

Oregon Health Policy Board
HB2009 Activities and Deliverables: A Status Report
January 18, 2011

Where have we been?

Duties of the Board as outlined in House Bill 2009:

1. Establish **cost containment mechanisms** to reduce health care costs;
Status: The Board's Action Plan for Health outlines 8 foundational strategies aimed at meeting the objectives of the Triple Aim: better health, better health care, and lower costs. Included in those strategies, the Board has adopted specific recommendations to control costs and improve outcomes within the Oregon Health Authority, for example:
 - Aligning health purchasing for the more than 850,000 people who receive health care through OHA; reducing administrative overhead in the health care industry; crafting a value-based benefit essential benefits plan that removes barriers to preventive care in association with innovative payment strategies that reward efficiency and outcomes; and setting global health care budgets fixed at a sustainable rate of growth;
 - Administrative simplification to reduce unnecessary overhead costs in health systems. The Administrative Simplification workgroup recommended adoption of uniform electronic transactions between payers and providers as a first step. Board recommendations were forwarded to the Health Leadership Council's technical workgroup. The Council is expected to approve the technical work in February; they then go to DCBS for rulemaking.
 - Delivery system reforms are aimed at delivering better, more coordinated health care at lower costs (e.g., access to primary care homes); integration of physical and behavioral health;
 - Incentives and Outcomes Committees recommendations to initiate innovative payment methodologies and to quickly reform payment for treatment of pressure ulcers, hospital readmissions, and health care acquired infections;
 - Incentives and Outcomes Committee recommendations to strengthen review of appropriate use of imaging, treatment for low back pain, maternity care, joint replacement and cardiac diagnostics; and
 - Shifting our focus to prevention by removing barriers to preventive care and by supporting programs reduce obesity, tobacco use and drug and alcohol abuse.

2. Establish **statewide health care quality standards** for use by all purchasers of health care, third-party payers and health care providers as quality performance benchmarks.
Status: The Incentives and Outcomes Committee has recommended the development of metrics around specific domains of patient and family-centeredness, and has developed recommendations for specific measurement sets for quality, safety and efficiency. Work is ongoing to establish the statewide "scorecard" of quality performance benchmarks.

3. Develop and submit a plan to the Legislative Assembly to provide and fund **access to affordable, quality health care for all Oregonians by 2015**;

Status: The *Action Plan for Health* was delivered to Oregon legislative leadership on December 30, 2010. The Board's plan meets this statutory charge by laying out strategies that reflect the urgency of the health care crisis and a timeline for actions that will lead Oregon to a more affordable, high quality health care system.

4. Develop and submit a plan to the Legislative Assembly for the **Oregon Health Insurance Exchange**;

- OHA: shall submit the plan developed under this section to the OHPB for approval.
- OHPB: the HPB shall submit a request to Legislative Counsel for a measure to implement the plan.

Status: A business plan for the Oregon Health Insurance Exchange was approved by the Board and submitted to Oregon legislative leadership on December 30, 2010. A bill reflective of the Board's recommendations to establish an Oregon Health Insurance Exchange has been pre-session filed.

5. Establish a **health benefit package** to be used as a baseline for all plans offered through the Exchange;

Status: The federal government has not yet issued guidance for the federally required minimums for the essential benefits package. The Office for Health Policy & Research has spent the past year working on various aspects of the design of a value-based essential benefit package.

- The Oregon Health Services Commission developed a list of value-based benefits that could be used as the core of a value-based essential benefit package.
- Building off the design work of the Oregon Health Fund Board's Benefit Committee, the Office worked with an actuarial consultant and the Actuarial Services Unit of the Oregon Health Authority to develop a model to determine the costs and potential savings of a value-based essential benefit package.
- Focus groups and one-on-one interviews were conducted with potential consumers, employers, insurers, agents, providers and hospitals to better understand consumer reactions and operational considerations of implementing a value-based benefit design.

6. Develop and submit a plan to the Legislative Assembly for the development of a **publicly owned health benefit plan** within the Exchange;

Status: The Board developed three alternative business plans for a publicly owned health benefit plan that could be offered within the Exchange and submitted those to legislative leadership for their consideration on December 30, 2010. The three options forwarded to the Legislature were a free standing benefit plan, a Medicaid buy-in and a PEBB buy-in.

7. Investigate and report to the Legislative Assembly on the **feasibility and advisability of future changes to the health insurance market** including an Individual mandate, a payroll tax, expansion of the exchange to include a premium assistance program and advance reforms of the insurance market and statewide implementation of interoperable electronic health records;

Status: HB 2009 predated the passage of federal health reform, which addresses most of the insurance market issues outlined in this section. Federal reform includes an individual mandate, tax credits (premium assistance) within the Exchange. A payroll tax to be considered as a mechanism for financing premium subsidies is also addressed by federal financing of the tax credits offered within the Exchange.

The Health Information Technology Oversight Council (HITOC) has developed a strategic plan for statewide adoption of health information technology and for state wide health information exchange. That plan was submitted to the Legislature on December 30, 2010.

8. Ensure **health care workforce** sufficient in number and training;

Status: The OHPB established and chartered the Healthcare Workforce Committee to coordinate state efforts to recruit, educate and retain health care professionals to meet demand. The Workforce Committee identified three priorities to address both the current workforce needs and needs Oregon might have in the future:

- Prepare the current and future workforce for new models of care delivery;
- Improve the capacity and distribution of the primary care workforce; and
- Expand the workforce through education, training, and regulatory reform to meet the current projected demand of 58,000 new workers by 2018.

The Committee made five short-term actions and seven longer-term strategies to help Oregon move forward in these priority areas. The five short-term actions are:

- Revitalize the state's primary care practitioner loan repayment program;
- Standardize the administrative aspects of student clinical training;
- Re-interpret an "adverse impact" policy that makes it difficult for educational institutions to offer programs in response to industry and community needs
- Maintain funding for health professions education programs; and
- Expand health care workforce data collection

The Oregon Association of Family Physicians (OAFP) has a bill to revitalize the primary care practitioner loan repayment program, and bills are being drafted to standardize administrative aspects of student clinical training and to address the "adverse impact" policy. A bill to expand health care workforce data collection was also pre-session filed.

9. Work with the **Public Health Benefit Purchasers Committee**, administrators of medical assistance program, and Department of Corrections to identify uniform contracting standards;

Status: The Public Employers Health Purchasers Committee was established by the Board to align purchasing policies and standards and to foster collaboration across public employers and other interested health care purchasers. They have defined their work as being the link between policy development and managerial implementation. In that vein, the Committee voted to support the broad adoption of uniform standards for the electronic exchange of information between providers and carriers or third-party administrators (a key recommendation of the administrative simplification work group). Further the Committee voted to endorse contract provisions relating to patient safety similar to those used by PEBB/OEBB and Medicaid and recommends that public and private employers in Oregon

discuss with their carriers or third-party administrator including patient safety standards in their contracts. They also endorsed standardizing payment methods (not rates) to Medicare. OHA has begun to develop a communications and dissemination plan for the Committee, working with counties and cities, to further the adoption of uniform contracting standards.

10. Develop **uniform contracting standards** for the purchase of health care, including the following:

- **Uniform quality standards and performance measures**

Status: Inclusion within OHA contracting is a “next step” from the work of the Incentives and Outcomes Committee.

- **Evidence-based guidelines for major chronic disease management** and health care services with unexplained variations in frequency or cost

- **Evidence-based effectiveness guidelines** for select new technologies and medical equipment;

Status: OHP staff including the directors of the Health Resources Commission and the Health Services Commission have been working with OHSU's Center for Evidence-based Policy to develop a list of potential topics areas of clinical guidelines and a process to review the best comparative evidence, use expert opinion and develop consensus on them.

Initial first topic was jointly identified with the Health Leadership Council (HLC) and the Oregon Quality Corporation (QCorp) who have joined efforts with the state around the treatment of acute low back pain (first 6-12 weeks). Further topics will be based on OHA's lines of coverage utilization and costs and potential ongoing partnership with the HLC and QCorp.

Efforts for widespread dissemination with providers and consumers are under development but will include working with the HRC and the HSC public processes, as well as looking for partnerships with those with expertise such as QCorp and the provider community for multiple best means of communication

- **A statewide drug formulary** that may be used by publicly funded health benefit plans.

Status: When HB 2009 passed there was a drug list for only 30 of the 118 classes of drugs. It was not enforceable in any part of OHA.

- **DMAP:**

- HB 2126 of '09 allowed DMAP to enforce drug list for all non-mental health drugs. Began to enforce on 1/1/10
- Expanded PDL from 30 classes to 85 classes. Enforceable by DMAP for all NON-mental health drugs. Began to enforce on 1/1/11.
- Have started discussions with plans about their using the DMAP PDL. If we are successful in discussions it will start 1/1/12

- **OPDP/OEBB/PEBB/OMIP**

- OEBB and OPDP have same drug list but not the DMAP drug list. Have started process to price DMAP list. Expect to work with OEBB for using DMAP list as part of OEBB's next contract cycle--late 2012
 - Have started discussion with PEBB.
 - Legislative issues:
 - Need authority to create and use a P&T Committee to develop formulary using best evidence. Legislation introduced for 7/1/11 start.
 - Need authority to enforce mental health list. Legislation introduced with 7/1/11 start date.
11. Develop health insurance premium assistance program to all low and moderate income Oregonians;
Status: The federal Affordable Care Act (ACA) establishes a premium assistance (tax credit) program for low and moderate (up to 400% FPL) for all persons purchasing health insurance through the individual or small group market beginning January 1, 2014.
 12. Work with Oregon congressional delegation on federal law/policy changes to promote Oregon's comprehensive reform plan;
Status: Ongoing
 13. Establish **permanent standing committees** as outlined in House Bill 2009.
Status: Two permanent standing committees were established and chartered: Health Care Workforce and Public Employers' Purchasers. In addition OHPB established and chartered an Incentive and Outcomes Committee, a Health Improvement Plan Committee, a Medical Liability Taskforce, Administrative Simplification Workgroup and a Patient-Centered Primary Care Home Standards Workgroup were established and chartered.
 14. While not required by HB 2009, the **Medical Liability Task Force** was appointed by the Board in March 2010 to develop medical liability reform proposals for consideration by the Policy Board and the Legislature.

The Board adopted three of the Task Force's recommendations for action in 2011:

- The legislature should enact a statute explicitly providing that a health care facility or provider's duty to cooperate with an insurer does not preclude disclosure of an adverse event or the reasons underlying it to a patient or the patient's family and that such disclosure may not be the grounds for refusal to defend or for cancellation or nonrenewal of coverage.
- The legislature should consider amending Oregon's "apology" law, which precludes use of statements made to a patient that express "regret or apology" for harm that occurred during treatment to prove liability in a negligence case so that the law clearly protects facilities in addition to physicians and more clearly describes what statements are included in its protection.
- It would be worthwhile for the Legislature or the Oregon Health Authority to sponsor a study to determine whether or not an administrative system could be designed that would achieve the reform objectives the Task Force has enunciated and if so, whether implementation is financially, legally, and politically feasible.

Status: The Office for Health Policy and Research (OHPR) is developing cost estimates for the recommended study of an administrative system. In addition, two bills have been pre-session filed:

- Legislation to amend Oregon’s “apology” law. Clarify that statements of regret or apology may not be used to prove negligence.
- Legislation to prevent liability insurers from canceling coverage or refusing to defend providers who disclose errors to patients.

Finally, there are directives within HB2009 for the Oregon Health Authority that the Board about which the Board has been regularly updated:

15. Implement the statewide registry of Physician Orders for Life-Sustaining Treatment (POLST) with metrics for monitoring and evaluation.

Status: In its first 365 days, the Oregon POLST Registry has received more than 40,000 POLST forms from Oregonians with advanced illness or frailty. The registry, based at OHSU, was officially launched statewide on December 3, 2009.

16. Establish All-Payer, All-Claims Database (APAC) to examine variations in cost and quality within the state.

Status: OHA is in final contract negotiations with Milliman to establish and maintain the APAC. Data is expected to begin flowing in late Spring 2011.

Oregon Health Policy Board
January 18, 2010

Where are we going?

2011 Workplan

1. Health System Transformation (see attached)
2. Implementation of Action Plan: Delivery system, focusing first on the Oregon Health Plan, then stage for statewide.
(See timeline in Action Plan, p. 19-21)
 - Payment reform
 - Patient-centered primary care homes
 - Focused quality and cost improvement efforts
 - Reduce administrative costs
 - Decrease obesity, tobacco use and alcohol and drug abuse
 - Value-based benefit design
 - Expand health information technology (HIT) and (HIE)
 - Focus on triple aim metrics
3. Use purchasing power
 - Identify areas for collaboration and alignment with PEBB/OEBB and Medicaid partners and implement changes
4. Health Insurance Exchange
 - Establish public corporation and governance
 - Complete planning grant
 - Apply for implementation funds

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Health System Transformation Committee Charter

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I. Problem Statement

Like many states, Oregon is facing an unprecedented budget shortfall in its Medicaid program—the Oregon Health Plan (OHP). The cost of health care for state publicly funded health care is an estimated 16 percent of the general fund budget and growing. The services people receive are not integrated, which leads to poorer health outcomes and higher costs. Treatments for physical health, mental health, substance abuse, oral health and long-term care needs are fragmented and are insufficiently tailored to meet the needs of an increasingly diverse population. If we do not act today to rein in these costs and change the delivery of health care, they will continue to overwhelm the state budget even while delivering unexplained and unnecessary variations in cost, quality and outcomes. Given Oregon’s structural budget deficit, we have an imperative.

In short, we have a “burning platform” upon which our health care system rests. The current fiscal climate calls for bold action to design a new, more sustainable platform by fundamentally restructuring our delivery system as an innovative model that doesn’t wait for federal health reform to take effect, but positions Oregon to deliver better health care, better health and lower costs.

II. The Solution

Achieve the Triple Aim Objectives – better health, better care, lower cost—in a newly designed OHP system with the goal of then including broader statewide markets. This will require shared sacrifice, strong leadership and vision for a better future.

The Oregon Health Policy Board’s *Action Plan for Health* outlines eight fundamental strategies to achieve an integrated and coordinated system that cares for people through the full continuum of their lives. The first stage of implementing these strategies is created by the budget imperative: focus first on the Oregon Health Plan.

The transition to a transformed delivery system can be set in motion through the following changes in the OHP:

- Coordinate all benefits, including physical health, mental health and addiction services, oral health and long-term care services, through integrated care and service entities serving geographic areas reflective of natural communities of care. In addition, begin to include coordination of social supports that promote health and keep individuals out of high cost medical care.
- Include all Medicaid eligibles, including dual eligibles and beneficiaries of behavioral health Services
- Pool Medicare and Medicaid Funding for dual/triple eligible to create more efficient use of resources, care management, and to align incentives

- Eliminate fragmentation of mental, physical, and oral health and long-term care
- Develop capitation payments and/or global budgets set at levels sufficient to achieve best-practices, provider incentives for prevention efforts, and address unsustainable growth in health care costs.
- Create a framework within which local/community-based health bodies can assume increasing responsibility for health in their community.
- Build upon best practices that exist within communities

III. Deliverables

The Health System Transformation Committee is chartered to develop a common vision, to assure the needed expertise and cooperation and to provide guidance for operational planning of the new delivery system model based on integration of physical health, behavioral health, oral health and long-term care; the OHPB's Triple Aim goals; and their eight foundational strategies. The model is to be implemented with a goal of achieving substantive changes **no later than July 1, 2012.**

The Committee's charter expires July 1, 2011.

The Committee shall deliver the following:

- An operational plan that outlines **specific, well-defined operational plans** for the key elements of a redesigned delivery system to achieve budget and outcomes goals, including, but not limited to:
 - **Payment reform implementation:** enhanced payment systems for primary care homes, Medicare methodology for hospital inpatient care, innovative systems that reward high-value care.
 - **Benefits and services integration:** includes definition of benefits and services to be provided; definition of an integrated services and health organization; elements of a request for applications/request for proposals.
 - **Triple Aim metrics:** includes definition of Triple Aim metrics by which the health care delivery system will be held accountable at both the statewide and local level.
 - **Value-based benefit plan:** includes development of sequenced implementation of the value-based benefit plan.
 - **Local accountability:** creating a framework within which integrated health and service organizations serving geographic areas reflective of natural communities of care can assume increasing responsibility for health in their community
 - **Global budget:** methodology for development of fixed budget that grows sustainably.

IV. Principles and Policy Objectives

- Services should be population-based, culturally appropriate, and person-centered. They should be provided through individual service plans addressing health, long-term care, and support services.
- Funding streams should be pooled for Medicare and Medicaid services to dual eligibles, so that resources are directed for cost-effectiveness, evidence-based practice, and best outcomes.
- Wasteful spending for health and long-term care service must be reduced as soon as possible to achieve patient safety and savings goals. It is not enough to bend the cost curve gracefully.
- Services should be coordinated across provider types and service settings, including acute care, long-term care (LTC), and public health to emphasize preventive services and to address social and economic issues bearing on health and well-being.
- Appropriate services should be delivered in the least intensive setting feasible given all available support services.
- Delivery systems should be afforded sufficient flexibility to meet beneficiary needs, within budgets, within and beyond services explicitly covered under Medicare and Medicaid.
- Integrated services and health organizations – ISHOs should be developed to administer benefits for Medicaid eligibles on a risk basis in regions of Oregon, based on geographic areas reflective of natural communities of care. These organizations may be based on partnerships including currently contracting Medicare and Medicaid health plans.
- All clients should be enrolled in an ISHO of their choice.
- Payments to both ISHOs and providers should increasingly be based on outcomes rather than on units of service.
- Beneficiaries should be involved in delivery system reform planning.
- Effectiveness of performance monitoring and metrics (including quality of care and beneficiary safety) must be increased to match the expanded scope of services across divergent settings of care.
- Savings should be shared by federal and state government and also used to invest in the development of infrastructure, population health management, delivery of enhanced services (including case management and support services), and oversight of ISHO and provider performance. The state will use its share to address quality of service and beneficiary safety issues, and to reduce the rate of growth in expenditures for health and LTC services.

V. Timing

- The Committee work plan will be completed by February 14, 2011.
- The Committee will provide a model with budget savings/estimates to the Board and the Governor's office by April 4, 2011.

- The Committee will provide the operational plan for delivery system redesign within the Oregon Health Plan as outlined in Section III, Deliverables, by June 1, 2011, including elements that would be included in future request for proposals for integrated service delivery.

VI. Staff Resources

The Oregon Health Authority will provide staffing to the Committee.

VII. Committee Membership

(TBD)

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Oregon Health Policy Board

How are we going to get there?

Oregon Health Policy Board

**Health System
Transformation
Committee**
(Chartered for 6 months)

Committee structured to represent a broad range of stakeholders including public health, long term care, behavioral health, providers, insurers, labor, advocates, hospitals, Medicaid managed care, etc.

**Health Care Workforce
Committee**
(qtrly mtgs, possibly reconfigure)

**Public Employers Health
Purchasing Committee**

**Incentives and Outcomes
Committee**
(hiatus, reconfigure)

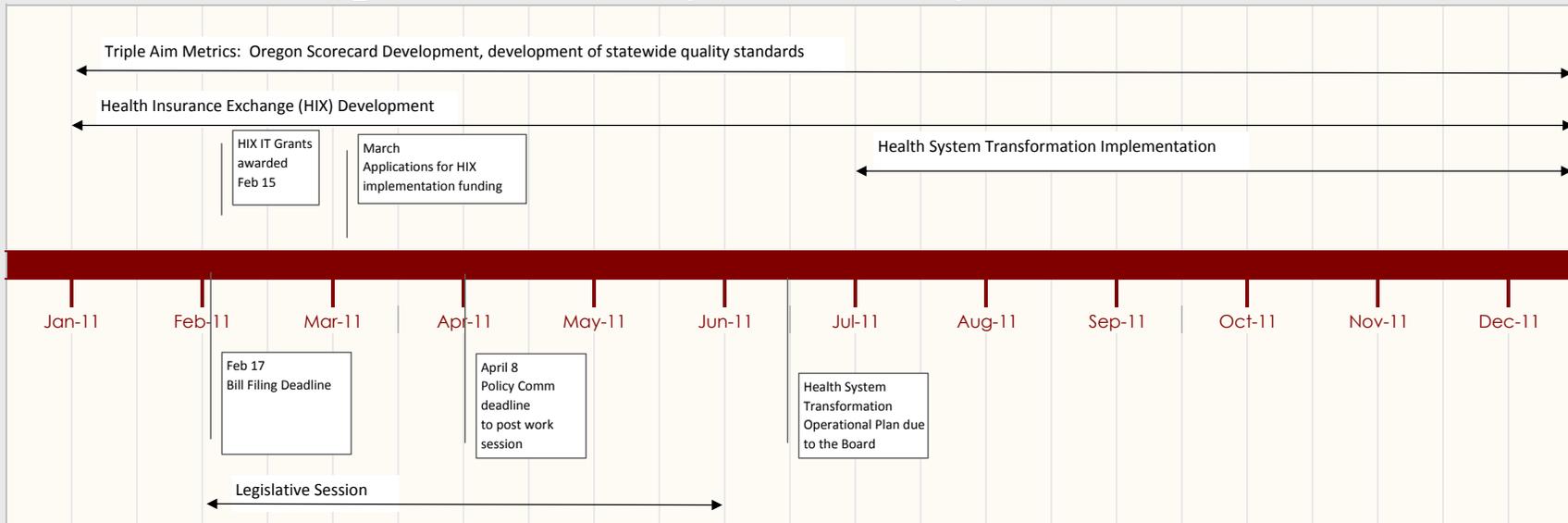
**Health Improvement
Plan Committee**
(hiatus, reconfigure)

**Administrative
Simplification
Workgroup**
(re-establish in Sept)

Health Information Technology Oversight Council
(HITOC)

Equity Review Committee
Safety Net Advisory Council
Medicaid Advisory Council

Oregon Health Policy Board Workplan Timeline - 2011



Health System Transformation Budget Work
 Health System Transformation Operational Planning
Health System Transformation Committee