

Oregon Health Policy Board

AGENDA

August 10, 2010

Market Square Building

1515 SW 5th Avenue, 9th floor

8:30 am to Noon

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

#	Time	Item	Presenter	Action Item
1	8:30	Welcome, call to order and roll Announcement of September Community Forums Action item: Consent agenda: 7/13/10 minutes Comprehensive plan status HITOC Strategic Plan Executive Summary	Chair	X
2	8:35	Director's Report	Bruce Goldberg	
3	9:00	Action item: Administrative Simplification recommendations <i>Public comment on Administrative Simplification recommendations</i>	Tina Edlund <i>The Board will accept public comment immediately after review of the recommendations.</i>	X
4	9:30	Building Oregon's Health Insurance Exchange: DRAFT Recommendations	Barney Speight, Nora Leibowitz	
5	10:20	<i>Public Comment on Health Insurance Exchange DRAFT Recommendations</i>	<i>The Board will accept public comment on the DRAFT Health Ins. Exchange recommendations.</i>	
	10:30	Break		
6	10:45	A Public Option within Oregon's Health Insurance Exchange: Laying out the strategic decisions	Bill Kramer	
7	11:30	<i>Public Comment on a Public Option</i>	<i>The Board will accept public comment on a public option</i>	
8	11:40	Next steps for Public Input on Health Insurance Exchange, Public Option and the Comprehensive Plan	Jeremy Vandehey	
9	Noon	Adjourn	Chair	

Next meeting:

October 12th, 2010

All day meeting: 8:30 am to 5 pm

TBD

Oregon Health Policy Board
DRAFT Minutes
July 13, 2010
Market Square Building
1515 SW 5th Avenue, 9th floor
8:30am – 12:00pm

Item

Welcome and call to order

Chair Eric Parsons called the Oregon Health Policy Board (OHPB) meeting to order. All Board members were present, with the exception of Vice-Chair Lillian Shirley and Felisa Hagins. Oregon Health Authority (OHA) staff members present were Bruce Goldberg and Tina Edlund.

Consent agenda –

Minutes from June 8, 2010 meeting

The June 8, 2010 minutes were reviewed. No changes were noted. Minutes were approved by unanimous voice vote. Final minutes will be posted on the web.

Health Resources and Services Administration (HRSA) Grant Opportunity

There is a significant grant program opportunity for a state health care workforce development grant. The grant will provide \$150,000 the first year, and then up to \$1.5 million for the next two years, with the possibility of a third year of funding. This type of grant is usually run through the state workforce investment board, but the Oregon Workforce Investment Board (OWIB) does not have the authority needed to apply for this grant. The Office of Oregon Health Policy and Research (OHPR) has worked with OWIB to come up with a way to apply for this grant through the Health Care Workforce Committee. The grant requires that three new members be added to the Committee: one from the state secondary education system, one from recognized federation of labor (AFL-CIO), and one from another labor organization. Board unanimously approved expanding the Workforce Committee membership by these three types of members.

Nominee for Payment Reform Subcommittee

Dick Stenson was nominated and unanimously approved for the Payment Reform Subcommittee of the Health Incentives and Outcomes Committee.

Director's Report – Bruce Goldberg, MD

- Dr. Goldberg took a moment to offer congratulations and to recognize Oregon Health Sciences University (OHSU) and Board Member Joe Robertson, informing us that OHSU is rated in the top ten percent of medical schools in the US for social missions, and is the highest ranking school in the West. Dr. Robertson informed us that OHSU is one of only two medical schools in the US that is in the top twenty schools for both research and social mission.
- The biggest challenge over the last month has been the budget issues. DHS/OHA has been implementing an almost 10% budget reduction, which has resulted in workforce reductions, a decrease of services, and has lowered morale. As we look to future funding, we must be aware that there will most likely be several years, if not a decade, of slow economic growth, and we must act accordingly.
- Other matters the state is working on surround federal health care reform.
 - ❖ The federal high risk pool contract has just been signed. The state will take control on August 1.
 - ❖ Two grants for retirees insurance have been submitted.
 - ❖ The next big focus is the insurance exchange.
- The work of splitting DHS into DHS and OHA continues.
- Enrollment in Healthy Kids has continued to increase, which has drawn criticism because of the decreases in other services that has occurred. Healthy Kids is funded by by a one percent insurance provider tax and hospital tax, which are federally matched, and those federal funds

make up 70% of total funding.

- Current enrollment is 48,000 children, with a total enrollment goal of 80,000 children by January 1, 2011. Enrollment currently is slightly above projections. The last 25% of enrollees will most likely be a challenge, and we are looking at different strategies we can employ to succeed in getting the last quarter of children enrolled.
- Kids Connect has been under-enrolled, due to two issues.
 - ❖ The first issue is enrollment. We have processes in place that focus more on qualifying federal standards than ease of enrollment.
 - ❖ The second issue is eligibility. Focus groups indicate that families are having more difficulty with eligibility and concerns about the stability of the program more than affordability.
 - ❖ The Board asked for monthly enrollment projections for Healthy Kids Connect. The Board asked for monthly enrollment projections for Healthy Kids Connect.

↪ The Board asked for monthly enrollment projections for Healthy Kids Connect.

Update on Administrative Simplification Recommendations – Tina Edlund

- Originally, the intent was to bring administrative simplification forward for decision at this meeting, but the Board had requested more discussion and input from small group practices.
- There is a group of small practice providers who have volunteered to provide information over the next month about issues in small practices versus large practices, and that information will be presented at the next Board meeting.

Draft Health Improvement Plan (HIP) Recommendations – Tammy Bran and Lila Wickham

- Tina asked the Board to remember that the charter for the HIP Committee was very aggressive and that their work is seen as a central piece of the work the Board is doing.
- The primary goal is to improve the health of Oregonians by promoting and supporting lifestyle choices that prevent and manage chronic diseases. The action plan is to improve population health through tobacco education, prevention of obesity, and prevention and management of chronic diseases.
- Listening sessions and committee meetings were held all over the state. The committee really wanted the participants in the listening sessions to focus on health improvement, not just health care.
- Goal 1 – health equity and population health are achieved by improving social and economic factors
 - ❖ Health equity means having a safe, walkable community, access to fresh fruits and vegetables in a local store, access to environmentally safe cleaning materials, and not having a community bifurcated by an interstate.
 - ❖ Recommendation 1 – Request a Governor’s Executive Order to create a Coordinating Council on Health Equity that will include state agencies, private business, health care providers, tribes, county public health departments and community advocacy organizations. The purpose of the Council is to promote and monitor health equity in all statewide policies through funding and administrative and legislative actions.
 - ❖ Recommendation 2 – Request legislation requiring Health Impact Assessments for all publicly funded building and transportation projects, including plans to remediate identified health impacts.
- Goal 2 – Oregon public and private entities significantly invest in prevention and public health.
 - ❖ Recommendation 1 – To achieve population health improvement goals, increase funding for public health and raise Oregon from the 41st state in the nation for investment in public health to at least the national average.
 - ❖ Recommendation 2 - To achieve population health improvement goals and build public health capacity, all counties and state public health divisions seek accreditation through the Public Health Accreditation Board by 2015.
 - ❖ Recommendation 3 – Link revenues to related chronic disease prevention and wellness strategies.
 - ❖ Recommendation 4 – Request Governor’s Executive Order requiring state agencies to implement and monitor wellness policies designed to increase fruit and vegetable

- consumption, physical activity and chronic disease management, support breast feeding, and reduce tobacco use and sugar sweetened beverage consumption.
- Goal 3 – make chronic disease prevention and health improvement a local priority throughout the state and actively supported by communities
 - ❖ Recommendation 1 - On a regional or local level, health departments convene (or delegate) key stakeholders to create and implement the HIP that address identified needs based upon comprehensive community assessments. Key stakeholders include but are not limited to: tribes, hospitals, health care providers, businesses, social service agencies, educators, institutions of higher learning, community based organizations, land use, housing and transportation.
 - ❖ Recommendation 2 – In concert with county and tribal governments where feasible, create regional “health collaboratives” that track and are responsible for local policy, health improvement planning, priority setting, system development, financial investment and health outcomes.
 - ❖ Recommendation 3 – Prioritize resource provision to communities with a HIP that identifies effective strategies to improve health equity.
 - Goal 4 – reduce obesity through physical activity and nutrition
 - Goal 5 – reduce tobacco use and exposure
 - Goal 6 – support people in managing chronic diseases
 - The committee hopes to influence Oregonians to think about health as behavior, not health care
 - Further work will focus on organizing the recommendations, strategies and tactics that HIP Committee members support and the development of the action plan once the Board approves the primary goals and recommendations.
 - As we move forward, we have to be integrated, assess what we do before we do it, and come up with a coherent, evidence based emerging plan.
 - Dr. Goldberg commented that we need to become very action-oriented and strategic. The Board and HIP Committee need to be on the same page.
 - The Board would like to see population health as the top of the Triple Aim pyramid. The Board would also like to see a Triple Aim scorecard to use as a guide as the action items are created. Finally, framing the one to three year plan is important, but we also need to look at the 10-20 year plan.
 - The Board commented that as the action items go forward, changing health behaviors and working with environmental factors can be an effective use of resources. They suggest incentivizing people to change unhealthy behaviors.
 - ↪ The Board would like to see the actual health rankings of the counties.

Public Comment

Representative Tina Kotek sent a staff member to read her testimony. She would like to see more targeted goals with achievable recommendations. The charge of the committee was to identify evidence-based interventions to promote population health and to recommend strategies to interconnect these interventions with the health care delivery system. She also asked that the committee focus on how their work can make Oregonians healthier over the next five years.

Break

Update on Comprehensive Plan – Gretchen Morley, OHPR

- Tina Edlund informed the Board that this is a project that is being continually worked on. The focus is to make it a real action plan that moves us toward our goals.
- The comprehensive plan is known as the Blueprint. It has three major component areas, which are healthy people in healthy communities, transformation of health care delivery, and ensuring that all Oregonians have equitable access to health care.

The Board requested a scorecard or dashboard that will show how actions will achieve the Triple Aim.

Essential Benefit Package (EBP) – Jeanene Smith, OHPR

- Value-Based Benefit Design supports Oregon’s Triple Aim for health:
 - ❖ Improves lifelong health of all Oregonians – incents better chronic disease management
 - ❖ Increases quality, reliability and availability of healthcare services

- Reduces barriers to care needed to manage disease
 - Aims to get the right care at the right time and right place
 - Partner with payment reform to use effective care
- ❖ Lowers or contains cost of care so it is affordable – lowers more expensive, emergency or delayed care costs.
- Essential Benefit Package
 - ❖ No cost share for
 - Value-based services
 - Basic diagnostic services
 - Comfort care
 - ❖ Tiered coinsurance/co-pays for other services
 - Four tiers based on evidence methodology of Prioritized List
 - Lower cost sharing for primary care outpatient services
 - ❖ Use of an evidence-based drug formulary is also suggested
- 20 Sets of Value-Based Services in the Essential Benefit Package
 - ❖ Value-based services are medications, tests, or treatments that are highly effective, low-cost, and have evidence supporting their use
 - ❖ Most of these services should be provided via outpatient care – ideally in a patient-centered primary care home
 - ❖ These services should be offered at no cost to patients (no copays or coinsurance) in order to encourage use of these services given their high level of benefit
 - ❖ Goal is to have these services used as much as possible
- Remove Barriers to Care
 - ❖ EBP's tiered benefits for other services: cost sharing applied based on best evidence
 - ❖ EBP's other components
 - Excluded conditions – non-emergent services that would have no coverage, similar to many commercial plans presently, such as cosmetic surgery, infertility services, experimental treatments
 - Discretionary services – non-emergent services that might have a separate benefit limit, such as restorative dental services, glasses and other vision care supplies
- EBP
 - ❖ Furthers Oregon's Triple Aim by incenting the most effective services
 - ❖ Could be considered by health care purchasers now
 - ❖ Preliminary review shows that the EBP's cost sharing could be adjusted to fit federal reform limits and still provide incentives to use the most effective care
 - ❖ Further details on the federal minimum benefit to be eligible for subsidies in the Exchange are yet to be determined, but appears the EBP could certainly be a product in the Exchange

↪ The Board requested that at the next meeting, someone come from the Health Leadership Council to give an overview of their projections of the cost savings the EPB could provide.

Public Comment

Chris Apgar commented that there was not a lot about preventive care for mental health issues and asked that the Board take into account not just what procedures cost at this moment, but what total treatment costs in the long run.

Public Testimony

Jennifer Valley provided information on the I-28 Initiative and informed the Board that data needs to be collected for medical marijuana users and that those users need safe access to their medicine.

Peter Ball, President of the Professional Insurance Agents of Oregon/Idaho spoke on behalf of insurance agents and asked that the exchange be structured in a way that allows them to continue to be a valuable resource to Oregonians choosing health insurance.

Nathan Fisher provided information on hemp oil and its many uses and benefits.

Elizabeth Wazzara, speaking on behalf of the Oregon Chiropractic Organization, read a letter from Dr.

David Duemling, who was concerned that alternative forms of medicine, such as chiropractic, will not be adequately covered under the Essential Benefits Package.

Dr. Don Ferrent, President of the Chiropractic Association of Oregon, voiced the same concerns as Dr. Duemling.

Chris Apgar – Chair of OR and SW WA Healthcare Privacy and Security Forum, was concerned about adopting the Minnesota standards for the administrative simplification plan when an Oregon document already exists. The document was created by a group that included DHS, ODS, Providence and others as a companion document for the initial set of HIPAA transactions and has been available on the internet since 2003 but was not implemented because there was no mandate. Mr. Apgar asked the Board to take another look at the Oregon document and to seriously consider using it in addition to the Minnesota standards.

Adjourn 4:43 p.m.

Next meeting:

August 10, 2010

8:30am – 12:00pm

Market Square Building

1515 SW 5th Avenue (Between Market and Clay), 9th floor

A Message from HITOC

Health Information Exchange: Strategic and Operational Plans for Oregon

August 5, 2010

To our fellow Oregonians,

We have heard from many of you as we traveled across the state to attend community meetings gathering input on the draft strategic plan on health information exchange (HIE). We also received many written comments from both individuals and organizations. As we have reviewed all of the input, we realized that the structure of the plans doesn't succinctly convey the underlying philosophy behind the work that we are embarking on around health information exchange in Oregon. Our goal is to facilitate the development of a system of HIE across Oregon with the consumer at the hub that ensures the privacy of each individual's personal health information, and allows for information, when and where it is needed, to improve health and health care.

The strategic and operational plans before you are documents developed for submission to the Office of the National Coordinator for Health Information Technology (ONC) and are structured to meet the criteria as set out in ONC's HIE Cooperative Agreement. Those requirements, coupled with the decision to use a phased approach and make many key policy decisions over the next 12 to 18 months, means that many sections of the strategic plan are laying out a general framework for action. Our commitment to you is that the framework's details will be determined only after many hours of research, discussion and deliberation in new workgroups for Technology, Legal and Policy, and Finance to be formed in the coming months. There will also be discussions in our soon-to-be-formed HIO Executive and Consumer advisory panels, continuing HITOC meetings and ongoing stakeholder engagement in a variety of formats. We will continue to operate through an open, transparent process as we move beyond the development of the strategic and operational plans to the development of policy and technology acquisitions.

The Consumer Advisory Panel will ensure that our conversations about health information exchange in Oregon have a strong patient-centric view. Our vision is to have *"Information, when and where it is needed, to improve health and health care,"* and for consumers to have control over their information through an opt-out consent model. We understand that there is much work to be done to ensure that all consumers in Oregon have the education and opportunity to make informed choices.

During Phase 1, we will be working on broad-based outreach and education strategies with both providers and consumers. The Consumer Advisory Panel will play a key role in helping us determine the best ways to engage consumers. Outreach is a long-term effort that requires a wide-ranging strategy. It must start early and reach both consumers and health care providers, because most conversations about the benefits and risks of health information exchange will occur between providers and their patients. Consumer education must also address how personal health records factor into overall health management and the best ways to use those records in a secure environment to empower consumers and

improve their health while maintaining the privacy of the information.

Also, under the auspices of the Oregon Health Authority, any policies that HITOC recommends will take into account that health, economic and social welfare policies in the United States and Oregon have, historically, intentionally or inadvertently disadvantaged communities of color and other under-represented communities. These inequities, well documented by race and ethnicity, are avoidable and unjust. In 2010, the Oregon Health Authority and the Oregon Health Policy Board acknowledged health equity as a fundamental value. As such, all Oregon Health Policy Board members, committee members (including HITOC) and Oregon Health Authority staff will strive to avoid creating or maintaining health policies that perpetuate or increase avoidable and unjust health inequities. All members and staff acting on behalf of the Oregon Health Policy Board or the Oregon Health Authority will make every effort to proactively evaluate all recommended policy improvements throughout the policy making process to assure they fully promote and resource health equity and the elimination of related inequities.

While broad-scale efforts will be undertaken, health information exchange will also require clear privacy provisions, support for increased health literacy, administrative simplification, specific and dedicated data management tools and greater coordination of care focused on vulnerable and underserved populations.

Although the majority of the attached plans focus on technology infrastructure, policy frameworks, governance models, business plans and financial modeling, the foundation of those elements is a patient-centric model maintaining the privacy of personal health information as the information is exchanged to be available when and where the patient needs it to receive quality care.

We look forward to working with you as we move into Phase 1 and launch the work of implementing health information exchange across Oregon.

Oregon Health Information Technology Oversight Council

Steve Gordon, MD, Chair
Vice President and Chief Quality Officer, PeaceHealth

Rick Howard
Chief Information Officer, Oregon Department of Human Services

Robert E. Brown
Consumer Advocate

Brian DeVore
Director of State Health Policy, Intel

Gregory Fraser, MD, MBI
Medical Director of Information Systems and Informatics, Mid-Valley Independent Physicians Association

Bridget Haggerty

Vice President and Chief Information Officer, Oregon Health and Science University

William H. Hockett

Director, Web Strategy, ODS Companies

Marie A. Laper

Behavioral Health Clinical Coordinator, OCHIN, Inc.

Robert F. Rizk

Director, Information Technology, Good Shepherd Health Care System

Sharon Stanphill

Health and Wellness Director, Cow Creek Health and Wellness Center
Cow Creek Band of Umpqua Tribe of Indians

Dave Widen

Adjunct Professor, Pacific University

**Health Information Exchange:
A Strategic Plan for Oregon**

Draft

August 5, 2010

**For approval by the
Oregon Health Authority
and
Health Information Technology Oversight Council**

Executive Summary

HEALTH INFORMATION EXCHANGE AND THE HEALTH OF OREGONIANS

Health information exchange (HIE) is a key building block for system improvements to enhance population health and to improve the health care delivery system. The inconsistent and fragmented nature of patient records is a highly visible example of the problems caused by the U.S. health care system's reliance on multiple, disparate players in a complex health system. Sharing patient information in a secure, efficient manner has the potential to substantially reduce costs, waste and consumer heartache. It will support efforts to track patients' medical outcomes, reduce errors and make medical processes more efficient. It can empower consumers to better understand their own health, choose high-quality providers and make healthier choices. And information sharing can vastly improve public health agencies' ability to track disease and combat chronic illness leading to improved population health.

The transformation of the health system, with health information technology (HIT) at its core, is already underway. The HIE effort will involve broad engagement from the public and private sector, providers, health plans and consumers. And once designed, Oregon's health information exchange approach will require flexibility and ongoing refinement. Oregon's history of strong civic engagement throughout the state will serve this process well.

OREGON HEALTH REFORM, HEALTH INFORMATION TECHNOLOGY AND HEALTH INFORMATION EXCHANGE

Oregon has long been in the forefront of innovation in health care delivery, access and technology, dating back to its groundbreaking Medicaid waiver design with the Oregon Health Plan in 1987 and continuing to 2009, when the state Legislature approved an ambitious health reform law (House Bill 2009). Oregon's new law anticipated many of the innovations contained in the federal recovery law (American Reinvestment and Recovery Act) that same year and in national health reform (Patient Protection and Affordable Care Act) a year later. The central role of health information technology in improving access, quality and value in the health care system has been a thread running through Oregon's health reform, with one tangible result being the creation of the Health Information Technology Oversight Council (HITOC) to guide these efforts within Oregon.

One of HITOC's early focuses has been the creation of a strategic and operational plan for HIE within Oregon. This opportunity came about after Congress made the acceleration of health information technology an urgent priority in early 2009; it included the HITECH Act as part of its economic recovery legislation. Ultimately this resulted in federal grant funding for the nation's states and territories to lead the planning of health information exchange, and the creation of this strategic plan.

The work of organizing electronic health information exchange in Oregon is advanced by the health system planning processes that have already taken place and in particular by the strong participation by average Oregonians along with health industry stakeholders throughout the state. This plan builds on those efforts over the past several years, along with existing health information infrastructure in both the private sector and within government.

Oregon's leadership has established three main goals for health care system improvement:

- Improve the lifelong health of all Oregonians;

- Increase the quality, reliability and availability of care for all Oregonians; and
- Lower or contain the cost of care so it is affordable to everyone.

Oregon’s approach to statewide health information exchange will include nurturing a new and growing marketplace of local and regional health information organizations (HIOs), setting and monitoring standards to ensure the security of personal health information, developing an accreditation program to ensure health information exchange with a common set of rules, providing valued centralized services and filling the gaps in availability to rural providers and other identified stakeholders. Oregon is using a phased approach to HIE to allow flexibility to adjust over time to new federal rules, marketplace evolution and real-world lessons learned. It will designate a non-profit, public-private state designated entity (SDE) to carry out this work after a sustainable financing plan has been developed and appropriate legislation has been passed.

VISION

The core of this work centers around the Oregon Health Authority’s vision of healthy Oregonians and the three key goals: improved patient experience, improved population health, affordable health care.

Oregon Health Authority Vision and Mission:

Healthy Oregonians

Helping people and communities achieve optimum physical, mental and social well being through partnerships, prevention and access to quality, affordable health care.

HIE Mission:

Information, when and where it is needed, to improve health and health care.

Given the complexity of this effort—which includes a rapidly changing regulatory, economic, political and technical environment—the stakeholders, planning team and HITOC have developed a strategy that includes the following key elements:

- A phased approach to allow for flexibility and to ensure a stable finance plan
- Oregon Health Authority in a role of facilitation, coordination, communication and oversight
- Adherence to federal standards and certifications as they evolve and the development of Oregon-specific standards, accreditation processes and accountabilities
- Collaboration and support of HIE efforts underway through local and regional health information organizations

OVERARCHING IMPERATIVES

- Establish a governance structure that achieves broad-based stakeholder collaboration with transparency, buy-in and trust.
- Set goals, objectives and success measures for the exchange of health information that reflect consensus among the health care stakeholder groups and that accomplish statewide coverage of all providers for HIE requirements related to meaningful use criteria.
- Ensure the coordination, integration, and alignment of efforts with Medicaid and public health programs.
- Establish mechanisms to provide oversight and accountability of HIE to protect the public interest.

- Account for the flexibility needed to align with emerging nationwide HIE governance that will be specified in the future.
- Incorporate national and state health reform goals.
- Support opportunities to improve health outcomes and equity in all populations.

GOALS OF HEALTH INFORMATION EXCHANGE

- To ensure patients have safe, secure access to their personal health information and the ability to share that information with others involved in their care.
- To engage in an open, inclusive, and collaborative public process that supports widespread electronic health record (EHR) adoption and robust, sustainable statewide coverage.
- To improve population health.
- To improve health care outcomes and reduce costs.
- To integrate and synchronize the planning and implementation of HIE and health IT in the public and private sectors, including Medicaid and Medicare provider incentive programs, the Regional Extension Center, local and regional HIOs and other efforts underway.
- To ensure accountability in the expenditure of public funds.

Objectives and deliverables in achieving HIE capacity and use

PHASE	OBJECTIVES	DELIVERABLES
One	<ol style="list-style-type: none"> 1. Provider and HIO education programs are conducted 2. HIE services reviewed, finalized and communicated to stakeholders 3. Services requirements definition process is completed 4. Strategy for meeting the HIE needs of underserved areas is developed, reviewed, and approved 5. Sustainable business plan for SDE developed, reviewed, and approved 6. HIE Participant Accreditation Program designed, announced and implemented 7. HIE Participant Accreditation Pilot Project started 8. At least one intrastate and one interstate data usage and reciprocal sharing agreement (DURSA) are executed 9. One HIE participant exchanges information with another HIE participant 10. Legislative changes necessary to implement consent model are identified and bills drafted 11. Define and begin transition of HIE operations to SDE 12. HIE Participation Survey/Study initiated 13. Strategic and operational plan reviews and adjustments 	<ol style="list-style-type: none"> 1. Intrastate and interstate DURSA created, reviewed and finalized 2. List of Phase 2 business support and technology service offerings and associated sustainable finance plan created, reviewed and made final 3. Requirements documents for Phase 2 services created 4. Meaningful use criteria review process document created 5. Strategy for meeting the HIE needs of underserved areas created, reviewed, and made final 6. Sustainable business plan for SDE created, reviewed, and made final 7. Consumer, provider and HIO education programs defined and documented, including topics and timelines 8. Provider and HIO education program materials made final 9. HIE Participant Accreditation Program defined, documented and operational 10. Standards for HIE Participant Accreditation Program chosen 11. Document detailing laws pertaining to consent including identification of the law/statute, reconciliation with consent model and necessary changes created, reviewed and made final 12. Transition plan for HITOC-to-SDE developed, reviewed and accepted 13. Measures and benchmarks for HIE participation and impact defined 14. HIE participation study/survey program parameters and deliverables defined and documented 15. Success criteria for HIE participation defined and reviewed 16. Plan to monitor and maintain a targeted degree of participation in HIE-enabled state-level technical services developed
Two and Ongoing	<ol style="list-style-type: none"> 1. Complete transition of HIE services and programs operation to the SDE 2. Consumer education sessions have been conducted 3. Phase 2 services start 4. Success metrics for HIE participation defined 	<ol style="list-style-type: none"> 1. Consumer education program materials made final 2. Project plans for Phase 2 services created and published 3. Plan for follow-on services defined and reviewed (offerings, scope, timing) 4. Process to monitor, measure, and assess gradual attainment of benchmarks identified in Phase 1. 5. Process for assessing use of HIE services defined 6. List of additional services to be offered by SDE defined and reviewed including costs, timelines, and financials 7. Process for reviewing costing models, utilization and budgets for additional services to be provided in continuing operation

HIGHLIGHTS OF STRATEGIC PLAN DETAILS

Environmental Assessment

- Oregon has several large health systems that are actively pursuing health information exchange.
- 65% of Oregon physicians work in practices with EHRs, well ahead of the national average.
- There are a growing number of local HIOs within the state whose work needs to be supported.
- The interstate sharing of electronic health information is supported by the fact that Oregon's health care markets already extend across state borders through consumer choice, large hospital systems, health plans and current data sharing agreements.

Governance

- Oregon Health Authority, guided by HITOC recommendations is the body that provides oversight for health information technology issues.
- Oregon's HIE approach will be conducted in phases to allow for careful planning, input and strategic adjustment as elements of the plan are carried out.
- Oregon Health Authority, guided by HITOC recommendations, will serve as the governance entity for HIE during the first phase.
- The statewide infrastructure for carrying out the goals of HIE in Oregon will be developed with the core tenets of efficiency and flexibility and will leverage and support existing resources within the state.
- The statewide infrastructure for carrying out the goals of HIE in Oregon will be as minimal as possible and will leverage and support existing resources within the state.
- Oregon will designate a public/private, non-profit entity to take on statewide HIE governance and operational duties during the second phase.

Finance

- Recent state and federal health reform efforts have created imperatives and some short-term financing sources to accelerate the adoption of EHRs and health information exchange among health care organizations and providers.
- Priorities in designing ways to pay for exchange include maximizing meaningful use for providers, being equitable among stakeholders in costs and benefits, utilizing user fees and ensuring those fees have broad benefit.
- State contracts can be modified to provide incentives for providers and payers to participate in exchange.
- Specific financing sources for HIE could include Office of the National Coordinator for Health
- Information Technology (ONC) Cooperative Agreement funds, Medicaid 90/10 money, philanthropic and stakeholder contributions and revenue from centralized HIE services.

Technical Infrastructure/Business and Operations

- The first phase of operations will have Oregon Health Authority, guided by HITOC recommendations, as the initial governance entity, establishing standards and requirements for statewide HIE and implementing technology needed to enable Oregon providers to meet meaningful use requirements in 2011.
- During the second phase a non-profit entity with a public/private governing board will be designated to operate centralized services for exchange implemented in Phase 1.

- During Phase 2 the SDE will identify additional services and ensure that all centralized services are reaching unserved and underserved areas.
- This work will take place in concert with Oregon's neighbors: Washington, Idaho, Nevada and California.
- It will coordinate with administrative simplification efforts already under way.
- HIE standards will be based on technical standards, criteria and frameworks that are nationally recognized and/or adopted by the U.S. Department of Health and Human Services.
- The Oregon HIE effort will align with the National Health Information Network (NHIN), including NHIN Direct, by adopting technology standards and business processes that are interoperable, either directly or by proxy, with NHIN-adopted processes and frameworks.

Legal and Policy

- An "opt-out with exceptions" consent model for the use and disclosure of protected health information will support the initial phase of electronic exchange of information while excluding specially protected health information from HIE without express patient consent, as current Oregon law specifies.
- A legal and policy workgroup will convene in Phase 1 of operations to examine state laws that define specially protected health information.
- Proposed revisions of current Oregon statute to allow for a full "opt-out" consent model will be considered and may be presented to the Oregon Legislature.
- This strategy addresses all eight of HHS' principles in its Privacy and Security Framework.
- Oregon's HIOs will be held to national standards, federal and state law.
- Oregon Health Authority, with guiding recommendations from HITOC, may act as an accrediting body for regional and local HIOs in Phase 1, or may contract with another organization to serve in that function.

HIT Adoption Strategies

- O-HITEC, Oregon's Regional Extension Center, is working to support providers' adoption of electronic health records and achievement of meaningful use and is an important adjunct to health information exchange.
- Work is also under way to bring broadband capabilities to more providers and particularly to those in rural and other underserved areas through the work of Oregon Health Network and the Oregon Public Utilities Commission.
- Efforts for HIE through local, regional and statewide entities will support EHR connectivity to data sharing between unaffiliated organizations, beginning with three priority services: electronic prescription transmission, clinical summaries of care and receipt of structured laboratory data.

Coordination

- The Oregon Medicaid program's comprehensive planning work to develop a State Medicaid HIT Plan (SMHP) will be a natural coordination point with the statewide HIE effort.
- A wide variety of other state and federal programs touch on electronic health information exchange and will be part of a coordinated plan, including focused coordination with O-HITEC, Oregon's Regional Extension Center.
- HITOC and eventually the state designated entity will work with Oregon HIT workforce development programs.

- Oregon's health care markets extend across state borders so continued coordination with neighboring states will be a priority of this strategic plan.

Role of Consumers

- Security and privacy are important to Oregon consumers.
- The strategy takes into account the development of personal health records.
- A core HIE goal is to ensure patients have safe, secure access to their personal health information and the ability to share that information with others involved in their care.
- Access to accurate health information will help consumers make better decisions about their health care and lifestyle choices.

**Monthly Report to
Oregon Health Policy Board
August 10, 2010**

Bruce Goldberg, M.D.

PROGRAM AND KEY ISSUE UPDATES

Federal Medicaid Extension

As you now know the Senate passed the Medicaid Extension last week and the U.S. House is expected to do the same this coming week. The Medicaid increase for Oregon will amount to approximately \$143 million and there are funds for schools as well.

How the funds are ultimately used is up to the Legislature and the Governor. It is likely that given the volatility in the economy and the revenue forecasts, the legislature will need to wait several more revenue forecasts before making any firm decisions about using the funds. I hope they will help alleviate pressure to make further reductions in the future, and more importantly, provide the kind of reserve funds we will likely need to make it through the rest of the biennium and avoid the kind of reduction and restoration cycles that create confusion for clients and providers of services.

Healthy Kids Program

• Enrollment

- Through June, just over 50,000 children have been enrolled. This is 63% of our goal of 80,000 more children and an 18% increase in enrollment since June 2009 (baseline).
- Just over 1,600 children are enrolled in Healthy KidsConnect (See chart on pg. 8 for more details).

• Outreach

- We continue to do aggressive outreach to community organizations to enlist their help in spreading the word about Healthy Kids.
- We worked with a number of school districts to have a Healthy Kids direct mail piece sent to 250,000 households with school-aged children at the end of July.
- Community partners are signed up to do outreach and enrollment at 281 summer food sites throughout the summer
- Developing an employer campaign to reach out to more families above 200% FPL, as many working parents don't have access to or can't afford coverage for dependents.

- Implementing statewide media buy in September to coincide with a Back to School enrollment push.

● **System Improvements**

- Improving the application and eligibility determination process remains the #1 goal of the Office of Healthy Kids.
 - We contracted with the Center for Health Literacy to revise our medical application and have worked with community partners, advocates, and other stakeholders over the last month to come up with an improved application. This application was also tested with current and potential clients.
 - We are now working on printing the new application and creating an online version. Our goal is to roll out the revised application by the end of September.
 - Working with Children, Adults and Families (CAF) to streamline and simplify the eligibility determination process used by eligibility staff, with the goal of reducing the amount of time it takes to process an application while maintaining high standards of accuracy. Using Lean "rapid improvement process" to achieve this goal quickly.

● **Pushing forward with other system improvements**

- Using SNAP (Food Stamp) data to enroll as many as 15,000 - 20,000 children using "Express Lane Eligibility" methods (i.e., use income information in SNAP data to automatically enroll children into Healthy Kids).
- Working with willing school districts to use Free and Reduced Lunch applications for express lane eligibility starting later this year.
- Streamlining redetermination system, so that eligible families can keep their children enrolled quickly and easily.
- Developing partnership with the Department of Revenue to set the groundwork for using state tax data for eligibility determinations, an important step for Healthy Kids as well as the implementation of an insurance exchange.

OHP Standard

- Enrollment in OHP Standard is now **31,339** and more applications are coming in each week.
- As of July 23, 2010, **142,447** individuals had signed up for the OHP Standard reservation list since it opened in October 2009. About 20,000 are "opt-ins"¹ from the 2008 list, and the rest are from new sign-ups. Factoring in the drawings that have occurred, there are now 30,061 names active on the reservation list.
- The biennial goal is to have an enrollment of 60,000 people in the OHP Standard program by June 30, 2011.
- There have now been nine random drawings to date the next drawing will be August 18, 2010 for 20,000 names.

¹ This is the group of people who were on the 2008 reservation list and who affirmed they wanted to be on the new list.

Board Committee Progress Reports

Administrative Simplification Workgroup:

The group has made its recommendations to the Health Policy Board, which is scheduled to take action on the recommendations today, at the August 10 meeting.

Healthcare Workforce Committee

Next meeting: 1-4pm on August 18, Portland

Having completed their inventory of workforce resources, the committee in July focused on recommendations in three initial priority areas:

- Preparing current and future health care professionals to support system transformation via emerging models of integrated, team-based care delivery;
- Building the size and capacity of the healthcare workforce, particularly primary care; and
- Strengthening the healthcare workforce pipeline to ensure that Oregon has enough health care workers with the right training in the right places workforce.

The Committee debated some specific strategic recommendations under each of these priorities, looking for removable barriers or early action steps that can accomplish their priorities but may not need a large infusion of dollars due to the severe budget crisis facing the state. However, the committee also noted the urgent need for workforce investments such as in education and loan repayment. They discussed the need for different types of curriculum necessary for enhanced care coordination and inter-professional training to prepare the workforce for the medical home model workplaces. To assist their understanding, the committee heard from representatives from CareOregon/OPCA's safety net medical home pilot project who shared their clinics' observations about workforce needs and opportunities in the medical home team-based model. Based on July's discussion, more focused recommendations and needed action steps for each of the priority areas are being developed for review at the August meeting. A final version of their short-term strategic priorities and recommendations, with suggested action steps, will be presented to the Board at their October meeting. The Committee also identified the need to closely coordinate their work with the efforts of the other committees and will identify volunteers amongst the members to attend and/or participate in the other committees' meetings.

Health Incentives & Outcomes Committee

The full committee met to review and align the work of its two subcommittees. The committee approved principles for payment reform strategies developed by the Payment subcommittee and had a detailed discussion of how the initial set of recommended quality metrics need to compliment the initial payment strategies so can provide a means of measuring health outcomes and support payment approaches.

- **Payment Reform Subcommittee of the Health Incentives & Outcomes**
Next subcommittee meeting: 1-3pm on August 12, Portland

At the last meeting, the subcommittee discussed some of the data/evidence that could be used to identify opportunities for reform. It agreed to work with staff in small staff review

panels to develop recommendations for payment reform, focusing on three areas: 1) hospitals; 2) specialty care; and 3) primary care, building on the previous patient centered primary care home standards work. The full subcommittee will look across these three groups' draft ideas to develop a set of initial payment recommendations, focusing on steps that can be achieved over the next 1-3 years. This will include looking at federal requirements and reform, and where there is large variation in payment approaches or costs based on current data/evidence. The recommendations will also have a strong focus on chronic disease care, since it is a key driver of health care costs based on the evidence. Determining and aligning the current variability of payment approaches, such as variation in DRG payments with hospitals is one area was discussed, anticipating that greater uniformity of payment could improve efficiency of payment transactions and be a base to build an incentive, outcome-based payment methodology. There was some discussion of looking closely in the area of cardiology and orthopedics as initial areas of focus in specialty care. The workgroups will be meeting in early August and come together for the full subcommittee August 12th. The subcommittee's recommendations will be aligned with the quality outcome metrics being developed in the Efficiency and Quality subcommittee in preparation for a full Incentives and Outcomes report to the Board at the October Board meeting and for the Public Purchasers Committee to consider for contract changes in both the Authority and other purchasers.

- **Efficiency & Quality Subcommittee of the Health Incentives & Outcomes**

- **Next subcommittee meeting: 10-12 on August 12, Portland**

- At the last meeting, the subcommittee reviewed the quality & efficiency priorities and the work of its small workgroups that have been focused on three areas 1) effectiveness and safety, 2) patient-centeredness; and 3) cost and efficiency measures. The workgroups, since the full Incentives and Outcomes meeting, are now identifying how to focus on those metrics most useful for payment reform initiatives as immediate next steps. This will allow them to narrow the subcommittee's inventory of the most common measures in each focused area, and refine the list to key metrics for the anticipated areas of new payment strategies that address high variation in cost or utilization or effect chronic diseases. There is a recognized need to build on currently collected chronic disease metrics by Quality Corp, those of the Patient Centered Primary Care Home Standards work, as well as the newly finalized Health Information Technology Meaningful Use requirements in order to build on state and federal efforts already in place or almost underway. Also they have reviewed upcoming Medicare and Medicaid quality metric changes that are anticipated. They realize their work needs to be usable to purchasers, such as those represented on the Public Purchasers' committee, for inclusion into contracts. Staffs from both this subcommittee and that of the payment subcommittee are working closely to align the work of each for the groups' discussion. The workgroups' preliminary recommendations will be discussed at the Efficiency and Quality subcommittee in August, and then further refined in September and discussed at the full Health Incentives and Outcomes committee. At the October Board meeting, the Board will be presented with recommended initial state quality improvement

strategies that align with the recommended set of payment reform strategies that will aim to address chronic disease and high variation in cost, quality or utilization.

Medical Liability Task Force

Next meeting: 1-4pm on August 4, Wilsonville

The task force, in defining how they would approach their charge, finalized their principles that any recommendations should:

- Make the medical liability system a more effective tool for improving patient safety;
- Ensure that it more effectively compensates individuals injured as a result of medical errors; and
- Reduce its collateral costs (including costs associated with insurance administration, litigation, and defensive medicine).

Using these principles, they have focused their work on three main approaches to review: disclosure and offer; administrative “health courts”; and safe harbor provisions.

The Task Force discussed at their July meeting disclosure and offer programs with a focus on PeaceHealth’s efforts in this area, and the role of the Patient Safety Commission’s reporting could play as they consider recommendations in this area. Some straw recommendations on disclosure and offer were initially considered at their recent August meeting but the majority of the time was spent on health courts, including a discussion with a national expert. The health courts discussion highlights included how there could be an alignment with the earlier discussed disclosure and offer in setting up this administrative approach to assess liability concerns, how further detailed analysis on potential impact and some interest in consideration of developing a pilot approach to better assess its effectiveness at achieving the task force’s principles. Brief discussion was done on the concept of a provider reinsurance pool, as an addition to the disclosure and offer recommendations and concerns were raised that though extensively discussed in past liability task forces or work groups, it doesn’t fit with the principles they are using to evaluate approaches, and there is the issue of how it would be funded. September’s meeting will be focused on safe harbor approaches and review of some straw recommendations regarding health courts. The Task Force will be finalizing their recommendations in October to prepare for presentation to the Policy Board in November.

Public Employers Health Purchasers Committee

Next meeting: 1-4pm on September 27, Wilsonville

In August, some members of the committee will be meeting with the Physician Hospital Alignment for Central Oregon in Bend to learn about their efforts and how that model could be adapted for use in other communities. Some members and staff will also be meeting with health systems to discuss DRG hospital reimbursement methodologies for a report to the full Committee in September.

Health Information Technology Oversight Council (HITOC)

Next meeting: 1-5pm on August 5, Portland

The committee held a webinar public meeting to review the operational plan and draft budget for health information exchange. The discussion included the timing of technology purchases to support providers' eligibility to receive incentive payments from Medicare and Medicaid for the meaningful use of electronic health record systems. At the August meeting, HITOC approved the Strategic and Operational Plans for Health Information Exchange for submission to the ONC, and discussed the process of building the new structure of workgroups and advisory panels for the next phase of work outlined in the health information exchange operational plan.

Oregon Health Improvement Plan (HIP) Committee

Next meeting: 10-2, August 6, Eugene

In June, the HIP Committee worked to synthesize the previous three months of information gathering and community engagement into core goals and recommendations for the health improvement plan. These were presented as a draft to the Health Policy Board in July. The HIP committee did not meet in July. Based on the Board's feedback and public input, committee members at their August 6th meeting will work to further define specific actionable strategies and population health outcomes for each of the six goal areas (equity, resources, community infrastructure, tobacco, obesity and chronic disease self-management) and begin to work out timelines for actions in the next and future biennia.

Health Insurance Exchange

Staff recommendations for the development of an exchange will be presented at this (August) board meeting. The recommended policy choices will help the state establish an exchange within the requirements of the framework established in federal law.

Essential Benefit Package

While the Cost Sharing Workgroup initial work is completed pending more federal reform details, OHP is organizing focus groups of consumers, providers and insurers to assess the marketability and administration issues of the value-based benefit design under discussion. Presentations on the Essential Benefit Package (EBP) similar to that given at the July Board meeting were subsequently given to PEBB and OEBC. Further modeling of the EBP using commercial data will be done to provide assistance to these boards as they consider this plan design as an option. In the fall, OHP will give the Board an update on the focus group results, the commercial data modeling, and the status of published regulations as they become available on the federal health reform plan that will better inform the value-based benefit discussion.

From D.C.

HHS Announces Exchange Planning Grants / Requests Public Comment on Exchange

Standards: HHS announced the availability of up to \$1 million in grants per state to help states begin work to establish Exchanges and published a request for comment calling for public input as HHS develops standards for the Exchanges.

Prevention and PH Infrastructure

Component 1: Performance Management Improvement Grant of \$200,000.

Application Due: Due August 9, 2010.

Component 2: Prevention and PH Infrastructure - Transformation Grant of \$1M to \$2.7M.

Application Due: Due August 9, 2010.

The goal of this program is to increase the performance management capacity of public health departments. The grant will allow states to hire a full time Performance Improvement Manager, as well as enhance departments' abilities to train staff, organize infrastructure, evaluate public health programs, and more effectively implement public health policies.

Oregon Health Policy Board
ADMINISTRATIVE SIMPLIFICATION
Executive Staff Recommendation

Date: August 10, 2010

Action item: Administrative Simplification Work Group Final Report – **Request for endorsement of recommendations**

Executive staff recommendation:

- Endorse the work group recommendations (*See below*).
- Emphasize the importance of broad participation in future work groups.
- Recommend prior authorization, referrals, and plain language billing for consumers be the next stage for further administrative simplification activity,
- Develop metrics to measure cost savings from administrative simplification activities,
- Explore/develop mechanisms to capture savings for consumers,
- Recommend that the State Office for HIT develop an implementation plan that addresses issues particular to small medical practices,
- Require quarterly Board updates on progress on implementation.

Benefit: The work group estimates annual savings of approximately \$93 million by 2014 if there is reasonably rapid compliance with the requirements and rapid adoption by providers of internal processes that take full advantage of electronic transactions.

The benefit accrues to physician practices and health plans primarily through savings in labor: it has been estimated that administrative simplification could save four hours of professional time per physician and five hours of practice support staff time each week, potentially creating opportunities for increased access and improved patient care. (*Health Affairs, June 2010*).

Lower practice support staff costs and back office support costs may translate into lower premiums and lower Medicaid costs. Lower costs in health plans can translate into either lower premiums or increased retained earnings.

Why the project was undertaken: To reduce the administrative cost of health care. Estimates of inefficient claims processing, payment and claims reconciliation are between \$21 and \$210 billion in the U.S. It has also been estimated that these administrative costs account for 10% to 14% of revenue in physician practices. (*American Medical Association Administration Simplification White Paper, 2008*).

The work group was created at the direction of the 2009 Legislative Assembly, which required the Office for Oregon Health Policy and Research (OHPR) to convene a stakeholder work group to develop uniform standards for insurers, including standards

for eligibility verification, claims, and remittance advice transactions and authorized the Department of Consumer and Business Services (DCBS) to adopt the recommended standards through administrative rules.

Previous Board Discussion:

Administrative Simplification recommendations were initially brought before the Board on May 11th, 2010. The workgroup recommended that Oregon adopt the Minnesota Plan, which is to standardize electronic processes by replacing companion guides with a single uniform companion guide for three key transactions and then require all plans, providers and clearinghouses to conduct those three transactions electronically.

The Board requested further information about the Minnesota plan; staff prepared a memo and further information about the Minnesota plan (*attached here*).

The Board also expressed concern that issues related to small medical practices were not adequately addressed in the workgroup recommendations. Staff, working with the Oregon Medical Association, identified and interviewed several practice representatives between June and July to address issues that may be particular to small practices (*See below*).

Work group recommendations:

Recommendation #1: DCBS should adopt the uniform guides for three common administrative and financial transactions between providers and payers (eligibility verification, claims and remittance advice transactions)

Recommendation #2: All health plans should be required to conduct administrative transactions electronically on a phased timetable

Recommendation #3: In 2011 the legislature should authorize DCBS to apply the requirements to health plans, including third party administrators and clearinghouses that are not licensed by DCBS.

Action steps to implementing the recommendations:

1. A public-private technical workgroup will begin the industry analysis of the Minnesota companion guides and any other additional work completed in Oregon for an eligibility verification companion guide to be completed by December 2010. It will then complete work on a claims companion guide by July 2011 and a remittance advice companion guide by January 2012.
2. The Department of Consumer and Business Services (DCBS), in collaboration with OHA, will adopt administrative rules based upon the Policy Board workgroup recommendations and use the "Oregon" companion guides for eligibility verification by April 2011, claims by October 2011, and remittance advice by July 2012.

3. The Oregon Health Authority as a payer should follow the DCBS rules and require Medicaid managed care organizations, Medicaid providers, and others with which it deals to do so as well.
4. The OHA and DCBS will pursue legislation in 2011 giving DCBS authority to establish uniform standards for healthcare administrative transactions to all payers (including third party administrators and self-insured plans) and clearinghouses and to collect data from them to monitor progress and identify future opportunities.
5. DCBS and OHA should establish a leadership team to coordinate current and future work on administrative simplification. The leadership team would:
 - a. Continue close collaboration with health care stakeholders to monitor progress of current work and develop goals for future work.
 - b. Include the State HIT Coordinator and the Medicaid Director in order to ensure coordination with adoption of health information technology especially in small practices.

New information developed at the request of the Board's previous discussion:

Following the work group's presentation to the Board on June 8, staff has done additional analysis of the impact of the electronic transaction requirement on small providers.

- **Provider Cost:** Average initial implementation costs for an electronic practice management system will be about \$21,000 per provider—including the cost of lost productivity during the transition. The practice management systems required for electronic administrative transactions are a foundational component of a certified electronic health records (EHR) system; implementation of a full EHR system averages an additional \$25,000 per provider—for a total of \$46,000. The initial investment is potentially recoverable through the federal Medicaid and Medicare incentive programs. After the initial investment is recouped, annual savings of about \$11,000 per provider can be realized with those savings exceeding the ongoing costs of an EHR system.
- **Small Practice Feedback:** Staff, with assistance from the Oregon Medical Association, had targeted conversations with small physician practices so they could react to and provide feedback on the draft recommendations. Comments overall support the recommendations. Physician practices emphasized the importance of applying the requirements to third party administrators and clearinghouses to ensure standard electronic processes from all payers and vendors to providers. The primary barrier to physician compliance with proposed requirements that was mentioned was the physical absence in some rural communities of high speed internet access necessary to effectively transmit electronically. The physician practices interviewed would like the administrative simplification work to address credentialing, more standardized drug formularies, and more standardized prior authorization systems and requirements.

Risks: (1) The federal government could change standards or fail to adopt standards by the dates specified in the federal health reform law, which would require Oregon to re-examine and perhaps modify its approach. (2) The recommendation is for DCBS to require health plans to do business electronically; the requirement for providers to do so is indirect, through the plans. Additional steps may be required to achieve near universal compliance by providers. (3) Most of the savings from administrative simplification take the form of reduced labor time; therefore, jobs could be eliminated if affected workers are not redeployed to other activities within a health plan or health care facility.

Conclusion: The opportunity for reducing administrative workload and cost savings from adoption of the recommendations is substantial. The risks outlined are outweighed by the significant return on investment for both providers and payers.

Building Oregon's Health Insurance Exchange

**Draft Recommendations
to
Oregon Health Policy Board**

Nora Leibowitz
Barney Speight

August 10, 2010

Presentation Overview

- Background
- Goals for Oregon's Exchange
- Vision of Success
- Staff Recommendations
 - Structure & Governance
 - Market/Operational Framework
 - Choice of Health Plans
 - Coordination w/ Public Programs
 - Risk Mediation
 - Financial Sustainability

Who will use the Oregon Exchange?

Starting 2014:

- Individuals who do not have employer-sponsored coverage
- Small employer groups (1 – 50 or 1 – 100)
- To access tax credits and assistance with cost-sharing expenses individuals & small employers must purchase through the Exchange
 - Federal premium tax credits and cost-sharing reductions are available for people with income up to 400% of the federal poverty level (\$88,200 for a family of 4)
 - Federal assistance will reduce out-of-pocket expenses for those with lower incomes

Timeline for Implementation

- **10/1/2010:** Federal planning grants awarded
- **2011 OR Leg:** Statutory charter enacted
- **Mid-2011**
 Thru 2012: Oregon Exchange built per Federal specs
- **1/1/2013:** Deadline for Federal certification of State readiness
- **Mid-2013:** Enrollment via Exchange will start (1/1/14 eff. date)
- **1/1/2014:** Exchange operational
 - Guaranteed issue coverage in effect
 - Individual insurance mandate in effect

Goals for Oregon's Exchange...

From the Health Policy Board:

- Facilitate access to coverage
- Simplify
 - Health plan designs and rules
 - Plan enrollment
 - State health insurance regulation
- Change the way health services are provided/paid for
- Contain costs where possible

What Does Success Look Like?

Oregon's Exchange will:

- Provide useful & timely assistance to Oregonians through multiple media (Web, printed, in-person)
- Offer a range of health plan choices that meet diverse consumer needs
- Make enrollment & premium assistance easy for customers
- Improve access to insurance coverage and health care
- Score high in customer focus, responsiveness, & service
- Grow through customer Trust, Service & Value
- Be financially strong & sustainable

What's Happened Since May?

- Technical Advisory Work Group
 - Diverse group met 3 times
 - Identified values: efficiency; flexibility; accountability; consumer focus
 - Discussed options, implications
- Additional discussions with stakeholders
- Staff & consultant analysis

ACA Defines Core Exchange Functions

- Provide Consumer Information
- Certify Health Plans that Participate (QHP)
- Offer Meaningful Coverage Choices
- Grade Health Plans
- Provide Customer Assistance
- Facilitate Community-based Assistance
- Administer Exemptions
- Provide Information to the Federal Government

Staff Recommendations:

1. Organizational Structure
2. Governance
3. Market/Operational Framework
4. Choice of Health Plans
5. Coordination w/ Public Programs
6. Risk Mediation
7. Financial Sustainability

1. Structure: Public Corporation

- Chartered by State statute
 - e.g., OHSU, SAIF, Port of Portland
- Unique statute that will address:
 - Governance
 - Authority & Duties
 - Personnel & Finance
 - Programs
 - Applicable & Non-Applicable provisions of Oregon Revised Statutes (ORS)
 - Stakeholder Advisory Committees (consumers, small business, carriers, etc.)

2. Governance: Board of Directors

- Appointed by Governor, confirmed by Oregon Senate
- Number: 5 to 9
- Qualifications: Broad, specific, combo?
- Ex-Officio (voting):
 - Directors of DCBS & OHA
 - Member of OHPB
- Responsible for hiring skilled executive leadership

3. Market/Operational Framework _A :

- Enrollment in Exchange begins 1-1-2014
- Several issues need to be investigated or addressed if the state wants to pursue an earlier implementation date.
 - Access to federal subsidies before 2014 (pilot?)
 - Impact of guaranteed issue products in Exchange when rest of individual market is underwritten (adverse selection)
 - Access to implementation funding for early roll-out
 - Consistency of federal rules, including benefit package

3. Market/Operational Framework _B :

- Individuals & small groups can buy plans outside the Exchange
- Market regulation promotes competitive “level playing field” between Exchange & Non-Exchange markets
 - Standard age cohorts
 - Standardized health plan benefit option (s)
 - Web-based clearinghouse for market transparency

3. Market/Operational Framework _c:

- Oregon's Exchange should be a single organizational entity:
 - With 2 product lines: Individual + Small Group (aka SHOP)
 - Serving the entire State but with knowledge of regional variations in delivery systems & health plan networks
 - That investigates opportunities for multi-state partnerships to leverage operational infrastructure costs

3. Market/Operational Framework _D:

- Young adult (catastrophic plan) only offered by carriers participating in the Exchange
- Premium parity for plans sold inside & outside the Exchange & merged risk pools
- Federal guidelines & Board policy define the role of agents/brokers within Oregon Exchange
- Small group market defined as 1 to 50 for 2014 & 2015; in 2016, defined as 1 to 100
- State policy decision in 2017 regarding > 100 market

Phased Market Implementation

	2014	2015	2016	2017
Individual	TM + X	TM + X	TM + X	TM + X
1 to 50	TM + X	TM + X	TM + X	TM + X
51 to 100	TM	TM	TM + X	TM + X
> 100	TM	TM	TM	?
<p>TM = Traditional Market X = Exchange Market</p>				

4. Choice of Qualified Health Plans _A :

- Federal regulation will define basic requirements
- BUT... An Exchange may certify a health plan as a QHP if:
 - a) *the health plan meets the certification requirements of the Secretary; and*
 - b) ***the Exchange determines that making the health plan available through the Exchange is in the interests of qualified individuals & qualified small employers in the State in which the Exchange operates.***

4. Choice of Qualified Health Plans _B :

- Pursuant to Federal guidelines, state statute & Board policy, the Oregon Exchange can limit the number of QHPs in each tier (bronze, silver, gold & platinum)

5. Program Coordination

- Oregon Exchange must collaborate on:
 - Coordination of eligibility & enrollment policies & process for Oregon Health Plan (OHP)
 - Phase-out of OMIP in 2014
 - Role of FHIAP for subsidies to small business employees within Exchange

6. Risk Mediation

- Oregon Exchange will coordinate with Federal & State risk mediation programs:
 - Reinsurance (State; 2014 thru 2016)
 - Risk corridor (Federal; 2014 thru 2016)
 - Risk adjustment (State; TBD)

7. Financial Sustainability

- Utilize user fees on premiums permitted under Federal law
 - Clear line of sight between user and fee
 - Appropriate fiscal pressure on Exchange admin costs to remain competitive with non-exchange market

Questions & Discussion

Decision Guidance Document

Oregon Health Exchange

Issue # 1

Should Oregon's Health Insurance Exchange be a Public Corporation?

- Yes If yes, staff will develop draft components of statutory charter
- No Alternative organizational structure

Issue # 2

Board of Directors

- Size?
- Broad or specific qualifications for Board Members?
- Ex Officio Members?
 - Director, OHA?
 - Director, DCBS?
 - Member, OHPB?

Issue # 3

Market/Operational Framework

- Go early?
- Exchange Market + Outside Market?
- Level Playing Field Criteria
 - Standard Age Coherts?
 - One Standardized Choice In & Out?
 - Comprehensive Standards In & Out?
 - Clearinghouse = Full Transparency?
 - Other?
- One Exchange for Individual & Small Group Products?
- One Exchange for all of Oregon?
- Explore Multi-State for Operational Efficiencies?
- Young Adult Available in Exchange Only?
- Role of Agents/Brokers defined by Federal & Board policy?
- Small Group Market = 1 to 50 for 2014 & 2015?

Issue # 4

Choice of Health Plans

- Board Can Have Additional Criteria to Certify QHPs?
 - Number of Cost Sharing Options w/in Tiers?
 - Other?

Issue # 5

Support Coordination with Other Public Programs?

Issue # 6

Support Coordination with Federal Risk Mediation Programs?

Issue # 7

Support Fees on Premiums For Financial Sustainability?

A Publicly-Owned Health Insurance Plan

**Initial Presentation to the
Oregon Health Policy Board**

Bill Kramer, Principal
Kramer Health Care Consulting
August 10, 2010

History and Legislative Background

2002: CHOICE proposal – California

2007-08: Presidential primary campaigns

2009: Oregon legislation (HB2009): specific language re
“publicly-owned health benefit plan” within the
exchange

2009-10: National health reform

- Included in initial House bills and Senate HELP bill
- Excluded from Senate Finance bill and final ACA

July 2010: Reintroduced in Congress

What Makes a Health Plan a “Public Plan”?

- Owned by a public authority
- Accountable to the general public
- Insurance risk held by a public authority
- Managed by a public organization, although some functions may be outsourced
- Not necessarily a “government-run” delivery system
- Examples: Medicare, Medicaid

Some Assumptions about a Publicly-Owned Health Insurance Plan

- Offered only within the Exchange.
- Operating “under the same rules and regulations as all health insurance plans offered through the exchange” [HB 2009]
- Expected to be self-sustaining
 - Operating expenses and ongoing capital covered by premiums
 - Start-up costs repaid over a reasonable period

Advocates' Rationale for a Publicly-Owned Health Insurance Plan

- ✓ Increases choice
- ✓ Promotes competition – incentive for private health insurers to improve value
- ✓ Sets a standard for best practices: model for improved delivery of care, customer service, reduction in disparities, value-based benefit design, etc.
- ✓ Counters the adverse effects of market concentration

(cont.)

Advocates' Rationale for a Publicly-Owned Health Insurance Plan (cont.)

- ✓ Lower costs → lower premiums
 - Lower administrative expenses
 - Less marketing and advertising
 - Lower executive compensation
 - Lower payment rates set or negotiated with providers
 - Innovative provider payment mechanisms
 - No need to generate returns for shareholders

(cont.)

Advocates' Rationale for a Publicly-Owned Health Insurance Plan (cont.)

- ✓ Since there is an individual mandate, people should have a choice of public as well as private health plans
- ✓ Accountability to the general public, not just to shareholders
- ✓ Offers a trusted choice, improves transparency, builds public confidence

Opponents' Arguments against a Publicly-Owned Health Insurance Plan

- ✗ Unfair competition to private health insurers
- ✗ Would eventually eliminate the private insurance market
- ✗ Simply a path to a “single payer” system

(cont.)

Opponents' Arguments against a Publicly-Owned Health Insurance Plan (cont.)

- ✘ Misuse of government power to underpay providers
- ✘ Danger of cost shift to privately insured patients, if POHIP pays providers & hospitals less
- ✘ Even if POHIP is set up to be self-sustaining, the government wouldn't let it fail – would step in to bail it out

Key Strategic Issues

- What would be the POHIP's strategy for achieving superior value vs. private health plans? For example:
 - Lower cost (with same quality and service)?
 - Higher quality and service (with same cost)?
- How would the POHIP achieve lower administrative costs? How much lower?
- How strong would the medical management function be?
 - Trade-off between strong UM (high admin costs/lower med costs) and weak UM (low admin costs/higher med costs)

(cont.)

Key Strategic Issues (cont.)

- What would its provider network strategy be?
 - How much would it pay providers?
 - If rates are negotiated, how much leverage would a POHIP have?
 - Would providers be required to participate in POHIP in order to participate in OHP? or other incentives?
 - What would the impact of payment rates be on access to care, quality of care, hospitals' access to capital markets?

(cont.)

Key Strategic Issues (cont.)

- Why is size important? How big does it need to be?
 - Economies of scale
 - Attract providers
 - Negotiating leverage with providers
- How can the POHIP minimize the danger of adverse selection?
- How would start-up costs be financed?

Organization and Governance Options

- Standalone plan
 - State agency
 - Public corporation
- Buy-in to existing plan
 - PEBB
 - OHP

Each has pros and cons – further analysis needed.

How Much will this Cost?

- Start-up costs (planning, infrastructure development, marketing, initial reserves): *TBD*
- Ongoing administrative expenses
 - Range: 2% (Medicare FFS) – 12% (BCBS average)
 - Variables: size, network strategy, utilization management, marketing
 - *Estimates need refinement – more analysis needed.*

Elements of the Business Plan

- Strategic and operational plans
- Start-up costs and financing
- Expense estimates: medical costs and administration
- Revenue estimates

Work Plan for Development of Business Plan

	September	October
Rationale, pros and cons	Final rationale	Final analysis of pros and cons
Organization and governance models		Final recommendations
Business Plan		Final analysis

Decisions for the Board – Preliminary List

- Issue 1: Organization and governance
 - Standalone plan (state agency or public corporation) or Buy-in to existing plan (OHP or PEBB)?
- Issue 2: Provider network strategy
 - Broad or select network? Provider payments negotiated or set by POHIP? Payments at market or below?
- Issue 3: Administrative functions and expenses
 - How much for medical management? marketing & sales?
- Issue 4: Financing of start-up costs
 - How much? How long for payback?



Oregon and Southwest Washington Healthcare, Privacy and Security Forum

August 7, 2010

Eric Parsons, Chair
Oregon Health Policy Board
500 Summer St NE
Salem, OR 97301

RE: Administrative Simplification Recommendations Questions
Formal Written Testimony

Dear Chair Parsons and Member of the Board:

The primary purpose of my testimony is to question why the State of Oregon is recommending modification of the Minnesota health care administrative transactions (X12N 5010 transactions) companion documents. Companion documents have been developed by the Oregon healthcare industry (including the, at the time, Department of Human Services) for the Oregon healthcare industry and have been available since 2002-2003 for free to anyone interested in accessing and downloading the companion documents.

I question the following time line for mandated companion document adoption. By federal rule, the healthcare industry must be prepared to exchange HIPAA covered healthcare administrative transactions by no later than January 1, 2012. The proposal put forth by the state indicates the final mandated companion documents for the claims transaction, as an example, will not be available for broad industry review until likely late 2011 with mandated adoption just three months prior to the mandated conversion date to the new transaction versions. Please see the following table that was extracted from the State of Oregon's health information technology final draft strategic plan. This is late in the process to convert to the new version of the transactions and will likely be costly and disruptive for health plans and providers alike given the conversion process is lengthy and requires multiple iterations of testing between payers, providers and healthcare clearinghouses.

I fully support the adoption of common mandated companion documents. I question the ultimate source of the companion documents to be modified to fit Oregon's needs and the time line given the federally mandated deadline to convert to the new version of the HIPAA healthcare administrative transactions. As an aside, the 5010 conversion does not address all mandated HIPAA transactions. It omits Web based transactions and it omits pharmacy mandated transactions.

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Table 11. Proposed Oregon timeline for standardizing HIPAA electronic transactions and going all-electronic

	ELIGIBILITY INQUIRY AND RESPONSE (270/271)	CLAIMS (837)	REMITTANCE ADVICE (835)	ELECTRONIC FUNDS TRANSFER
Period for industry review of Minnesota companion guides ends	1/1/2011 (end of Q4 2010)	7/1/2011 (end of Q2 2011)	1/1/2012 (end of Q4, 2011)	Not applicable
DCBS rule-making to adopt uniform companion guide completed	4/1/2011 (end of Q1 2011)	10/1/2011 (end of Q3 2011)	7/1/2012 (end of Q2 2012)	Not applicable
Date that uniform guide standards must be followed for electronic transaction	1/1/2012 (end of Q4 2011)	10/1/2012 (end of Q3 2012)	7/1/2013 (end of Q2 2013)	Not applicable
Date when all transactions must be processed electronically	7/1/2012 (end of Q2 2012)	1/1/2013 (end of Q4 2012)	10/1/2013 (end of Q3 2013)	1/1/2014 (end of Q4 2013)

Also, I understand use of the Minnesota companion documents as a basis for an Oregon mandated standard set of companion documents is not a “done deal” until this Board votes to adopt the recommendations presented by the state. Unfortunately, a fair amount of communication has been sent out, primarily via email, and the impression of many is this is a done deal even though this Board has not taken action. I did request OHPR announce in writing that the Board needed to take action prior to officially moving along the path recommended by the state. As of the date of this written testimony, the only written communication that has been sent out to participants in the companion document conversion effort that has already kicked off this is not a done deal until the Board takes formal action is from me as the chair of the Forum.

A bit of history... The X12 4010A1 Oregon companion documents (drafted in 2002/2003) can be found at <http://www.oregonhipaaforum.org/Page.asp?NavID=70>. The Oregon and SW Washington Healthcare, Privacy and Security Forum’s home page is <http://www.oregonhipaaforum.org>. The state was informed about these companion documents shortly after the close of the 2009 session. Specifically Lynn-Marie Crider, Office for Health Policy and Research (OHPR) Administrative Simplification Project manager requested a meeting with me very shortly after she was hired to manage the Administrative Simplification Project. I informed Ms. Crider of the Forum and the existing free companion documents at that time. Tina Edlund, OHA Deputy Director; Jeanene Smith, OHPR Administrator; and Sean Kolmer, OHPR Deputy Administrator were also informed (as were some of the Administrative Simplification Project workgroup members) at a later date.

As of today, I have been left with the impression that the state has no intention of considering any other option than the Minnesota option. What the Oregon industry created for Oregon appears to be something that has never been considered even though it is an option that is worth considering and the state was aware of the Oregon developed free companion documents. These guides were developed by DHS, ODS, Regence, Providence, Legacy, Payer Connection, Peace Health, Family Care, LIPA, OHSU, PerSe, NDC, PacificSource, etc. If you are interested in more history related to the guides, I would suggest contacting the co-chair of the newly launched effort to convert the Minnesota companion documents to meet the needs of the Oregon healthcare industry, Pat Van Dyke from ODS. Ms. Van Dyke was instrumental in moving the 2002 project along.

Besides chairing the Forum, I also chair the Forum’s Transaction and Code Sets (TCS)/National Identifier workgroup. The Forum purchased a complete set of 5010 implementation guides and access to those guides is free to Forum members through a secure web site. There is no cost to join the Forum. We

were in the process of updating the 4010A1 companion documents until it became rather clear the state was intent on moving forward with the Minnesota guides. The Forum update of the Oregon companion documents is on hold at this time.

I have informed all members of the Forum of what is occurring at the state level and passed along contact information so those who have been involved with the Forum's efforts can make sure they are at the table as the state moves forward with development of mandated companion documents. I do find the whole thing frustrating and interesting at the same time. Interesting given one of the strongest contributors to the Forum's workgroups, including TCS, has been DHS (now OHA). In fact one of the documents posted with the companion documents is DHS' instructions to providers converting to HIPAA transactions.

I would hope that this Board takes into account what has already been adopted by Oregon for Oregon and the adverse impact to Oregon's payers and providers if mandated companion documents are not available and mandates do not occur until just prior to the federally mandated conversion date to the new version of the HIPAA healthcare administrative transactions. If you have any questions, please let me know.

Sincerely,

A handwritten signature in black ink, appearing to read 'Chris Apgar', with a long horizontal stroke extending to the right.

Chris Apgar, CISSP
Chair

Cc: Senator Alan Bates
Oregon Senate

Representative Mitch Greenlich
Oregon House of Representatives

Tina Edlund, Deputy Director
Oregon Health Authority

Pat Van Dyke, Director, Privacy, Security and EDI
ODS Companies