December 3, 2009 (statewide "go live"), the OHSU Emergency Communication Center has received 133 calls to the POLST Registry - 15 of these calls (11.3%) have been a match with a POLST form in the Registry. This is in keeping with their projections for matching considering the volume in the Registry. Match rates will improve as more "existing" POLST forms are entered into the Registry.

The Registry team is currently entering about 1,000 POLST forms per week. Ultimately the maximum in the Registry was estimated to top out at 50,000 of which around 15,000 would be new in any given year.

Outreach to providers, facilities and emergency services personnel have been ramping up.

Federal Health Reform

To be discussed in detail at the Board's April meeting.

Board Committee Progress

The **Administrative Simplification Workgroup** last met on March 30 in Wilsonville. The workgroup heard a preliminary report on the results of a survey of payers and providers conducted by the Office for Oregon Health Policy and Research (OHPR). Staff for administrative simplification projects in Minnesota and Washington met with the workgroup to describe the contrasting approaches taken in the two states and answer questions. The next meeting is scheduled for April 7 at 1 pm at the Wilsonville Training Center of Clackamas Community College (Room 218, 29353 Town Center Loop East, Wilsonville, OR). The group will begin its discussion of the state's role in promoting cost-saving administrative simplification activity. No final decisions are anticipated at the meeting.

Two more meetings are scheduled for: April 20 at 1 pm at Wilsonville Training Center of Clackamas Community College, Room 111, 29353 Town Center Loop East, Wilsonville, OR 97070, and May 11 at 1 pm at Meridian Park Hospital, Education Center, Room 104, 19300 SW 65th Avenue, Tualatin, OR 97062

The **Cost Sharing Workgroup** convened its first meeting on March 25 at Meridian Park Hospital's Health Education Center. The workgroup will be developing recommendations for cost-sharing levels for the essential benefit package to be offered in Oregon's Exchange, and that may be used for other public and private benefit packages. The group reviewed prior cost-sharing work developed by the Oregon Health Fund Board's Benefits and Eligibility and Enrollment Committees, as well as the work of the Health Services Commission around the Prioritized List. In addition, they heard a presentation on the different cost-sharing structures that can be used in their work and an update of federal reform. The next meeting is April 15 from 2-4 pm at the Wilsonville Training Center of Clackamas Community College (Room 211, 29353 Town Center Loop East, Wilsonville, OR), and will cover the principles and objectives that will guide their work, the populations to be covered, the initial benefit level to be developed, and more information on how federal reform intersects with the committee's work.

The **Public Employers Health Purchasing Committee** held its first meeting on March 1 in Wilsonville Training Center of Clackamas Community College. The committee heard presentations on: the Healthcare Leadership Task Force's medical home pilots; the Patient Centered Primary Care Home Standards Advisory Committee recommendations; and PEBB/OEBB's purchasing principles and visions. The next meeting is April 26 from 1-4 pm at Meridian Park Hospital's Health Education Center, and is tentatively scheduled to discuss evidence-based best practices, an update on federal reforms, and an introduction to quality and contracting.

The **Medical Liability Task Force** has been appointed but has not yet met. The first meeting will be scheduled sometime in April.

The **Health Care Workforce Committee** held its second meeting March 31 in Lake Oswego. The committee heard a presentation about anticipated and potential delivery system reforms in Oregon and continued a discussion of workforce strengths, weaknesses and opportunities with the goal of identifying two to three areas in which to focus its short-term work. Committee staff will be synthesizing the discussion for the committee's further consideration before the next meeting, scheduled for April 29 from 9 am – noon at the Wilsonville Training Center (29353 Town Center Loop E, Wilsonville, OR 97070). The committee also gave feedback on a proposed format and data collection process for the inventory of workforce grants and other resources that is due to the Health Policy Board in May. At the April 29 meeting, the committee will likely address any potential impacts of federal health reform on the committee's short-term priorities and review preliminary information received for the inventory.

The first meeting of the **Health Incentives and Outcomes Committee** will be held Thursday, April 8 at Meridian Park Hospital's Community Education Center in Tualatin (19300 SW 65th Avenue Tualatin, OR 97062). The committee will become familiar with its scope and role, discuss committee vision and strategies, and review, revise and adopt committee by-laws. There will be time made for public comment. The committee is comprised of two subcommittees: Payment Reform and Quality and Efficiency, which will meet separately for the first time on April 29, again at Meridian Park. The Payment Reform Subcommittee will meet from 12:30-2:30 pm and Quality and Efficiency Subcommittee 3-5 pm. At those meetings, subcommittee members will refine their work plans and begin work toward their first deliverables.

The Health Information Technology Oversight Council (HITOC) most recently met in Portland. HITOC is currently focused on the development of the Strategic and Operational Plans for Statewide Health Information Exchange (HIE). These plans are required to be submitted to the Office of the National Coordinator for Health Information Technology by August 31, 2010. At the April meeting, the HITOC discussed the progress to date on the plans, and received input from the HITOC Strategic Workgroup on the technology domain that must be included in the plans. In addition, the council discussed the other HITOC responsibilities as outlined in HB2009 including the Medicaid Transformation Grant, the Medicaid Health Information Planning Process (P-APD) and Electronic Health Record (EHR) adoption strategies. The next HITOC meeting will be on Thursday, May 6 from 10 am – 5 pm (Oregon State Library, Room 103, 250 Winter St NE, Salem). The HITOC will receive input from the Strategic Workgroup on the legal and policy, business operations and finance elements of the state HIE plans, discuss how to integrate the different segments of the plans and identify areas of the plans that need additional clarification.

The **Oregon Health Improvement Plan (HIP) Committee** met for the first time on March 30 at Willamette University in Salem. The committee charter, by-laws, and work plan were reviewed and accepted. Members participated in a discussion about values for developing the heath improvement plan. The next meeting is April 9 at the Kaiser Mt. Scott Medical Office in Clackamas. Key agenda items include the health status of Oregonians, health disparities, the new federal health care law, best and promising population health practices. The presentations and discussions will begin to define the content and scope of the statewide plan.

II. BUDGET

Report attached.
Expenses tracking closely with budget allotments.

All state agencies need to submit to the Governor an "Agency Request Budget" for the 2011-13 biennium along with lists of budget reduction options. These are due at the end of the summer. The Department of Human Services, in conjunction with the Oregon Health Authority, will be holding a series of forums around the state throughout April and May to solicit community input on budget choices. I will provide additional background information at the meeting. The forum schedule is attached.

Oregon Health Authority
July 2009 - February 2010 Actual Expenditures vs LAB Spending Plan
(Millions)

Program	$ Variance General Fund	% Var GF	$ Variance Other & Federal Funds	% Var OF & FF	$ Variance Total Funds	% Var TF
Addictions & Mental Health Division	(2.2)	-1.2%	(2.4)	-3.0%	(4.6)	-1.8%
Division of Medical Assistance Programs	(0.4)	-0.1%	(39.5)	-3.1%	(39.8)	-2.5%
Public Health Division	0.2	1.7%	(5.8)	-4.2%	(5.6)	-3.6%
Oregon Medical Insurance Pool	-	-	1.8	1.6%	1.8	1.6%
*Public Employee's Benefit Board***	-	-	*(266.1)*	*-77.1%*	*(266.1)*	*-77.1%*
Oregon Educators Benefits Board	-	-	7.2	1.6%	7.2	1.6%
Office of Private Health Partnerships	(0.2)	-3.3%	(5.7)	-33.2%	(5.9)	-25.4%
Total	**(2.5)**	-0.5%	**(310.4)**	-13.0%	**(312.9)**	-10.7%

Negative numbers reflect underspent projections

** This report reflects actual expenditures to date. With the switch to self insurance in January 2010, there is a lag in incurring these expenditures at the beginning of the program, but expenditures will come into alignment with the budget later in the biennium.

Oregon Health Authority
Total 2009-11 Legislatively Approved Budget
(Millions)

Program	General Fund	Other & Federal Funds	Total Funds
Addictions & Mental Health Division	622.9	316.7	939.6
Division of Medical Assistance Programs	873.8	5,223.8	6,097.6
Public Health Division	48.9	474.9	523.8
Public Employee's Benefit Board	-	1,035.9	1,035.9
Oregon Educators Benefits Board	-	1,344.8	1,344.8
Oregon Medical Insurance Pool	-	409.0	409.0
Office of Private Health Partnerships	21.3	123.0	144.3
Total	1,566.9	8,928.1	10,495.0

Oregon Department of Human Services and Oregon Health Authority present the

2010 COMMUNITY FORUM

You are invited ...

... to this important discussion about the priorities of your community.

The Oregon Department of Human Services and Oregon Health Authority are hosting a series of statewide public forums this spring. We invite you to come share your ideas about local needs and priorities for the 2011–2013 budget and beyond.

Please join us!

Attend any or all of these events:

- **Pendleton, Thursday, April 15, 1–4 p.m.**, DHS Office, 1555 Southgate Place
  Teleconference on this date from **Baker City, Burns, Hermiston, John Day, La Grande** or **Ontario**. For location information, visit **www.oregon.gov/dhs** or **www.oregon.gov/oha**.
- **Salem, Monday, April 19, 1–4 p.m.**
  Cascade Hall, Oregon State Fairgrounds, 2330 17th St. NE
- **Portland, Wednesday, April 21, 1–4 p.m.**
  Oregon Convention Center, 777 NE Martin Luther King, Jr. Blvd.
- **Redmond, Thursday, May 6, 1–4 p.m.**
  Deschutes County Fair and Expo Center, Three Sisters Conference Center, 3800 SW Airport Way
- **Eugene, Wednesday, May 12, 1–4 p.m.**
  Lane Community College, Center for Meeting and Learning, 4000 E 30th Ave.
- **Medford, Thursday, May 13, 8–11 a.m.**
  Rogue Regency Inn, 2300 Biddle Road
- **Newport, Tuesday, May 18, 9 a.m.–noon**
  Best Western Agate Beach Inn, 3019 N Coast Highway

Get involved!

Help the Department of Human Services and the Oregon Health Authority work toward a healthy, independent and safe future for all Oregonians.

For more information, visit **www.oregon.gov/dhs** or **www.oregon.gov/oha**, or find us on facebook. If you can't attend the forums, send your ideas to **dhs.oha@dhs.state.or.us**.

DHS Oregon Department of Human Services

Oregon Health Authority

2011–2013

Overview of Patient-Centered Primary Care Home Pilot Development
Oregon Health Policy Board Meeting – 4/13/10

Overall Objectives

- Implement and evaluate the PCPCH model in clinical sites across Oregon
- Key evaluation parameters: costs, quality, access and patient and provider satisfaction

Key Activities

1. Develop PCPCH Standards to serve as a framework for pilot design – completed

2. Partner with the Health Leadership Task Force (HLTF) on a Multi-Payer Pilot - 2010

Description:
- "High Value" pilot focused on top 10% risk group of adult patients
- Similar to PCPCH Standards Advisory Committee model, but focusing on clinics already functioning at a high level for phase 1
- Key intervention is use of a RN case manager embedded in the clinic
- Primary goal is to demonstrate a short-term ROI in the first 12-24 months

OHA Steps:
- Plans identifying PEBB, OEBB and OMIP lives in potential clinic sites
- Commitments from PEBB and OMIP to provide funding
- DMAP identifying OHP lives in potential clinic sties
- Goal of maximizing the number of OHA lives in the selected sites
- Barney Speight and Bart McMullan involved in HLTF process

Timeline:
- April-May 2010 - Initial selection of clinic sites through an RFP process
- May-July 2010 – OHA negotiation with Medicaid MCOs on participation
- Summer 2010 – start of phase 1 (about 10 clinics)
- Anticipate additional sites in subsequent phases

3. Develop Additional Pilots or Expand to More Sites – 2010/2011

Goals:
- Test the PCPCH model in additional populations/clinics:
  - Clinical sites not invited to participate in phase 1 of the HLTF pilot
  - Children and healthier adults
  - Clinics serving primarily OHP and uninsured populations
  - Clinical sites integrating mental and physical health

OHA Steps:
- Explore potential funding opportunities to support pilots:
  - State Health Access Program (SHAP) grant
  - CHIPRA grant (for pilots focusing on children)
  - Use of existing quality improvement funds
  - 90/10 match in Federal health reform for state Medicaid pilots focusing on individuals with 1 or more chronic diseases

4. Implement Broader Delivery System and Payment Reform Based on Pilot Results

OHA Steps:
- DMAP/OHPR writing report on the feasibility of PCPCH payment (2010)
- Develop plans for broader payment reform (PR Committee)
- Develop statewide and regional learning collaboratives
  (Primary Care Extension Service funding in Federal health reform)
- Implementation of payment for PCPCH across all OHA lives as early as 2012

Implementing the Patient Centered Primary Care Home Model of Care

Initial Overview of Oregon Health Authority's Next Steps

Office for Oregon Health Policy and Research (OHPR)

Why Primary Care Homes?
Goals of the Oregon Health Fund Board & HB 2009

- Improve individual and population health outcomes
- Reduce inappropriate utilization
- Reduce health system costs costs
- Strengthen primary care
- Encourage prevention and chronic disease management over acute, episodic care
- Stimulate delivery system change

" Right care at the right time and in the right place"

Steps Towards Implementing Primary Care Homes

1. Develop PCH Standards (completed)
2. Partner with the Health Leadership Task Force on a multi-payer pilot (Summer 2010)
3. Expand to more sites or develop additional pilots (Fall 2010-2011)
4. Implement broader implementation and payment reform (2012?)

Health Leadership Task Force "High Value" Medical Home Pilot

- Building on successful pilot at Boeing
- Focus on top 10% of adult patients by risk
- Care model focused on Triple AIM - strong concordance with State PCPCH Standards
- Evaluation components including: utilization, quality and patient experience
  - Goal of short-term Return on Investment in 1-2 years
- Payment methodology: PMPM + FFS + p4p

Health Leadership Task Force "High Value" Medical Home Pilot

HLTF Care Model focused on:

- Access
- Intensive Care Management
- Coordination (transitions and ED follow up)
- Staffing requirements (RN Care Manager)
- Training and Culture

Health Leadership Task Force "High Value" Medical Home Pilot

Business Case Illustration:

- Population: top 10% of high cost individuals
- Expected costs based on MEPS 2007 data--$22K/yr
- If 4,000 enrollees in a pilot:
  - Total baseline costs $88M
  - New cost to support the model about $2M
  - Break even savings needed to cover total new cost: 2.2%
- If achieve 10-20% cost savings (as Boeing did):
  - ROI to Plans 180% to 400%

Health Leadership Task Force "High Value" Medical Home Pilot

Steps to Include OHA lives in the HLTF pilot:

- Plans identifying PEBB, OEBB and OMIP lives in candidate clinics
- DMAP identifying OHP lives in candidate clinics
- Anticipate selection of 8-10 clinics for initial pilot in late April/May
- Working to identify resources to pay similarly to private plans for OHP lives
- Goal of maximizing the number of OHA lives in the selected pilot sites

Steps Towards Implementing Primary Care Homes

1. Develop PCH Standards (completed)
2. Partner with the Health Leadership Task Force on a multi-payer pilot (Summer 2010)
3. **Expand to more sites or develop additional pilots**
   - **Clinical sites not participating in phase 1 of the HLTF pilot**
   - **Children and healthier adults**
   - **Clinics serving primarily OHP and uninsured populations**
   - **Clinical sites integrating mental and physical health**

** **Funding opportunity in health reform bill for 90/10 Federal match for pilots including Medicaid recipients with >1 chronic condition starting in 2011**

For More Information

Full Standards report will be available at:

http://www.oregon.gov/OHPPR/HEALTHREFORM/PCPCH/PCPCHStandardsAdvisoryCommittee.shtml

Overview of HLTF Pilot available at:

http://www.oregon.gov/OHA/OHPB/committees/pub-hlt-bn-prch-mtgs.shtml

Office for Oregon Health Policy & Research

- Website: www.oregon.gov/ohpr
- Call us at 503-373-1779
- Email at jeanene.smith@state.or.us

Federal Health Reform Overview & Considerations for the Oregon Health Policy Board

Oregon Health Policy Board

April 13, 2010

Based on OHA staff current understanding

Overall impact of federal law

- **Population health**
  - Significant funding opportunities to enhance and integrate prevention and health promotion in state and community health policy planning
  - Substantial increase in community health centers funding
- **Delivery system reform**
  - Funding allows experimentation with new models of payment and care delivery
  - Will change Oregon's federal revenue

    (e.g., Medicaid primary care increase 2013-14; additional Medicare hospital payments FY 2011-12; Medicare Advantage reductions start 2012)
  - Strengthens the federal focus and state support of value & quality

Overall impact of federal law

- **Coverage and Access in 2014**
  - Low-income adults up to 133% of poverty will have access to Medicaid with increased federal funding to support expansions
  - Federally-funded tax credits and cost-sharing reductions provided through a state health insurance exchange to individuals up to 400% of poverty
  - Individual mandate requires insurance coverage for all citizens (with some exceptions)
  - Insurance reforms remove barriers to coverage

What the federal law doesn't do

- **Population health**
  - No fundamental change to relationship between public health and health care; states and communities need to capitalize on funding opportunities to support system transformation
- **Delivery system reform**
  - Limited provisions for cost containment
  - May not fully address workforce shortages
- **Coverage**
  - Does not allow states to apply for waivers until 2017
  - Fails to get to universal coverage (can opt-out of individual mandate)
  - Still may not fully address affordability issues

Overview: Improving Population Health

- **Significant investments in prevention and public health, examples include:**
  - $25m nationally for childhood obesity prevention; could enable implementation of state obesity prevention taskforce recs.
  - $190m nationally to strengthen public health surveillance; could increase state's capacity to monitor and control infectious disease
- **HHS to develop national prevention and health promotion strategy**
- **Grants for school-based health centers, oral health, others**
- **Menu labeling required in chain restaurants (20+ locations) and vending machines**

Overview: Transforming Care Delivery

- **Payment Reform**
  - Increases Medicaid reimbursement for primary care services to 100% of Medicare at federal expense (2013-2014 only)
  - Medicaid medical home demonstration – planning grants and enhanced federal Medicaid match for implementation (starts 2011)
  - CMS Innovation Center to develop payment and other delivery system reforms
- **Medicare Payment**
  - Increases reimbursement to hospitals in Oregon (FY2011-2012 only)
  - Reduces Medicare Advantage payments (starts 2012)

Overview: Transforming Care Delivery

- **Community Health Center Funding**
  - Increases access to services for vulnerable populations through $11 billion nationally for CHCs from 2011-2015
- **Behavioral Health Integration**
  - Grants for co-location of primary and specialty care in community-based mental health setting, $50M available nationally beginning in 2010
- **Workforce**
  - Funding, pilots, and other opportunities for workforce development, coordination, training, and loans/repayment

Overview: Transforming Care Delivery

- **Quality Standards**
  - HHS to develop national quality improvement strategy
  - CMS to create quality standards for adult care in Medicaid
- **Administrative Simplification**
  - Requires compliance with new and revised HIPPA standards for electronic transactions (2013-2016)
  - Medicare providers must accept electronic remittance advice and funds transfer (starts 2014)
- **Comparative Effectiveness**
  - Establishes Patient-Centered Outcomes Research Institute to provide research and guideline development

Overview: Coverage and Access to Care

- **Early Benefits**
  - Young adults on parents' health plans
  - Prohibition on pre-existing condition exclusions for children
  - Prohibition against rescinding coverage after enrollment except in cases of fraud
  - Prohibition against lifetime benefit caps

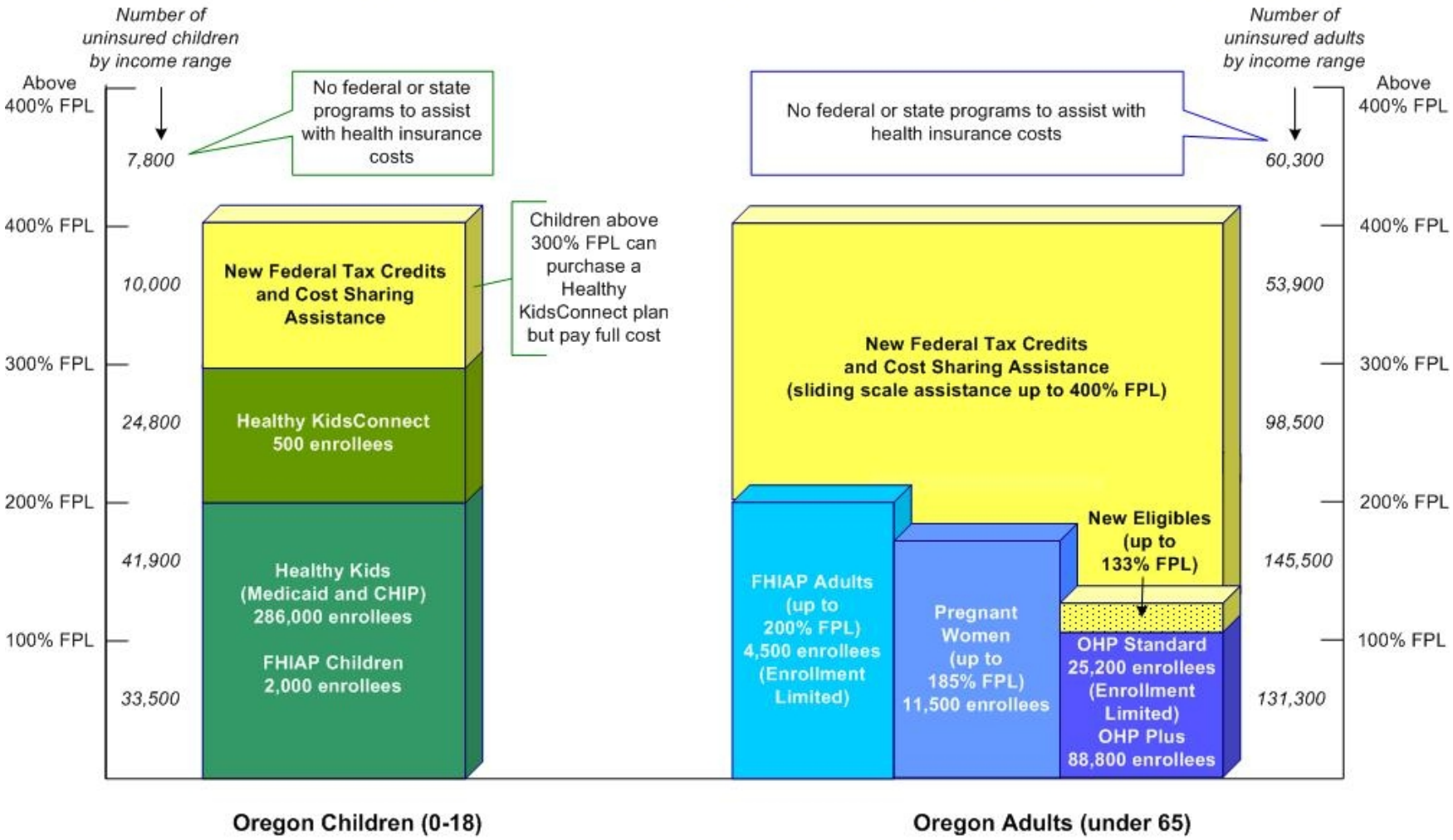
Overview: Coverage and Access to Care

- **Medicaid/Children's Health Insurance Program (CHIP)**
  - Coverage expansion for all individuals under age 65 up to 133% and former foster children at all income levels up to age 26 (starts 2014)
  - Enhanced federal funding for new eligibles
    - 100% in 2014-16
    - 95% in 2017
    - 94% in 2018
    - 93% in 2019
    - 90% in 2020 and beyond
  - Starting in 2015, federal match for CHIP match goes up 23 points
  - Gradually reduces disproportionate share hospital payments based on uninsurance rates (2014-2020)
  - States must maintain eligibility levels for adults until Exchange is fully operational, and for children until 2019

Overview: Coverage and Access to Care

- **Exchange**
  - States establish Exchanges for individuals and small employer groups with <100 employees (starts 2014)
  - Individuals and small groups can still buy insurance outside of Exchange
  - HHS defines minimum benefit package to be offered in Exchange
  - Federal premium tax credits and cost-sharing reductions
    - Reduce premiums for individuals 100%-400% FPL on a sliding scale (starts 2014)
    - Federal payments reduce out-of-pocket limit (starts 2014)
    - Tax credits and cost-sharing reductions only available through the Exchange
- **Public Plan**
  - No federal public plan; does not preclude state exploration of a public plan

Current Public Insurance Programs and Potential Expansions Under Federal Reform



Federal expansions reflect H.R. 3590, passed by the Senate in 2009.
All figures are rounded to the nearest hundred.
Program enrollment figures are the most current available on March 1.
Uninsured numbers are from the 2009 American Community Survey report.
Oregon populations figures for total children and adults under 65 are from Population Research Center at Portland State University, Dec. 2009

Overview: Coverage and Access to Care

- **High-Risk Pool**
  - Temporary national high-risk pool created (within 90 days of enactment until Jan. 2014)
- **Small Business/Employer Responsibility**
  - Tax credits to low-wage small employers to purchase coverage (2010-2013) and purchase through the Exchange (starts 2014)
  - Assessments on employers (> 50 FTE) whose employees receive tax credits or cost-sharing reductions (starts 2014)
- **Individual Responsibility**
  - Individuals must have qualifying health coverage, unless unaffordable (if premium >8% of income); phased-in tax penalty (2014-2016)

Overview: Coverage and Access to Care

- **Insurance Regulation**
  - Guaranteed issue and renewability (starts 2014)
  - Pre-existing conditions exclusions prohibited (for children 6 months from enactment and for adults by 2014)
  - Prohibits lifetime limits, allows certain annual limits until 2014
  - Eliminates waiting periods of more than 90 days for group coverage (starts 2014)
- **Reinsurance**
  - Temporary federal reinsurance program for early retiree benefits (within 90 days of enactment until Jan. 2014)
  - Transitional reinsurance program, individual and small group (2014-2016)

Federal Health Reform Timeline Highlights

- **2010**
  - Temporary national high-risk pool (June 2010 until Jan. 2014)
  - Dependent coverage for adult children up to age 26
  - Prohibitions on lifetime limits; certain annual limits until 2014
  - Temporary federal reinsurance program for early retirees (June 2010)
- **2011**
  - Develop a national quality improvement strategy
  - New annual fees on the pharmaceutical manufacturing sector
- **2012**
  - Require enhanced data collection and reporting on race, ethnicity, sex, primary language, disability status, and for underserved rural and frontier populations

Federal Health Reform Timeline Highlights

- **2013**
  - Simplify health insurance administration
  - Increase Medicaid payments for primary care services provided by primary care doctors for 2013 and 2014 with 100% federal funding
- **2014**
  - Medicaid expansions and health insurance tax credits begin
  - Excise tax on individuals without qualifying health coverage (phase-in 2014-2016)
  - Excise tax on employers (> 50 FTE) whose employees receive tax credits or cost-sharing reductions
  - Establish state Exchanges
  - Limit on waiting periods for coverage to 90 days
  - Annual fee on the health insurance premiums (starts 2014)
- **2015 and later**
  - Excise tax on high-cost plans (Jan. 2018)

Key Issues

- **Timing: Do we go early? Do we continue with initiatives that will be superseded by the federal legislation?**
  - Should Oregon explore setting up an Exchange sooner than 2014?
  - Should OHA implement standards for electronic transactions since federal ones starting in 2013 will supersede them?
  - Should OHA continue to work on a small business plan that will be superseded by the Exchange?
  - Should OHA expand Medicaid and/or subsidy assistance programs prior to 2014?
  - Should OHA continue work on an essential benefit package when HHS will be setting packages for the Exchange?

Key Issues

- **Should we do more?**
  - Should Oregon have a public plan to sell inside and/or outside the Exchange?
  - Should there be additional state-funded assistance in the Exchange to help lower costs to Oregonian's?
  - HHS will designate the essential benefit services for plans offered in the Exchange. If Oregon chooses to require additional benefits, it must pay for them. Should the state develop a benefit package that goes beyond the HHS definition?

Key Issues

- **Where there is federal flexibility, how do we ensure strategic alignment of design choices?**
  - Should Oregon explore working with other states on a regional (multi-state) Exchange?
  - Should Oregon's Exchange be operated by the state or contracted to a non-profit entity?
  - Should Oregon run separate individual and small group market exchanges or have a single Exchange for both markets?
  - Should Oregon pursue state-based reinsurance or other risk adjustment mechanisms for the multi-share programs or Healthy KidsConnect?
  - Should/can multi-share programs be integrated into an Exchange or CO-OP program and, if so, when?

Key Issues

- **How do we ensure strategic alignment of funding and pilot opportunities presented by federal reform?**
  - Which funding or pilot opportunities best support the state's strategic objectives for population health, delivery system reform?

Federal Health Reform in Oregon: Implications for Expanding Insurance Coverage and Access to Care

(Based on Oregon Health Policy and Research staff understanding as of April 1, 2010)

Policy/ program area	What federal reform does	Where there is state flexibility	Interactions with Oregon reforms and programs[1]	Details to be determined	Funding, pilots, and other opportunities
Medicaid/ CHIP	• All individuals under age 65 up to 133% of poverty and former foster children at all income levels up to age 26 are mandatory Medicaid populations (begins in 2014). • Federal funding established (100% for newly eligible in 2014-16; 95% in 2017; 94% in 2018; 93% in 2019; and 90% in 2020 and subsequent years). • Enhanced CHIP match for children by 23 percentage points which will raise Oregon's match to 96.7% from the current 73.7% (beginning in 2015). • Reduces federal aggregate disproportionate share hospital allotments gradually between 2014 and 2020 based on a state's uninsurance rate. Imposes smaller reductions for low-DSH states (which include Oregon with a FY 2009 DSH allotment of approximately $45.5 million). • States must maintain eligibility levels for adults until insurance exchange is fully operational and eligibility levels for children until 2019.	• Option to phase-in newly eligible population beginning in 2010. • Option to provide home and community-based services through state plan and not waiver for high-needs individuals up to 300% of the maximum SSI payment.	• Healthy KidsConnect will likely have interaction with an Oregon health insurance exchange. See Tax Credits for Purchasing Coverage and Health Insurance Exchange sections for further detail.	• Unclear as to whether Oregon would receive enhanced federal funding in 2014 for newly eligible individuals enrolled beginning in 2010. • Unclear as to how the community-based state plan option would affect Oregon.	Enhanced federal funding to implement coverage expansions.
Health insurance exchange	• Annual grants for Exchange start-up costs (1 yr past bill passage through 2014). • States establish Exchanges for individuals and small groups (Jan. 2014). • Minimum Exchange functions specified in the bill. • Individuals are eligible for the Exchange if citizens or lawfully in the United States and not incarcerated; but individuals under 133% who are eligible for Medicaid must be enrolled in Medicaid. • Small employers with fewer than 100 employees are	• States can choose to create two exchanges (individual and small business) or merge them • States can form regional exchanges. • States may allow employers with 100+ employees to	• Provides considerable definition to exchange business plan required by HB 2009. • More analysis required on how difficult the bill will make it to (1) require Exchange plans to use a value-based benefit package as specified in HB 2009 and (2) use a competitive bidding process to select plans to offer in the	• HHS Secretary to establish criteria for qualified health plans. • Risk adjustment requirements unclear. • HHS guidance on benefits required.	• Annual grants for exchange start-up available until January 1, 2015; amounts to be determined by HHS Secretary.

[1] Oregon Health Authority and Department of Human Resources staff will provide support for analysis of these issues in coordination with statutory as well as informal advisory bodies including but not limited to the Health Services Commission, the Medicaid Advisory Committee, the Health Insurance Reform Advisory Committee, and the Cost-sharing Work Group.

Policy/ program area	What federal reform does	Where there is state flexibility	Interactions with Oregon reforms and programs[1]	Details to be determined	Funding, pilots, and other opportunities
	eligible. • HHS defines the benefits package that must be offered in Exchange plans with package to parallel benefits in employer-based plans. • HHS establishes additional criteria for qualified health plans that may be sold in the Exchange, sets open enrollment periods, reviews insurance rate increases. • Plans offered in the Exchange pay for a standardized percentage of the actuarial value of covered services (bronze to platinum). • Federal tax credits and cost-sharing reduction payments are available only in the Exchange. • There will be individual and small group markets outside the Exchange.	participate in Exchange beginning 2017. • States may set additional criteria for plans selling in the Exchange (including but not limited to consideration of plan justifications for premium increases). • State may require Exchange plans to cover benefits not included in the benefits package established by HHS, but must pay additional cost of coverage for individuals receiving tax credits and reduced cost-sharing.	Exchange.		
Tax credits for purchasing coverage	• Advanced refundable federal income tax credits to individuals lawfully in the US between 100% and 400% FPL on sliding scale (beginning 2014). • Tax credits and federal payments to reduce premiums and cost-sharing are not available to employees with access to an employer plan unless the plan's actuarial value is less than 60% of the cost of covered services or the employee share of premium for the employer plan exceeds 9.5% of income.	• States may further reduce premiums and cost-sharing to make coverage affordable at state expense. • Basic health plan option: States may use federal tax credit and cost-sharing reduction dollars (95%) to	• Premiums may be higher than the 5% of household income standard recommended by the Health Fund Board's Eligibility & Enrollment Committee. • FHIAP and KidsConnect are income-based premium subsidy programs. State will need to decide how these program will fit into the structure of an	• HHS will establish rules for basic health plans.	Increased affordability of health insurance for individuals under 400% FPL.

Policy/ program area	What federal reform does	Where there is state flexibility	Interactions with Oregon reforms and programs[1]	Details to be determined	Funding, pilots, and other opportunities
	• Tax credits and federal payments to reduce premiums and cost-sharing only available for purchase in the Exchange.	provide the essential benefits package to individuals from 133-200% FPL through standard contracted plans instead of the Exchange.	Exchange.		
Cost-sharing reductions	• Federal payments reduce the out-of-pocket limit by specified amounts depending on income (2014). Silver plan is used as basis for calculation. • Additional federal payments will be made to plans to reduce cost-sharing as prescribed by HHS so the plan pays a specified percentage of total costs for covered services – from 94% to 70% depending on income (2014).	• See Tax Credits for Purchasing Coverage	• Cost-sharing levels and mechanisms will impact utilization incentives in the benefit plan.	• HHS will establish method of reducing cost sharing (by a date not specified)	
Public plan	• There will be no federal public plan. • However, created nonprofit Consumer Operated and Oriented Plan (CO-OP) program. • Office of Personnel Management to contract for at least 2 multi-state plans in Exchange.	• States can create own public plan and sell it under the Exchange provided it satisfies criteria for qualified plans.	• HB 2009 directs OHPB to do a feasibility study for a public plan. • CO-OP plan would be regulated by Ins. Division.	• Distribution formula for CO-OP appropriations.	• $6 billion available to finance CO-OP program.
High risk pool	• Temporary national high-risk pool program created. Effective within 90 days of enactment until Jan. 1, 2014.	• OMIP could apply to administer Oregon's program.	• OMIP statutes changed in 2010 special session to comply with federal requirements. • Eligibility criteria different and more restrictive than OMIP. • Additional federal funding will likely not cover costs for new eligibles.	• Application to be a high-risk pool entity not yet released.	• $5 billion appropriated, allocation methodology not established.
Small business assistance	• Tax credits for small employers with low-wage employees to purchase employee coverage (credit amount varies but does not exceed 50% of cost)		• HB 2009 requires development of a small business product; impact of such a product unclear		

Policy/ program area	What federal reform does	Where there is state flexibility	Interactions with Oregon reforms and programs[1]	Details to be determined	Funding, pilots, and other opportunities
	(2010-2013). • Tax credits for same employers available for maximum of two years for purchase through the Exchange (2014-forward).		in context of federal reform		
Employer responsibilities	• Waiting periods for coverage may not exceed 90 days (Jan. 2014). • Non-offering employers with 50+ full-time equivalent employees pay an assessment if one or more full-time employees receives a premium tax credit. (Fee is $2,000 per full-time employee, excluding the first 30 employees.) Offering employers pay $3,000 per subsidized full-time employee per year. (Jan. 2014) • Employers with fewer than 50 full-time equivalent employees exempt from assessment. • Employer must provide a "free choice voucher" equal to the employer's contribution to an employer-sponsored plan to employees below 400% FPL whose premiums for the employer's plan are between 8-9.5% of income. Voucher allows employee to purchase non-subsidized coverage in the Exchange using employer dollars. • Employers with 200+ full-time employees must automatically enroll full-time employees in coverage offered by the employer. Employees may opt out of coverage.	• Federal law may preclude states from taxing employers based on whether or not they provide coverage for employees.	• HB 2009 directed HPB to assess feasibility of payroll tax to encourage employers to continue to provide coverage to their employees; should consider if needed given federal provisions.	• It is not clear whether each federal requirement creates a floor or whether it pre-empts greater state requirements.	
Individual responsibility	• Individuals required to maintain minimum essential coverage unless not affordable (Jan. 2014). • Penalty for non-compliance beginning in 2014 with amounts gradually increasing to the greater of $695 or 2.5% of taxable income in 2016. • Exemptions defined (including those for whom	• No state flexibility on tax rules. • State could provide additional funds to eliminate the affordability gap	• "Minimum essential coverage" to satisfy the mandate need not meet the requirements of the HHS-defined "essential benefits package" for Exchange plans. In contrast, HB 2009 directed HPB to develop a baseline (essential)		

Policy/ program area	What federal reform does	Where there is state flexibility	Interactions with Oregon reforms and programs[1]	Details to be determined	Funding, pilots, and other opportunities
	premiums cost more than 8% of income, those below tax filing threshold, those with less than 3-month gap, etc.) • Current coverage is treated as minimum essential coverage (on a grandfathered basis); new coverage must meet essential benefit requirements.	(individuals for whom premium costs more than 8% of income) thereby tightening the mandate.	benefit plan to which all plans must conform. • Answers a question posed by HB 2009 re: advisability of a mandate. • Establishes what insurance benefit satisfies an individual insurance requirement.		
Insurance Regulation	• Guarantee Issue and renewability (Jan. 2014). • Rate Bands—allows variation based on age 3:1, rating area, family composition, tobacco use 1.5:1. • Pre-existing condition exclusions prohibited for children 6 months from enactment and for adults by 2014. • Eliminates waiting periods of more than 90 days for group coverage (Jan. 2014). • Prohibits lifetime limits, allows certain annual limits until 2014. • Dependent coverage up through age 26 for all plans 6 months from enactment.	• State could move to guarantee issue/renewability before 2014.	• HB 2009 directed the state to determine if such reforms were feasible and make recommendation for enabling legislation. • Oregon has different rating requirements so must come into compliance with new federal requirements by 2014. • FHIAP and PEBB/OEBB will need to allow dependent children to stay on plan longer.	• Intersection of federal review and state regulatory authority.	• Opportunity to apply for a 10-state demonstration to apply wellness incentives in individual market.
Insurance Oversight	• Plans must report expenses, spend minimum % of revenue on medical services or provide rebates. • Establishes federal process for annually reviewing premium increases, requiring plans to justify increases. • Establishes a federal consumer assistance or ombudsman program.	• States may collect additional information.	• Generally follows direction that Oregon has taken in making more insurance information more transparent. • Oregon law doesn't require annual review of "unreasonable" rate increases so federal review may be more exacting. • Insurance Division currently has regulatory authority for rate reviews.	• Intersection of federal review and state regulatory authority is not yet clear.	• $250 million in federal grants available to states to support premium review and approvals. • $30 million in federal grants to establish consumer assistance or

Policy/ program area	What federal reform does	Where there is state flexibility	Interactions with Oregon reforms and programs[1]	Details to be determined	Funding, pilots, and other opportunities
			• Insurance Division also has a consumer protection unit and ombudsman.		ombudsman programs.
Reinsurance and risk adjustment	• Establishes a federal temporary reinsurance program for early retirees 90 days after enactment. • States must establish transitional reinsurance program for individual and small group markets 2014-2016. • Secretary establishes risk corridors for qualified health plans 2014-2016. • States adjust risk in individual and small group markets, but not grandfathered plans.	• State can coordinate transitional program with state high-risk pool. • State can collect additional amounts on voluntary basis.	• HB 2755 requires DCBS to conduct reinsurance feasibility study and report by October 1, 2010. • Programs generally begin in 2014 and last through 2016. Risk adjustment appears to be only mechanism to continue beyond that timeframe. • PEBB/OEBB could choose to be a participating employer in the early retiree program. • Further analysis needed on transitional reinsurance, risk corridors, risk adjustment.	• Secretary establishes standards, formulas for payment and contributions from insurers to the transitional program. • Coordination with state high-risk pool. • Risk corridor formula described in bill, but administration of assessments/ payments not clear. • HHS must set criteria/methods for risk adjustment with state input.	• $5 billion appropriated to finance early retiree reinsurance program. • $25 billion over 3 years to fund transitional reinsurance program.
Other Financing Mechanisms	• Excise tax on high-cost insurance plans of 40% of excess over a cap. Applies to self-insured plans and plans sold in group market but not plans sold in individual market. (Jan. 1, 2018) • Annual fee on health insurance, increasing gradually from $8 billion in 2014 to $14.3 billion in 2018. Fees for subsequent years are indexed. • Other taxes include annual fees on the pharmaceutical sector, Medicare related taxes, excise tax on medical devices, tanning tax, amongst others.	• States required to adhere to federal provisions.	• PEBB and OEBB may be considered high-cost plans and subject to excise tax. • Oregon's premium tax applies on insurers from October 1, 2009, through September 30, 2013. There is no overlap between Oregon's current premium tax and the federal annual health insurance fee.		

Federal Health Reform in Oregon: Implications for Transforming Care Delivery

(Based on Oregon Health Policy and Research understanding as of 4-1-2010)

Policy/program area	What federal reform does	Where there is state flexibility	Interactions with Oregon reforms and programs	Details to be determined	Funding, pilots, and other opportunities
Primary care payment reform & primary care homes	▪ Increases Medicaid reimbursement to primary care docs for primary care services to 100% of Medicare for 2011-13. ▪ Creates a Medicaid medical home demonstration project for patients with chronic conditions starting January 2011; (see last column).	▪ State's choice to apply for medical home pilot project.	▪ Medicaid medical home demonstration is well aligned with planned pilots in Oregon. ▪ Small potential for medical home standards that HHS sets for demo. project to conflict with Oregon standards. *OHPB Incentives & Outcomes Committee to review.*	▪ Medical home standards; specific requirements for planning grants	▪ Federal government will cover 100% of incremental cost for Medicaid primary care reimbursement increase ▪ Medicaid medical home pilot opportunities: o Planning grants available Jan. 2011, $25M total available. o 90% federal financing for first 8 quarters of demonstration. o Secretary shall award grants for community health teams to support medical homes; amount and dates not given.
Other payment reform	▪ Authorizes several payment reform and/or system transformation pilots under Medicaid and Medicare - see last column ▪ Value-based purchasing (VBP) in Medicare: o Value-based incentive payment to hospitals beginning with discharges in October 2012 o Value-based adjustment for physician fee schedule developed by 2012; implemented 2015-17 o Plans for VBP in skilled nursing facilities, home health, and ambulatory surgical centers to be created in 2011 ▪ Hospital-acquired infections: Medicaid will	▪ State's choice to apply for pilot projects.	▪ Potential intersection with OR hospital quality reporting requirements (incl. infections) because hospitals can opt out of reporting to feds if states report instead. *OHPB Incentives & Outcomes Committee to review.*	Much of the strategy for value-based purchasing in Medicare yet to be developed.	▪ Medicaid payment reform pilots: o Global payments for safety-net hospitals – 5 states, 2010-12. o Bundled hospital & physician payments, CMS to develop method for grouping episodes of care – 8 states, 2012-16. o Pediatric Accountable Care Organization demonstration – number of awards not stated, 2012-16. ▪ Medicare payment reform pilots: o Independence at Home demonstration program for high-needs patients (Jan 2012) o Medicare Accountable Care Organization

Policy/program area	What federal reform does	Where there is state flexibility	Interactions with Oregon reforms and programs	Details to be determined	Funding, pilots, and other opportunities
	cease to pay in July 2011; Medicare will reduce payments to hospitals in top quartile of infection rates by 1% beginning 2015 ▪ Medicare hospital payment reductions starting FY2012 based on % of preventable readmissions; future expansions possible ▪ Establishes federal CMS Innovation Center to test new payment reform models (Jan 2011)				pilots beginning Jan 2012, 3-year, 5,000 beneficiary minimum o Bundled payments for acute and post-acute care on 10 conditions, with shared savings; pilots 2013; expand in 2016 if successful o Community Care Transitions Program for Medicare patients at high risk of hospital readmission, Jan. 2011, 5-yr funding, $500M total available o Extension of Deficit Reduction Act hospital quality gainsharing demonstration through Sept. 2011
Quality standards – accountability, measurement, and reporting	▪ HHS to develop national quality improvement strategy ▪ Instructs CMS to create a set of quality standards for adult Medicaid (similar to recently released core measure set for kids under SCHIP reauthorization in 2009) ▪ Adds reporting incentives and penalties under Medicare's Physician Quality Reporting Initiative (PQRI) – see last column. ▪ Instructs CMS to develop quality reporting systems for long-term care, hospice, inpatient rehab, and cancer hospitals by 2014 ▪ Establishes Federal Coordinated Health Care office to improve care for dual eligibles	▪ Little state flexibility here, apart from presumed ability to comment during rules process for measure or strategy development	▪ Will need to ensure that quality metrics adopted by Oregon don't burden providers by diverging strongly from federal requirements. *OHPB Incentives & Outcomes Committee to review.*	▪ Much of the quality strategy and measures yet to be developed.	Physician Quality Reporting Initiative incentives: ▪ 0.5% additional incentive for participation in 2011 and for incorporation of HIT meaningful use standards in 2012 ▪ Penalty for non-participation beginning 2014.
Behavioral health integration	▪ Authorizes two demonstration programs – see last column.	▪ State's choice to apply for	▪ Co-location grant is possible source of	▪ Not applicable.	▪ Co-location of primary and specialty care in community-based mental health program

Policy/program area	What federal reform does	Where there is state flexibility	Interactions with Oregon reforms and programs	Details to be determined	Funding, pilots, and other opportunities
		demonstration projects	support for ongoing behavioral health integration work in Oregon		setting, $50M available for 2010 and sums as necessary for 2011-14 ▪ Medicaid reimbursement for emergency stabilization services (under EMTALA) in private mental health facilities – number of awards not stated, 2010-15
Multi-share models	▪ Law does not address these non-insurance coverage programs directly.	▪ Not applicable.	▪ Unclear how Oregon's newly certified multi-shares would interact with Exchange or federal subsidies targeted at small businesses; need federal clarification.	▪ Not applicable.	▪ Not clear.
Comparative effectiveness research & evidence-based care guidelines	▪ Creates a Patient-Centered Outcomes Research Institute at CMS; sunsets the similar Federal Coordinating Council for Comparative Research created by the stimulus act (ARRA).	▪ Not applicable.	▪ How state comparative effectiveness efforts can complement federal work to be determined. *Health Services Commission, Health Resources Commission to review.*	▪ Law contains further details on Center operation & management.	▪ None noted.
HIT/HIE/ Electronic Health Records	▪ HIT provisions are woven into many of the law's reform initiatives (e.g. quality reporting requirements); analysis is ongoing.	▪ Analysis ongoing.	▪ Analysis ongoing *Health Info. Technology Oversight Council (HITOC) to review.*	▪ Analysis ongoing.	▪ Analysis ongoing.

Federal Health Reform in Oregon: Implications for Transforming Care Delivery

(Based on Oregon Health Policy and Research understanding as of 4-1-2010)

Policy/program area	What federal reform does	Where there is state flexibility	Interactions with Oregon reforms and programs	Details to be determined	Funding, pilots, and other opportunities
Administrative Simplification	▪ Establishes deadlines for HHS to issue new and revised HIPAA standards for electronic transactions to eliminate variation. Compliance deadlines phased in from 1/1/2013 to 1/1/2016) ▪ Requires Medicare providers to accept electronic remittance advice and funds transfer by 1/1/2014	▪ State could require compliance sooner.	▪ Federal standards will address some of the same topics for which HB 2009 requires OHPR to develop minimum standards; will need to consider need for state-level standards if federal ones supersede them. *OHPB Administrative Simplification Workgroup to review.*	▪ HHS rules will not be issued until 7/1/2011 to 7/1/2014.	
Medical Liability reform	▪ Public Health Service provides medical liability coverage extended to professionals practicing at free clinics (effective on enactment). ▪ Creates demonstration grants - see last column.	▪ Not applicable.	▪ Task Force on Medical Liability, which will begin to meet in April, could consider developing a reform approach that would qualify for funding. *OHPB Taskforce on Medical Liability to review.*	▪ None noted.	• Authorizes HHS to award planning grants (1-yr) and demonstration grants (5-yr) to states for voluntary alternatives to tort litigation, FY2011-16, $50M total available
Medicare payments	▪ Analysis is ongoing, but the law affects Medicare payments in several ways, including increased reimbursement to hospitals in Oregon for FY2011-12 and reducing Medicare Advantage payments beginning in 2012.	▪ Analysis ongoing.	▪ Analysis ongoing.	▪ Analysis ongoing.	▪ Analysis ongoing.

Policy/program area	What federal reform does	Where there is state flexibility	Interactions with Oregon reforms and programs	Details to be determined	Funding, pilots, and other opportunities
Healthcare workforce	▪ Authorizes many workforce training and/or retention grants – see addendum at below. ▪ Several investments and regulatory changes in support of primary care workforce: o Increased funding for the National Health Service Corps: $320M in 2010 building to $1.15B in 2015; increases annual max. loan repayment to $50,000 (from $35K) o 10-year cap on primary care practice requirement for physician loan recipients (vs. life of loan) and reduced interest rate for non-compliance (2% down from 18%). o Redistributes unused residency positions to primary care, priority to shortage areas o See also primary care related grants and pilot projects in addendum. ▪ Directs HHS to review its methodology for designating shortage areas, with a final rule due by July 2011 ▪ Creates National Healthcare Workforce Commission and provides funding for state and regional workforce planning and analysis centers (see addendum) ▪ Increases flexibility around training locations and activities that count for Medicare funding for residents (DGME and IME)	▪ State's choice to apply for various funding opportunities.	▪ Many potential sources of support for workforce development priorities identified by the Workforce Committee and others (see addendum) *OHPB Healthcare Workforce Committee to review.*	▪ Eligibility and requirement details for funding opportunities	▪ See list of opportunities listed in addendum.

Addendum – Healthcare Workforce Funding, Pilots, and other Opportunities
Based on OHPR staff understanding as of 3-30-2010

Base funding for healthcare professional training	Award Information	Effective Dates
▪ Potential funding for development, operation, or capacity building of primary care training programs (family medicine, internal medicine, pediatrics, and physician assistant)	5-yr grants from HHS; $125M for 2010 and sums as necessary for 2011-15	FY 2011-14
▪ Potential funding for new or expanded primary care residency programs at teaching health centers	Max $500,000 and 3 years of grant	FY 2011-15
▪ Grants for residency training in preventive medicine or public health	$43M available in FY 2011; sums as necessary for FY 2012-15)	FY 2011-15
▪ Potential funding for training programs and loan repayment in general, pediatric, & public health dentistry	5-yr grants from HHS; $30M for 2010 and sums as necessary for 2011-15	FY 2010-15
▪ Potential funding for mental or behavioral health training programs	$35m total available from HHS	FY 2011-13
▪ Extends nurse education grant program thru 2014	Analysis in progress	
▪ Clarifies which nurse-midwifery programs are eligible for advanced education nursing grants - could impact programs depending on accreditation status	Analysis in progress	Analysis in progress
▪ Expands allowable uses of nursing workforce diversity grants	Analysis in progress	Analysis in progress

Demonstration projects for healthcare professional training	Award Information	Effective Dates
▪ Potential funding for alternative dental health care provider demonstration project	5- year project; 15 grants total	Within 2 years
▪ Demonstration grants for family nurse practitioner training programs at federally-qualified health centers or nurse-managed health centers	Analysis in progress	FY 2011-14
▪ Demonstration grants to help low-income individuals get health profession training	Analysis in progress	FY 2010-14
▪ Demonstration grants to develop certification programs for home health aides	Max 6 states	W/in 18 months
▪ Graduate nurse education demonstration program	Max 5 hospitals to receive award	FY 2012-15
▪ Demonstration grants to help educational institutions train physicians likely to work in underserved rural areas		FY 2010-13

Career development, re-training, and retention	Award Information	Effective Dates
▪ Potential nursing workforce retention grants	Analysis in progress	
▪ Primary Care Extension Program to educate primary care providers in prevention, chronic disease management, etc.	Analysis in progress	FY 2011-14
▪ Program to award scholarships to mid-career PH or allied health professionals employed in public sector	Analysis in progress	FY 2010-15
▪ Grants for geriatric education centers & fellowships, and career incentives for advanced degrees in	Analysis in progress	FY 2011-13

geriatrics		
▪ Potential funding for cultural competency training for healthcare professionals	Analysis in progress	FY 2010-15
▪ Fellowship training in public health (like the Epidemiologic Intelligence Service, or similar) to address documented workforce shortages	Analysis in progress	FY 2010-13
▪ U.S. Public Health Sciences Track to train 800 healthcare professionals per year in "team-based service, public health, epidemiology, and emergency preparedness and response.' Tuition remission and stipend in return for service commitment.	Analysis in progress	Begin FY 2010
▪ States may award grants to providers serving high proportion (as defined by state) of medically underserved or other special populations.	No federal funds provided.	Not given.
▪ Support for training of direct care workers in long-term care settings	Analysis in progress	FY 2011-13

Training Pipeline	Award Information	Effective Dates
▪ Community-based training and education grants for Area Health Education Centers (AHEC)	Analysis in progress	FY 2010-14

Loans & loan repayment	Award Information	Effective Dates
Note: some loan provisions listed in main table above.		
▪ Increased loan maximums & scholarships to encourage diversity in health professions	Analysis in progress	Analysis in progress
▪ Increased maximums for nursing student loans and for nursing faculty loans	Analysis in progress	Analysis in progress
▪ Pediatric specialty loan repayment program	Analysis in progress	Analysis in progress
▪ Public health workforce loan repayment program	Analysis in progress	Analysis in progress
▪ Allied health professional loan forgiveness	Analysis in progress	Analysis in progress
▪ Loan repayment for nurses working as faculty (not just as clinicians in critical shortage areas)	Analysis in progress	Analysis in progress

Workforce development & coordination	Award Information	Effective Dates
▪ Grants to states for healthcare workforce development grants. Note: only state "workforce investment boards" are eligible to apply – Workforce Committee does not meet definition.	$150K planning grants requiring 15% match; implementation grants requiring 25% match	Begin FY 2010
▪ Grants and/or contracts for national, state, and regional centers for workforce analysis	$4.5M available nationally	FY2010-14

Federal Health Reform in Oregon: Implications for Improving Population Health

(Based on Office of Health Policy & Research understanding as of 4-10-2010)

Policy/Program Area	What Federal Reform Does	Interactions with Oregon reforms and programs*	Funding, pilots, and other opportunities
Investments in national public health systems	• Establishes with HHS, the National Prevention, Health Promotion and Public Health Council under the Surgeon General – develop national health improvement strategy within 1 year. • Establishes a Prevention and Public Health Fund. • Expands and increases coordination of taskforces for clinical and community preventive services. Preventive Services Taskforce (PSTF) provides recommendations to programs/policymakers. Effective immediately. • Creates national prevention and health promotion media and education campaign.	• Fund has potential to strengthen existing state public health programs. • Taskforce has both Medicaid and Medicare implications. • Campaign supersedes existing CDC funding for similar activities. Could result in reduced funding to states through CDC channels.	• Appropriates $7 billion for 2010-2015 and after for Prevention and Public Health Fund, which can be used to fund mandatory prevention, wellness and public health activities authorized by the Public Health Service Act as well as new grants and programs created by the law (e.g. Community Transformation grants).
Investments in community-based prevention and wellness	• Authorizes various grants and pilot programs (see last column). • Maternal and child health home visiting – needs assessment required within 6 months; optional grant program (see last column). • CMS to assess community prevention and wellness programs and make recommendations to Medicare.	• Coordinate with state Healthy Living programs.	• Community Transformation Grants through CDC to promote healthy living and reduce health disparities. Open to state and local governments, national CBO networks, tribes. • Healthy Aging Living Well 5-year pilot through CDC for community-level prevention to pre-Medicare population (55 – 64). $50 million available to state and local health depts., tribes. • Grants for maternal & child health home visiting programs FY 2010-14. States, tribes or (if state does not apply) non-profit entities eligible.
Access to clinical and preventive services for vulnerable populations	• Increased appropriations for Community Health Centers and establishment of a Community Health Center Fund. • Multiple grants or pilot opportunities for services to uninsured, services at community health centers, school-based health	• Need to determine what form the structure of the "Community Health Center Fund" will take in ongoing appropriations for health centers. • Need to determine whether funding is exclusively for the establishment of new school-based health	• Community Health Center (CHC) Fund allocates $9.5 billion for CHC expansion and $1.5 billion to improve existing facilities and constructing new sites between 2011 and 2015. • HRSA 3-year demonstration grants to provide

* Oregon Health Authority will provide support for analysis of these issues in coordination with advisory bodies including but not limited to the Governor's Wellness Taskforce and the Oregon Health Policy Board's Statewide Health Improvement Plan Committee and Public Employers' Health Purchasing Committee.

Policy/Program Area	What Federal Reform Does	Interactions with Oregon reforms and programs*	Funding, pilots, and other opportunities
	centers (SBHCs), oral health, etc. (see last column). • Oral healthcare: national prevention campaign, grants, infrastructure cooperative agreements and research in national surveys. • Preventive services and adult vaccines covered under Medicare and at state option under Medicaid can be modified to align with recommendations of national expert panels (USPSTF and ACIP). • Medicare coverage for initial assessment & prevention plan then annual wellness visits, with no cost-sharing • Medicare will cover 100% of costs (no coinsurance) for evidence-based preventive services. • Establish standards for making diagnostic equipment accessible to individuals with disabilities. Effective within 2 years of enactment.	centers (SBHCs). Establishes a federal definition for a comprehensive SBHC. • Potential coordination with community health collaborations/coalitions. • Potential support for Oregon Oral Health program. • OHP prioritized list currently follows national expert panel (USPSTF and ACIP) recommendations, as does the Health Services Commission's recent work on value-based benefit design. 2.2% additional federal financing available under Medicaid if recommended preventive services are covered without cost sharing. • May need rule change to implement federal standards related to diagnostic equipment.	access to comprehensive health care services to the uninsured at reduced fees. Up to 10 states, total funds up to $20 million. Requires state-based public private partnership. • Appropriates $50M/year for 2010-2013 for grants to open and operate school-based health centers; may not supplant existing state dollars. • Oral health: caries prevention demonstration grants to community-based providers of dental services including but not limited to state and local public health depts.; school-based sealant Programs. • Establishes a 5-year pilot program for provision of evidence-based prevention and management programs with Medicaid patients. Unspecified funding. • HHS to establish pilots in 10 CHCs to develop individualized wellness plans with patients.
Population health provisions	• Authorization for states to purchase adult vaccines through CDC contract (317 program); Government Accountability Office study of access to vaccines under Medicare; demonstration grant (see last column). • Requires nutrition labeling of standard menu items at chain restaurants (20+ locations) and vending machines. Proposed federal rules within 120 days of enactment. • Appropriates funds for childhood obesity prevention demonstration project originally described in SCHIP reauthorization in 2009.	• The state currently does not have funds to purchase adult vaccines. • Oregon passed a similar menu labeling law in 2009. The burden of enforcement would shift from the state to the federal government. • Potential to build state programs and infrastructure around childhood obesity. The state currently has no funding dedicated to obesity prevention. • Current Oregon law is more protective for nursing	• Demonstration grants to improve vaccine coverage • Appropriates $25 million for fiscal years 2010-2014 to carry out childhood obesity programs • Formula funds to all states for adolescent education on pregnancy prevention (min. $250K per state) and for abstinence-only funds ($50M available nationally) for FY 2010-14. Application required; no match requirement evident.

Policy/Program Area	What Federal Reform Does	Interactions with Oregon reforms and programs*	Funding, pilots, and other opportunities
	• Reasonable break time for nursing mothers. • Formula grants to states for programs to educate adolescents on pregnancy prevention and the prevention of sexually transmitted infections; also restoration of abstinence-only education funding. • Several new or re-authorized programs with related funding opportunities at state or local level (see also last column): o Centers of Excellence for Depression (aka ENHANCED Act). o Congenital Heart Disease Surveillance System & Research Program o National Diabetes Prevention Program o Public access defibrillator grant program o Young Women's Breast Health (EARLY Act) - education, prevention research, & patient support • Pain management conference, NIH research, & grants for pain care education/training. • Secretary to evaluate and report on federal health and wellness initiatives	mothers. The bill would not preempt. • Federal abstinence-only education funding is not in alignment with HB 2509 (passed 2009 session) that outlines sexuality education requirements or with the Oregon Youth Sexual Health Plan.	• Other program funding opportunities: o 20 Centers of Excellence for Depression to be established within 1 year of enactment; 30 by Sept. 2016. Institute of higher education or public or private nonprofit research institution may apply; requires 20% local match. o Cardiovascular disease surveillance and community-level diabetes prevention funding available FY 2010-14 o States, state subdivisions or tribes may apply for defibrillator funding through FY 2014. o EARLY Act grants available FY 2010-12, eligibility requirements not stated.
Support for public health infrastructure and research	• Infrastructure funding for epidemiology and Laboratory capacity (see last column). • Health disparities data collection & analysis in federally conducted or supported programs. Within 2 years of enactment. • CDC technical assistance to worksite wellness programs and periodic evaluation survey. Survey within 2 years of enactment.	• Possible need for rule changes to require new health disparities data collection or reporting under Medicaid, CHIP, etc. • Results of worksite wellness evaluation may not be used to mandate requirements for worksite wellness programs.	• Epi and Lab grants allocated to state and local health departments and tribal jurisdictions. Allocates $190 million per FY 2010-2013. • Potential grant funding for public health systems and services research through HHS, details not provided.

POLST Registry Data Update
Data from 5/15/09 through 02/28/10
Data as of 03/04/10

Terms in this report	Definition
Registry Forms or Registry Registrants:	Forms or registrants recorded in the Registry only, not all those received by the Registry office.
Not Registry Ready (NRR):	Forms received that are missing information to make them eligible for the Registry.
Not Registry Ready (NRR) - REQUIRED ELEMENTS ONLY:	Forms received that are missing any one or more of the REQUIRED data elements: First or Last Name, DOB, Signature, Date signed, Section A orders
Not Registry Ready (NRR) - Registry Unusable Only:	Forms received that are unable to be entered into the Registry but are still valid POLST orders. Includes copies that are illegible, copies that are too dark or too light, etc.
Total Forms:	Forms from both the Registry and those that are Not Registry Ready for any reason. Does not include duplicate form submissions.
Active Forms:	Forms in the Registry that are ready to be searched.
Archived Forms:	Forms in the Registry that are no longer valid. These have been removed from searches.
Pending Forms:	Valid forms in the Registry that are actively being entered, or those belonging to a Registrant who has submitted a new, not yet entered form.
Active Registrants:	Registrants with searchable, active forms who have not opted out.
Archived Registrants:	Registrants known to be deceased or those who have opted out of the Registry. Forms from these registrants are not searchable.

POLST Registry Data Update
Data from 5/15/09 through 02/28/10
Data as of 03/04/10

Registry Data Overall (5/15/09-02/28/10)	Count	Percentage
Total Forms Received (5/15/09-02/28/10): Includes Registry forms and NRR Forms but excludes duplicate form submissions	**12137**	
Forms in the Registry (5/15/09/09-02/28/10)	**10563**	% of all Registry forms
Active	9595	90.8%
Archived	964	9.1%
Pending	4	0.0%
	Count	% of all received forms
Not Registry Ready (NRR) Forms	**1513**	**12.5%**
Not Registry Ready (NRR) Forms - Required Elements ONLY	1050	69.4% of NRR forms 8.7% of all forms received
Not Registry Ready (NRR) Forms - Registry unusable only (illegible, too dark/light, etc)	463	30.6% of NRR forms 3.8% of all forms received
Registry Registrants	**10056**	% of all registrants
Male	3324	33.1%
Female	5434	54.0%
Not Indicated	1298	12.9%
Registry Registrants by Status	**10056**	% of all registrants
Active	9754	97.0%
Archived	302	3.0%
Time to Form Entry from Date of Receipt (Required in 10 days or less)*		
Mean	3.3 days	
Median	2.7 days	
Number of times required timeline not met	0	

*Forms received from 12/3/09-2/28/2010

POLST Registry Data Update
Call Log Data from 12/3/09 through 02/28/10
Data as of 03/04/10

Call Data by Month	Calls*	Succesful Matches	% with match
12/3/09-12/31/09	28	3	10.7%
1/1/10-1/31/10	29	4	13.8%
2/1/10-2/28/10	28	4	14.3%
OVERALL	**85**	**11****	**12.9%**

*Includes only calls that were not canceled

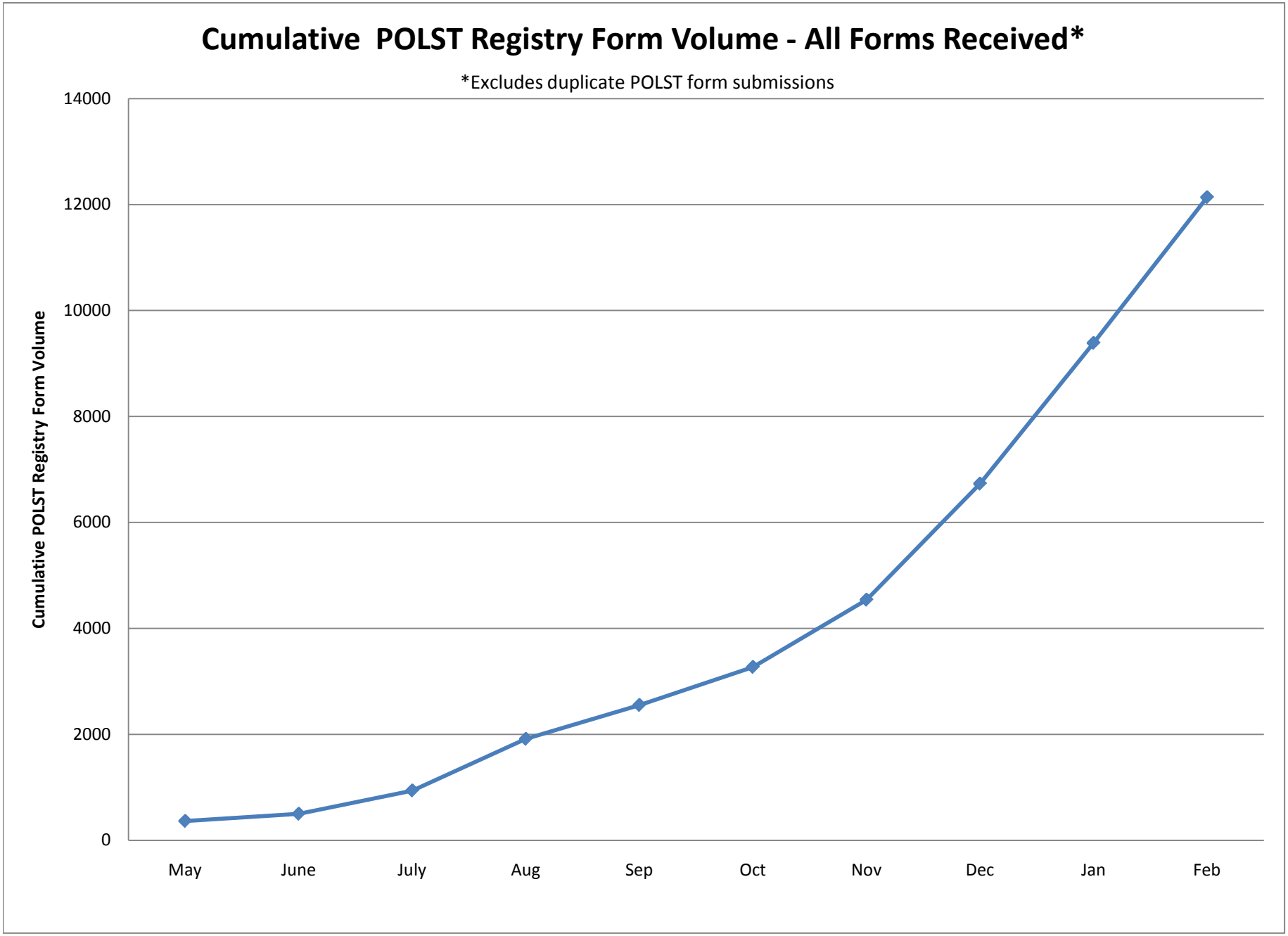
**For the 11 matches, 5 were calls from EMS (from the scene), 5 were from Emergency Departments (2 patients with terminal illness, 3 with respiratory arrests), and 1 was from an acute care unit.

Reasons registrant wasn't matched	Calls*	%
No match to SSN last 4	2	2.7%
Too few identifiers available	2	2.7%
Participant found, NO current POLST available	2	2.7%
No match to DOB	4	5.4%
No match to name	48	64.9%
Other or Not recorded	16	21.6%
OVERALL	**74**	100.0%

*Includes only calls that were not canceled where no registrant was found

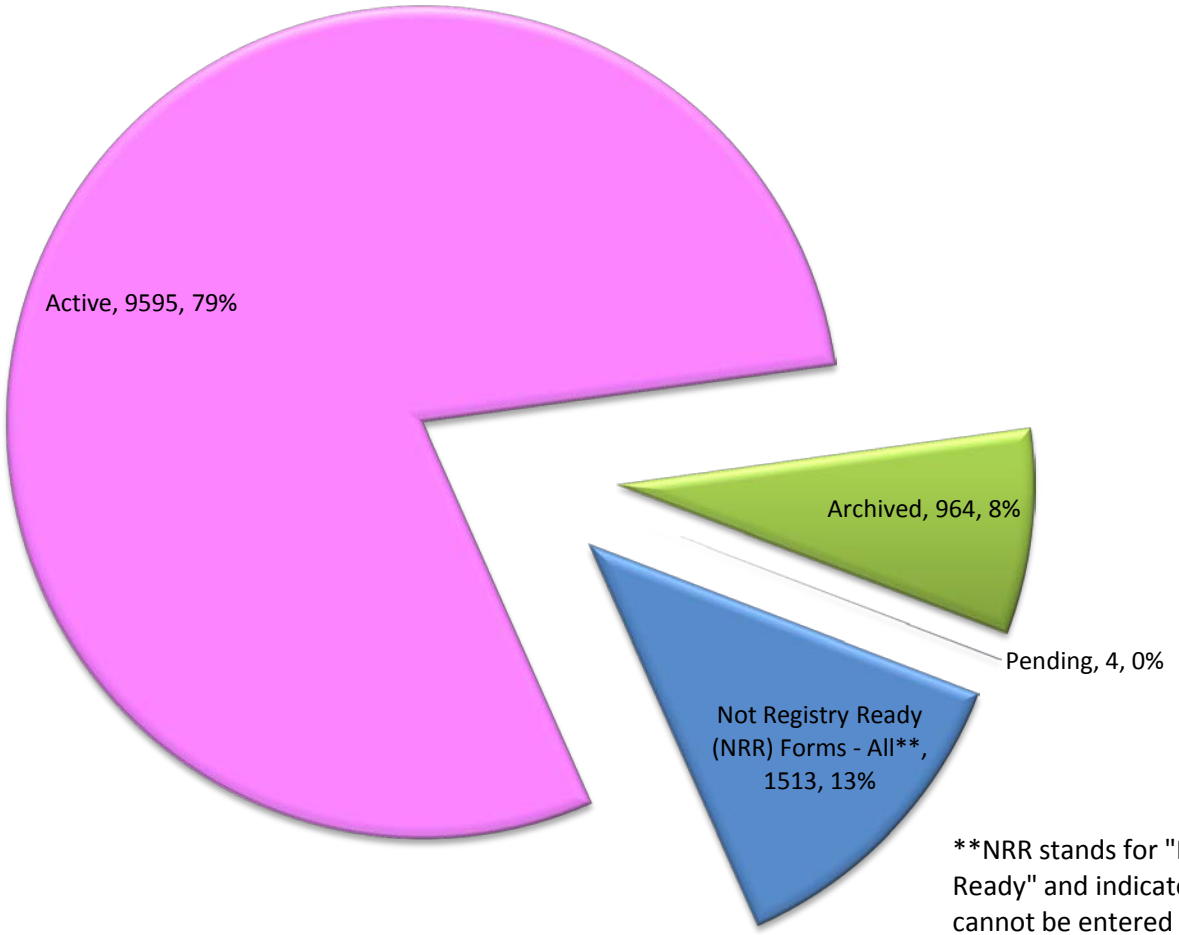
Length of call*	Mean	Median	Range
OVERALL	80.8 seconds** (1.35 minutes)	60.6 seconds (1.01 minutes)	460 seconds (7.67 minutes)

*Includes only calls that were not canceled


Cumulative POLST Registry Form Volume - All Forms Received*
*Excludes duplicate POLST form submissions
Cumulative POLST Registry Form Volume
14000
12000
10000
8000
6000
4000
2000
0
May
June
July
Aug
Sep
Oct
Nov
Dec
Jan
Feb

Received Forms, Overall*
N=12137 from 5/15/09-2/28/10
(Data as of 3/4/2010)

*Excludes duplicate POLST form submissions



**NRR stands for "Not Registry Ready" and indicates forms which cannot be entered into the Registry as received (e.g., the date signed is missing or the form is illegible).