

Oregon Health Policy Board

AGENDA

March 8, 2011

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 Action item: Consent agenda 2-8-11 minutes	Chair	X
2	8:35	Director's Report	Bruce Goldberg	
3	8:45	PEBB/OEBB Update	Joan Kapowich	
4	8:55	Medicaid Update	Judy Mohr-Peterson	
5	9:05	Summary report from January retreat: Driving system change through a Medicaid/PEBB/OEBB purchasing strategy	Diana Bianco	
6	9:30	Oregon Health Insurance Rate Review Process	Teresa Miller	
	10:15	Break		
7	10:30	Health System Transformation Team Update • Transformation savings • Legislative concepts	Bruce Goldberg Mike Bonetto	
9	11:15	Invited Testimony		
10	11:45	Public Testimony		
11	Noon	Adjourn		

Next meeting:

April 12, 2011

1:00 pm to 4:30 pm

Location: TBD

Oregon Health Policy Board
DRAFT Minutes
February 8, 2011
1515 Market Square
1:00-3:30pm

Item

Welcome and Call To Order

Chair Eric Parsons called the Oregon Health Policy Board (OHPB) meeting to order. All Board members were present, except for Joe Robertson, Felisa Hagins and Nita Werner. Chuck Hofmann and Eileen Brady participated by phone. Tina Edlund was present from the Oregon Health Authority (OHA).

Consent Agenda:

Minutes from the January 18, 2011 meeting were unanimously approved.

Director's Report – Tina Edlund

- Tina gave an update on the Health System Transformation Team and encouraged everyone to follow its progress
- John Kroger, the Attorney General filed an amicus brief on the individual mandate and testified before Congress
- Healthy Kids enrollment is almost to 80,000 children

This report can be found [here](#), starting on page 4.

Update on Health System Transformation Design Team – Mike Bonetto

- Mike discussed the roster and charter, and the updated time frame
 - ❖ In year one, the focus is on looking at reduction in payments and benefits to meet budget targets.
 - ❖ In year two, the delivery system transformation savings will be implemented in the Oregon Health Plan (OHP).

This presentation can be found [here](#).

Long Term Care in Oregon: Opportunities for Integration – James Toews and Invited Guests

- Oregon's long term care program is recognized nationally.
- The program uses a social model with eligibility and service planning organized around supports for activities of daily living, not needed medical services.
- Seniors and People with Disabilities (SPD) now directly manages six separate waivers and, together with the Division of Medical Assistance Programs (DMAP), multiple Medicaid State Plan Options.

This presentation can be found [here](#).

- Mr. Jerry Cohen, State Director for AARP Oregon spoke to the Board about coordinated care. He voiced three concerns:
 - ❖ Service and quality reductions – incentive to squeeze providers
 - ❖ Continuity of care and stability of the network
 - ❖ No guarantee of cost savings
- Mr. Jim Carlson, President of the Oregon Health Care Association provided some facts about the long term care system:
 - ❖ Over 80% of Medicaid long term care clients are served in home and community based services (HCBS)
 - ❖ Oregon serves fewer Medicaid clients in long term care today than in 2003
 - ❖ Areas to focus on are unnecessary hospitalizations (trips to the ER) and drug utilization and costs
- Mr. Arthur Towers, Political Director of SEIU Local 503 spoke to the Board about home health providers:
 - ❖ Because of improved wages and benefits, home health providers stay in the field longer
 - ❖ The proposed budget cuts could affect the work home health workers are paid to do, which affects the lives of the people they care for
- Lucy Morgan, representing the Governor's Commission on Senior Services (GCSS), spoke to the Board about options the GCSS has been considering to provide better care at lower cost:
 - ❖ Vans that travel to communities and provide screenings for diabetes, alcohol abuse and

- depression
- ❖ Wireless pill boxes that can help remind a person to take pills and let children who don't live in the same house know that their parent has taken his or her pills
- ❖ Sensors that let children know their parents are up and moving around
- Ellen Garcia, the Executive Director of Providence ElderPlace, gave a presentation about Program of All Inclusive Care for the Elderly (PACE):
 - ❖ Provider based program
 - ❖ Interdisciplinary team approach
 - ❖ Assumes full risk until death or discharge – meeting long term needs
 - ❖ 20 years of experience managing medically complex care with capitation
 - ❖ As of February 2011, there are 912 participants enrolled in PACE.
 - ❖ PACE clients have a lower risk of dying than clients in HCBS. By their third year in PACE, only 29% of clients had died, compared to 45% of HCBS clients.

This presentation can be found [here](#).

Public Testimony

Ruth Gulyas – Executive Director, Alliance of Senior and Health Services

Ms. Gulyas provided information to the Board about the work her organization has been doing, particularly in looking at how technology can help improve care.

David Fuks – CEO, Cedar Sinai Park

Mr. Fuks brought forward concerns voiced by not-for-profit providers, such as how to preserve rural providers and faith-based and culturally specific providers. He raised questions intended to begin a dialogue, focusing on system changes and sustainability.

Bonnie Matsler

Ms. Matsler spoke to the Board about leaving room for exceptions. She spoke about an experience she had in which care was very difficult to obtain because her situation kept precluding her from receiving services from several different avenues.

Mary Shortall – Aging and Disability Services, Multnomah County

Ms. Shortall urged the Board to ensure case managers have an active role in the future system, as they provide a valuable service in coordinating care.

Adjourn 3:40 pm

Next meeting:

March 8, 2011

8:30am – noon

Market Square Building

1515 SW 5th Ave, 9th Floor

Portland, OR 97201

**Monthly Report to
Oregon Health Policy Board
March 8, 2011**

Bruce Goldberg, M.D.

PROGRAM AND KEY ISSUE UPDATES

Healthy Kids Program

Enrollment

- Through January 2011, just over 78,000 more children have been enrolled into Healthy Kids.
- This is 98% of our goal of 80,000 more children and a 29% increase in enrollment since June 2009 (baseline).
- Just over 4,000 children are now enrolled in Healthy KidsConnect.
- See the chart below for a more detailed look at Healthy Kids enrollment.

Outreach and Marketing

- To date, we estimate that our outreach grantees and application assisters have provided application assistance to about 12,000 children. (This doesn't include all the outreach work they do that prompts families to apply for healthy kids on their own.)
- Office of Healthy Kids is working with providers to better engage them in outreach.
- Now that Healthy Kids brand is beginning to take hold, the next phase of marketing campaign under development. (Will begin to see shift in ads from basic explanation of program – “Your child can have health coverage” to more values / emotional messages.)
 - Both marketing and outreach campaign will begin to focus even more heavily on moderate and middle income families.
- Also in process of creating targeted marketing campaigns for the African American and American Indian communities.

Eligibility System Improvements

- OHA and DHS are one of 9 states just awarded a grant from the Ford Foundation to improve eligibility policies and practices, as well as provide the Federal government with important feedback regarding eligibility for the rollout of the 2014 coverage expansions.
- Using HRSA grant funds, just hired consultant (AKT) to conduct outside review of all eligibility policies and practices to help us continue to identify opportunities to streamline and improve the eligibility process.

OHP Standard

- As of January 15, 2011, enrollment in OHP Standard is now **68,352**.
- There have now been fourteen random drawings to date. The last drawing was on December 15, 2010 for 10,563 names.
- The program will implement a 12 month certification period in March, 2011. Eligible applicants and current enrollees who qualify on or after March 1, 2011, will be granted 12 months of benefits. Previously, the certification period was six months.

Health Insurance Exchange IT Early Innovator Grant

On February 16, the Oregon Health Authority was named as one of seven states to receive an “Early Innovator” grant to design and implement the information technology (IT) infrastructure needed to operate our Health Insurance Exchange. The award is worth just over \$48 million. It is truly a testament to all the hard work put into this project by the Oregon Health Policy Board and OHA staff over the last year.

Legal Status of Federal Health Reform

On January 31, 2010, a U.S. District Court Judge in Florida ruled that the Affordable Care Act (ACA) was unconstitutional. On March 3, he issued a stay of his ruling, allowing implementation of the ACA to continue in Florida while appellate courts review the constitutionality of the ACA.

The initial ruling was the result of a lawsuit brought by 26 states and the National Federation of Independent Business, which argued that the individual mandate is outside the scope of Congress’s powers under the Constitution.

In total, three federal judges have ruled that Congress has the authority under the Commerce Clause of the Constitution to require Americans to get health insurance. Two judges have concluded that the requirement is not constitutional.

Oregon’s Attorney General has been invited to join the Board at its May meeting to review the legal status of federal health reform and his amicus brief arguing the constitutionality of the individual mandate.

Upcoming

Next OHPB meeting:

April 12, 2011

Market Square Building

Next Health Systems Transformation Team meeting:

March 9, 2011

Putnam University Center

Willamette University

**Oregon Health Policy Board
January 18, 2011**

**Using the State's Purchasing Power: Coordination among PEBB, OEBC and Medicaid
Summary of Group Discussion**

Members of the Oregon Health Policy Board, representatives from the Medicaid program, and some board members and staff from OEBC and PEBB came together to discuss how Medicaid, PEBB and OEBC might work together to drive system change. Participants talked in small groups and reported back to the full group. A summary of the small group conversations and the report-out is below.

Priority ideas for coordination

We asked each group to share their top ideas for coordination between PEBB, OEBC and Medicaid:

- Delivery system and payment reform are linked and must be addressed simultaneously. We can use the Exchange to integrate the two goals. Pursuing delivery system change along with aligned purchasing encourages competition;
- Focus on partnerships to achieve payment reform. For example, start by having hospitals move to a DRG-based system;
- Partner with others and use a common set of evidence-based/value-based care treatment standards (where evidence exists). We could use the prioritized list as a basis. Barriers include where evidence may not be available (oral health) and the political challenge of legislative involvement when access is restricted in Medicaid (even on the basis of evidence);
- Together, promote the development of a more robust primary care system;
- Incremental alignment can lead to integration. Start with an effort like a shared DME formulary and go from there.

Next steps

We asked the group how we should move forward:

- Keep talking and provide more time for the conversation – the idea of aligning purchasing makes sense;
- Create a workplan for how the three entities can align;
- Joan Kapowich will talk with OEBC and PEBB boards about the discussion and hear their ideas for moving forward;
- Figure out who else should be included in the conversation. For example, provider groups can help determine how payments are made;
- Look at global budgeting for OHP as soon as possible;
- Solidify common metrics tied to the Triple Aim. Use the same language to get to the same outcome.

Additional ideas from small group discussions

The breakout groups brainstormed a number of additional ideas for working together:

- Push providers to give more value for cost;
- Use a shared risk strategy;
- Use the Exchange as a tool to reach shared goals;
- Support shifting the focus to prevention by changes in financing. If we want integration in services, we must integrate payment;
- Consider aligning benefit packages. There also should be aligned payment methods. In this way, we start to make PEBB, OEBC and OHP more similar;

- Emphasize primary care and de-emphasize specialty care. Raise payments to primary care.

Other ideas and considerations

The small groups discussed a number of issues that are relevant as OEBC, PEBB and Medicaid consider more coordination and collaboration:

- **Increased purchasing power can be the key to transforming the delivery system.**

Rolling the groups together can help force payment reform. The challenge is that it would only impact state-controlled lives.

 - One thought is this can be an iterative, progressive alignment. An analogy is that it is more like tributaries of a river coming together to meet at a final agreed-upon ending point, rather than a lake that eventually all filters out into the same river. In other words, we do not have to clump all the plans together at the beginning and force them forward in an aligned way. Rather, we can allow for a more natural alignment. Setting final goals and priorities, and letting health benefit plans move there incrementally -- maybe even on different paths from one another.
 - OHP/PEBB/OEBC could be the early "Apollo" missions to show this kind of effort -- to realign payment and change the delivery system -- can be successful.
- **We are talking about a new social contract for all parties.**
 - How do we create enough will/power for change? An agreed-upon social contract makes clear the expectations for a better system -- the system will care for you not just a specific provider(s).
- **Perception is important.**
 - How do we deal with the public perception of rolling the groups together? Messaging is important to convince the public, as well as providers that this is a great idea.
 - If people see that OHA affiliates are all moving *together* in the same direction, even if it is iterative movement and not one all-at-once group leap, people will see that and maybe not immediately jump to conclusions such as: "You are sticking me in the Oregon Health Plan? I think not!!"
 - It's much easier, too, for contract negotiations, when you can point to recent successes that plans have had with implementing payment and delivery system reforms. And you can say, "look others are doing this already *and* it's working."
- **Challenges exist for integrating OEBC, PEBB and Medicaid.**
 - We need to figure out a way to avoid Medicaid stigma. We can use the Exchange to do that.
 - The disparity of payment rates between PEBB/OEBC and OHP can make it difficult to buy more for less simply by aligning purchasing power.
 - Medicaid doesn't have competitive bidding. Only bargaining power is with providers and that is limited. Must guarantee access, so ability to negotiate is limited.
 - There is a challenge in breaking down silos even in OHA to align purchasing.
- **We need to ensure accountability.**
 - We need to ensure accountability across all lines of purchasing.
 - How do we create regional accountability? ACOs and other regional models will have to show they can deliver the benefits we expect.
- **We need to create metrics so we know when we've been successful.**
 - It is important to identify *what* success looks like, which is really just another way of stressing the importance of driving change towards uniform, aligned priorities.
 - Metrics also need to be aligned and coordinated, so we can effectively compare plans and compare reform efforts and programs. Solidifying metrics will take buy-in from

stakeholders on all sides. It may be a good idea to write metrics into benefit contracts.

- We need overt patient and “user” satisfaction metrics in any redesign.
- We must be able to communicate our successes to other purchasers.
- **Collaboration is key.**
 - It is important to connect and realize strategic partnerships to leverage change. Coordination is critical to achieve transformation.
 - There should be a system of best practices that allows plans, especially on a local level, to share, compare and collaborate on reform efforts.
 - How do we create incentives to collaborate?
- **Other considerations**
 - What is the risk vs. reward for using strong purchasing power, especially in smaller “one-hospital” communities?
 - PEBB is viewed very favorably and has clout. But some providers have the same amount of clout.
 - A new system should be co-designed with “users” that include patient, providers and others.
 - Operationalizing a policy framework is difficult (i.e. PEBB and OEBC have bold visions but been harder in practice)
 - Don’t reinvent what we already know how to do. Just do it.
 - Let provider groups decide how they distribute funds.
 - We need better “social” service connections with education, etc, so the health care system is not “catching” the shortcomings of other “social contract” systems.
 - One way to achieve our priorities is to set them up and let plans compete to get there.
 - We should maintain an open forum and dialogue about changes that are being made.
 - Granular level conversations are important.
 - Ensure that we are really redesigning the system.
 - Don’t forget long-term care.

* * * * *

The group agreed it would like to meet again to further discuss ideas for working together.

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Oregon Insurance Division

Health Insurance *Rate Regulation*

Financial Regulation

- Financial exams (at least every 5 years)
 - Sample claims
- Quarterly statements
- Independently audited annual statements

Policy Form Review

Read health policies to ensure:

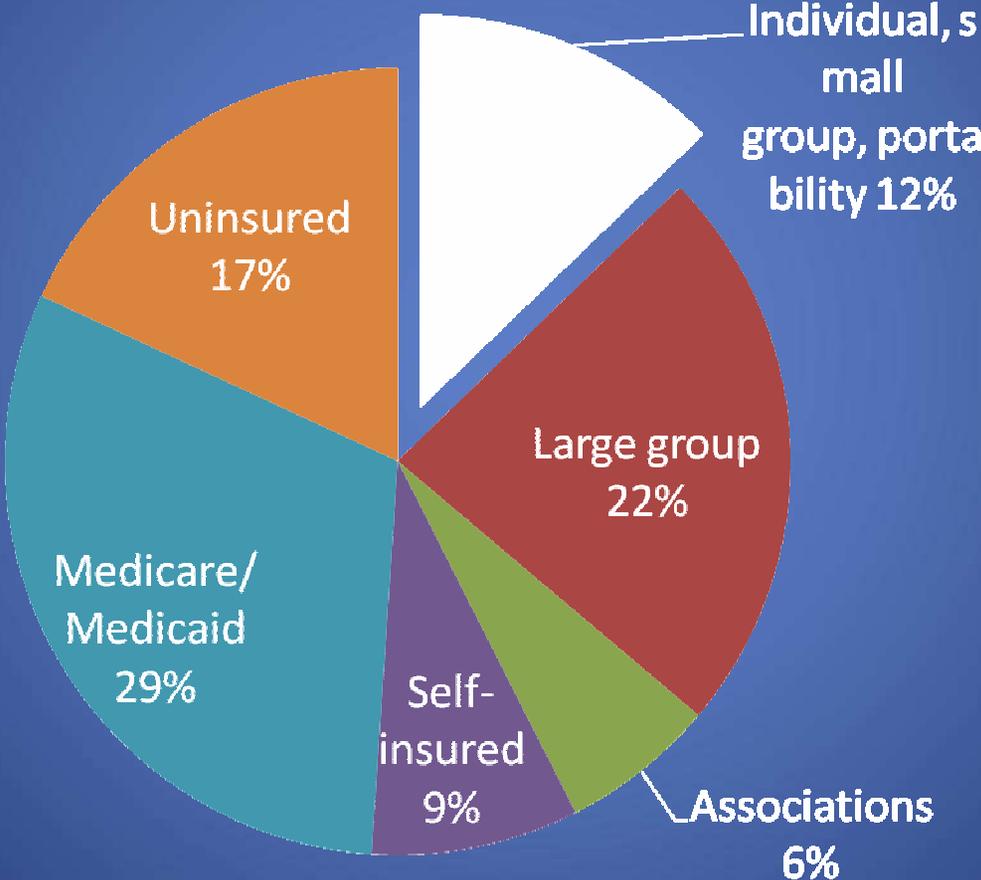
- Mandated benefits are included
- Consumer protections are included (claims handling)
- Compliance with new federal reform law

*Rates must be reasonable
in comparison to benefits*

Oregon Rate Review Law

- Oregon has one of the strongest rate review laws in the country
- Model for other states

Markets Subject to Rate Review



Rate Review Process

- Insurer submits rate filing at least 60 days before proposed effective date
- Rate filing (request) posted on website
- All information submitted with rate request is public
- Includes summary of rate request with 5-year history of rate increases

Rate Review Process

- Website posting triggers:
 - 30-day public comment period
 - 40-day timeline for the division to review the filing and issue decision. (Decision due 10 days from close of comment period)
- Department summary explains decision

Rate Review Law

Disapprove rates if...

“benefits ... are not reasonable in relation to the premium charged”

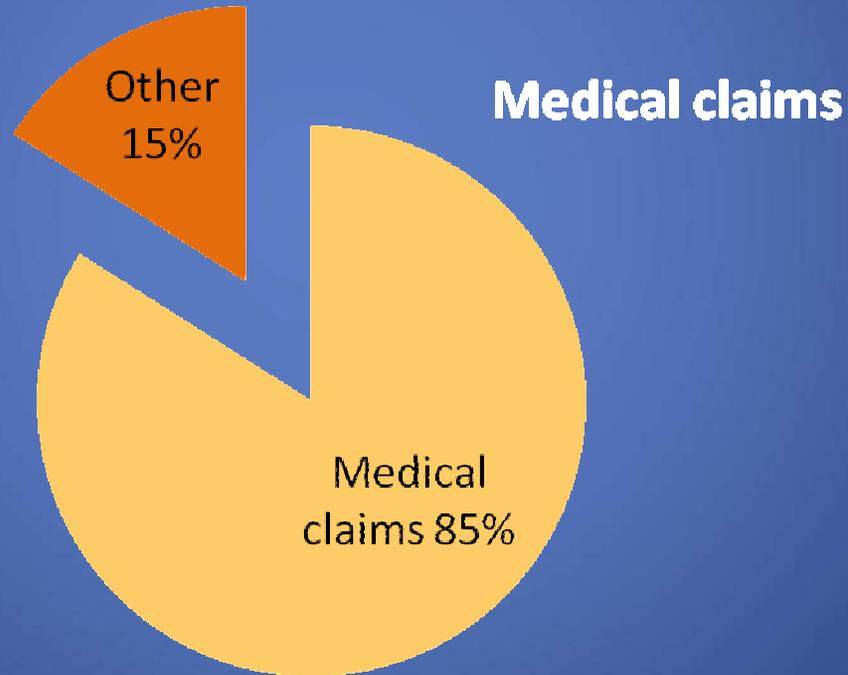
Approve rates that are...

“Reasonable and not excessive, inadequate or unfairly discriminatory”

- Is the aggregate rate request justified?
- Is the request fairly allocated among ratepayers?

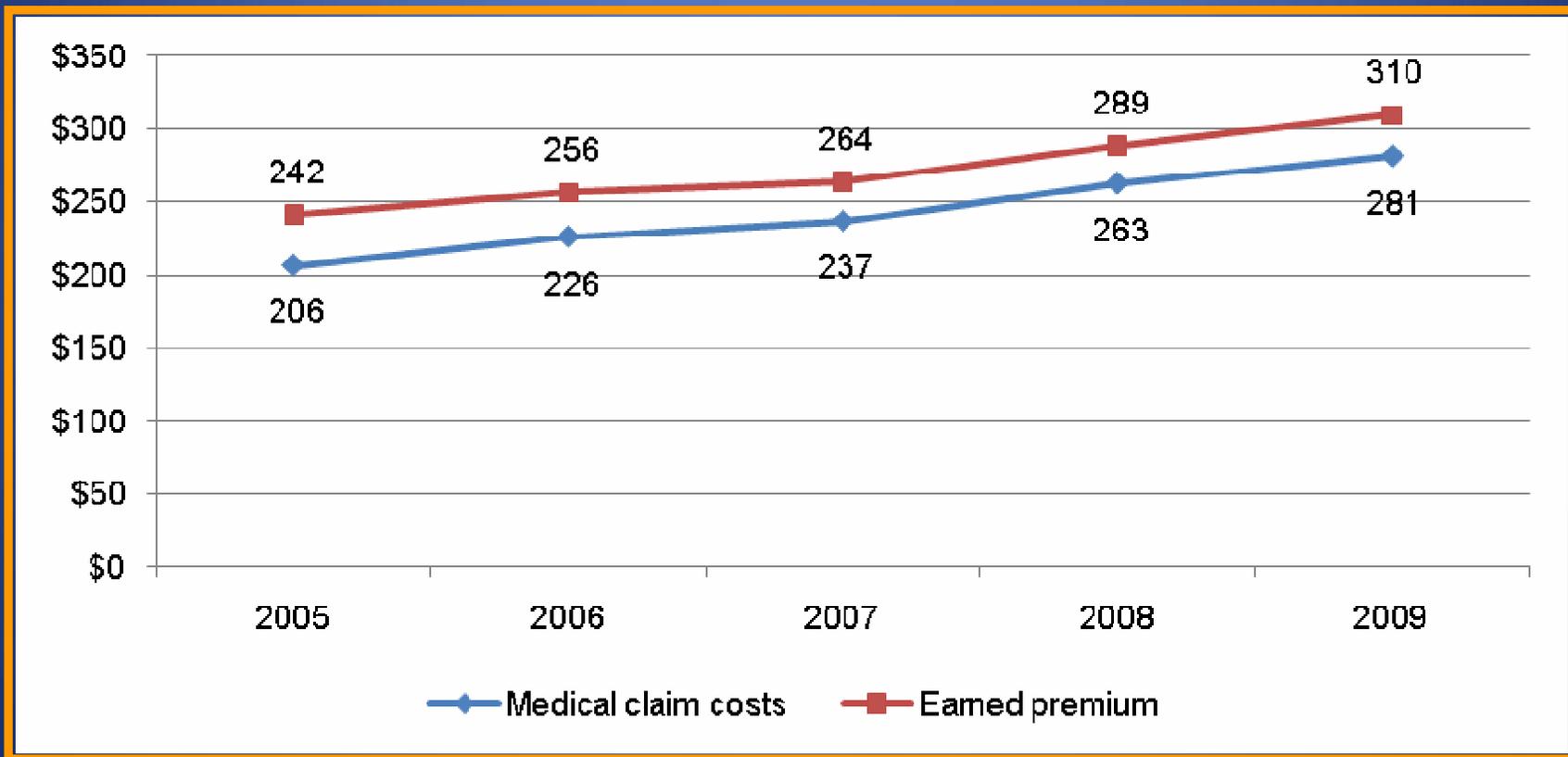
Rate Review Factors

Past and Projected Loss Ratios



Medical Claims Costs

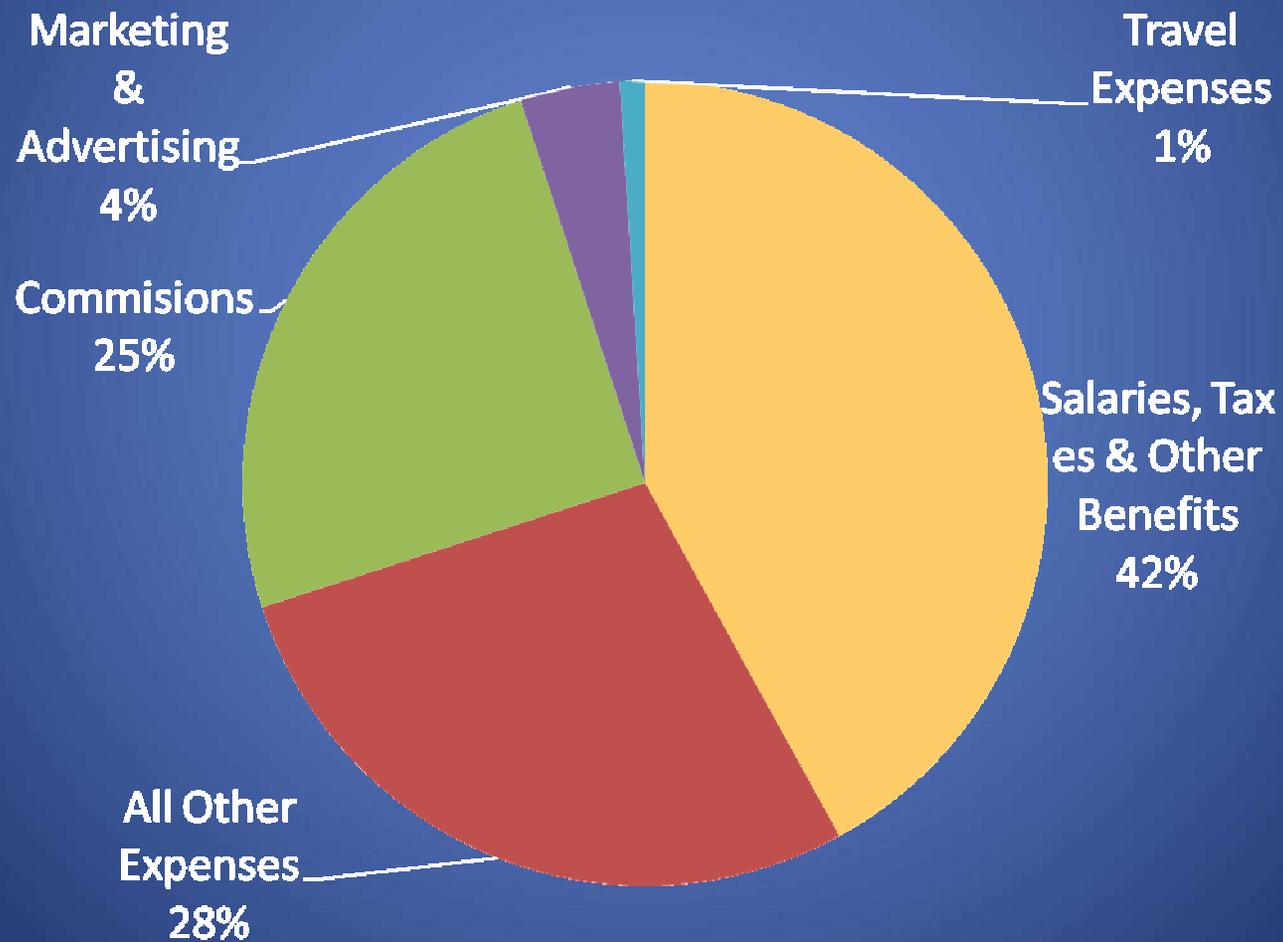
Monthly Premium vs. Medical Claims Costs



Past and Projected Claims Costs

- Two parts to claims costs (trend)
 - Medical inflation
 - Use
- Recent filings show Oregon medical claims costs increasing by 12 percent a year

Administrative Costs



Insurer Profit

Seven largest insurers; all markets

1%

2009

3%

2010

2%

10-Year
Average

Surplus and Rate Review



- The department is careful about using surplus/overall profitability to mitigate rate increases
- Artificially low rates = greater increases in the future

Profit (Loss) in State-Regulated Markets

Recent rate filings

-2.0%

Small Group

-5.6%

Individual

Benefit Issues

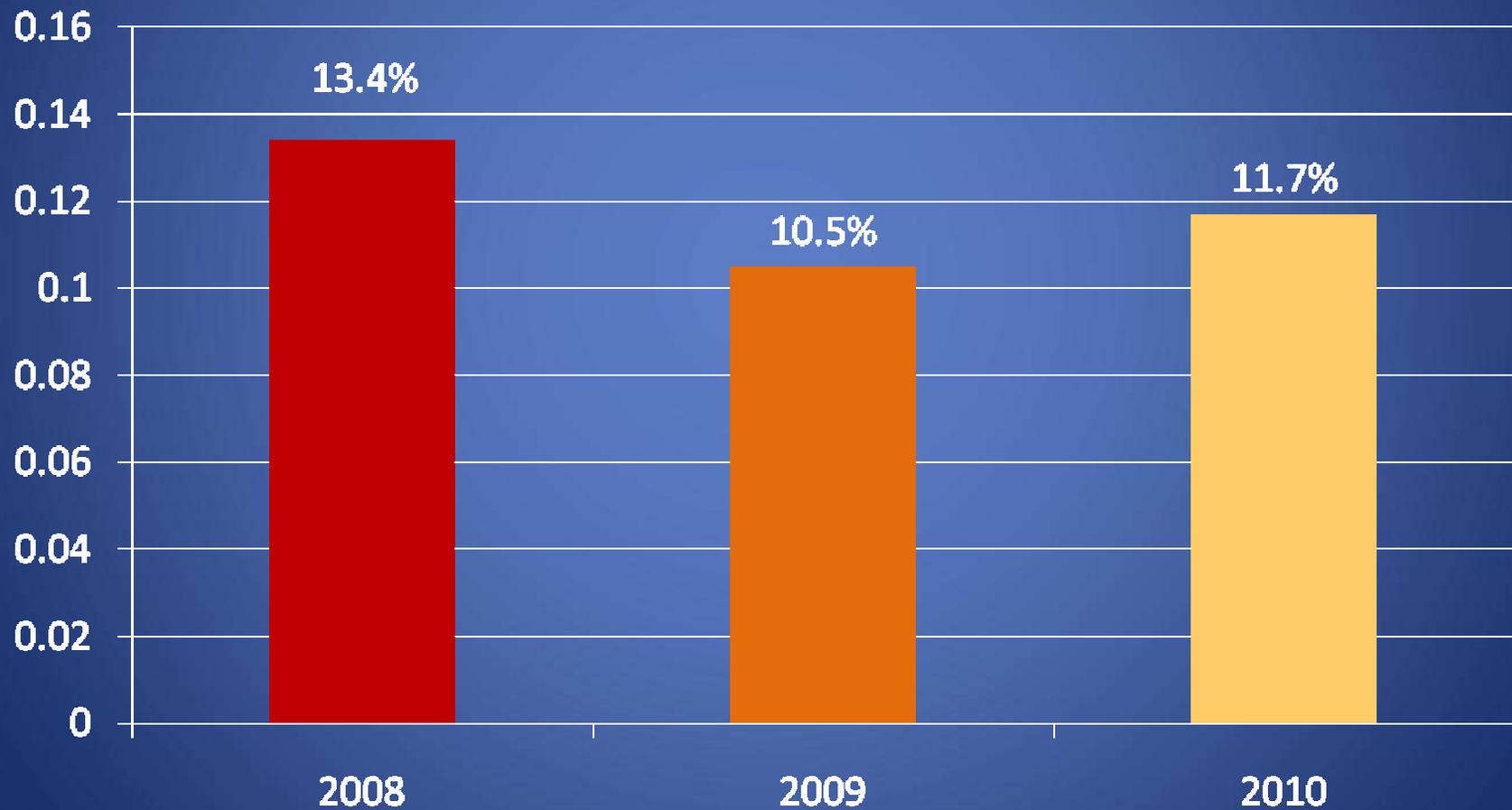
- Federal reform (1-4 percentage points)
 - Preventive care (no cost sharing)
 - Child coverage to age 26
 - No lifetime maximums
 - Must cover kids with preexisting conditions

Distribution of a Rate Increase

- Families with more than 1 child pay more
- Enrollees in a particular geographic region may see a higher or lower increase

Average Rate Increases

Small employers



Recent Small Employer Rate Requests

Company	Requested	Approved
Regence	17.1	15.5
Kaiser	9.2	9.2
PacificSource	15.4	15.4

Oregon Premiums vs. National Small group market, 2009



Oregon Ranking

1

Alaska, \$14,975

35

Oregon, \$11,319

51

Montana, \$9,510

Rate Review Summary

- We have the authority we need to scrutinize rate requests
- Federal grants gave us an additional actuary/market analyst and other staff to...
 - conduct more detailed review
 - provide more consumer-friendly information

Summary

To bend the cost curve, we must understand and address increases in medical claims

- All-payer, all claims database
- Study on ways to use rate review process to address underlying health care costs
- Oregon Health Authority's Action Plan

Health System Transformation Saving Opportunities

Overall Strategy: Improve quality of services, thereby eliminating inefficiency that unnecessarily contributes to high health care costs.

Assumptions for estimating savings opportunity:

- 1) The cost of the US health care system could be reduced 34% by eliminating \$850 billion in inefficiencies (Thomson Reuters). The three categories of improved efficiency outlined in the table below account for \$525 billion of the inefficiency across the US health care system.
- 2) For each category of inefficiency, the proportion of total spending that is quality-related inefficiency is the same for Medicaid in Oregon as it is for all US health care spending.
- 3) Savings from transformation strategies are taken as a percent of spending after payment and benefit reductions assumed in the Governor’s Balanced Budget (GBB).

Category of Inefficiency	Examples: Quality Issues that Drive Spending (Savings strategies identified by the Oregon Health Policy Board and the HSTT)	% of Total Health Care Spending Represented by Category	GBB target Reduction in Medicaid Spending for 2011-13 Biennium
Preventable conditions, avoidable care, and lack of care coordination	<p>Avoidable ED visits: An employed man reported to the emergency room with an infected foot, having been unable to get in to see his physician at a time when he could get off work; due to the progression of the infection, he was hospitalized for treatment of sepsis.</p> <p>Avoidable hospitalization: An individual with a mental disease controllable with prescription drugs loses her job and cannot afford her medication; she is hospitalized when she behaves inappropriately and frightens her family.</p> <p>Avoidable readmission: An elderly person with diabetes is discharged to a nursing facility following a hospitalization for a hip fracture; she is given appropriate pain medications and antibiotics and</p>	4.1%	-1.3% -\$27.1m general fund

Health System Transformation Saving Opportunities

Category of Inefficiency	<p style="text-align: center;">Examples: Quality Issues that Drive Spending (Savings strategies identified by the Oregon Health Policy Board and the HSTT)</p>	<p style="text-align: center;">% of Total Health Care Spending Represented by Category</p>	<p style="text-align: center;">GBB target Reduction in Medicaid Spending for 2011-13 Biennium</p>
	<p>told she should see her surgeon for follow-up. While the nursing facility is advised of her physical rehabilitation needs, the facility is not familiar with her other medical issues. Her primary care physician is not notified of either the hospital or nursing home admission. She returns to the hospital with symptoms of hypoglycemic shock within 14 days.</p> <p>Savings strategies identified by HSTT:</p> <ul style="list-style-type: none"> • <i>Change payment to incent primary care homes and enhanced care coordination. (Estimated savings for providing primary care home for adults with chronic conditions in FFS and managed care in the second year of the biennium: \$13m GF.)</i> • <i>Pay for enhanced coordination and effective care (TBD)</i> 		
<p>Unwarranted Use</p>	<p>Inappropriate choice of diagnostic test: A patient comes to her physician office having injured her foot playing ball; her physician orders an MRI when an X-ray would have been sufficient for diagnosis.</p> <p>Inappropriate surgery: A young man has an onset of back pain after helping a friend move. Rather than following a conservative treatment protocol, he is referred to a surgeon who performs surgery within a month of the injury.</p> <p>Inappropriate treatment: An individual who has suffered upper respiratory systems for five days asks her physician for antibiotics. They are ordered although the condition is unlikely to respond to them.</p> <p>Defensive medicine: For example, an ER doctor ordering an abdominal CAT scan for a nursing home resident presenting with abdominal pain that is most likely to be benign in nature, performing breast biopsies in women with lumps unlikely to be cancer, or hospitalizing low-risk patients with chest pain.</p>	<p>13.6%</p>	<p>-8.7%</p> <p>-\$185.0m general fund</p>

Health System Transformation Saving Opportunities

Category of Inefficiency	<p style="text-align: center;">Examples: Quality Issues that Drive Spending (Savings strategies identified by the Oregon Health Policy Board and the HSTT)</p>	<p style="text-align: center;">% of Total Health Care Spending Represented by Category</p>	<p style="text-align: center;">GBB target Reduction in Medicaid Spending for 2011-13 Biennium</p>
	<p>Savings strategies identified by HSTT:</p> <ul style="list-style-type: none"> • <i>Eliminate payments for marginally effective treatments. (Estimated savings from eliminating payment for the least effective 5% of treatment for covered diagnoses: \$43m GF.)</i> • <i>Tighten restrictions on prescribing brand name drugs where good generic options are available. (Estimated savings from limiting utilization of non-preferred drugs: \$1.6m GF. Included in GBB benefit changes.)</i> 		
<p>Service Delivery Errors and Inefficiency</p>	<p>Hospital acquired infections: A man is catheterized in connection with treatment for heart attack; he is infected as a result. His stay is extended and the hospital bills for his visit at a higher rate.</p> <p>Inefficient facility use: A nursing home sends a resident with symptoms of disorientation to the hospital ED rather than calling in a professional to see her on-site. As a result, Medicare rather than Medicaid-paid facility bears the cost; but the resident's life is disrupted and total cost is higher.</p> <p>Inefficient provider use: A patient reports a plugged ear. A physician, rather than a nurse or other health worker, removes the wax.</p> <p>Savings strategies identified by HSST:</p> <ul style="list-style-type: none"> • <i>Eliminate payment for never events and healthcare-acquired conditions. (TBD)</i> 	<p>4.1%</p>	<p>-1.3%</p> <p>-\$27.1m general fund</p>
<p>Totals</p>		<p>21.8%</p>	<p>-11.2%</p>

Health System Transformation Saving Opportunities

Category of Inefficiency	Examples: Quality Issues that Drive Spending (Savings strategies identified by the Oregon Health Policy Board and the HSTT)	% of Total Health Care Spending Represented by Category	GBB target Reduction in Medicaid Spending for 2011-13 Biennium
			-\$239.2m general fund

Health System Transformation Saving Opportunities

Overall Strategy: Work out an agreement with CMS that Oregon will share in savings that accrue to Medicare

Assumptions for Medicare Savings:

1. Oregon receives approval from CMS to receive 2/3 of savings that would have accrued to Medicare for dual eligible individuals during the 2011-13 biennium.
2. For each category of inefficiency, the proportion of total spending that is quality-related inefficiency is the same for Medicare spending in Oregon as it is for all US health care spending.
3. The Medicare expenditure total in Oregon for 1 year is estimated to be \$1.1 billion.
4. These savings are assumed in both the traditional Medicare program and Medicare managed care.

Category of Inefficiency	% of Total Health Care Spending Represented by Category	Potential HSTT savings to Medicare by category (in millions)	Amount if 2/3 of Medicare savings is shared with Oregon
Preventable conditions, avoidable care, and lack of care coordination	4.1%	1.3% \$14.0m	\$9.2m
Unwarranted Use	13.6%	8.7% \$95.7m	\$63.2m
Service Delivery Errors and Inefficiency	4.1%	1.3% \$14.0m	\$9.2m
Totals	21.8%	11.2% \$123.7m	\$81.6m

Health Systems Transformation Team
LEGISLATIVE CONCEPT
Preliminary Synopsis for Discussion Purposes

Primary Sources:

Oregon Health Policy Board – Oregon’s Action Plan for Health (Dec. 2010)

And reports of OHPB advisory groups

Governor Kitzhaber’s Budget Report (January 2011)

Meetings of the Health System Transformation Team

Assumptions:

- This LC does not make any changes to eligible populations or covered benefits.
- This LC uses the existing statutory framework in ORS Chapter 414 (Medical Assistance) to describe changes to statute appropriate for transformed delivery system that applies integrated health and services.

Key features of LC discussion draft:

- Goals and policies for integrated health care and services
 - Adopt the goals of improving the health of Oregonians, increasing quality, reliability and available of care, and reducing costs of care.
 - Care and services are integrated and coordinated, including physical health, mental health, addictions treatment, oral health, home and community based services, and long term care services and support.
 - Consumers get the care and services they need, coordinated locally with access to statewide resources when needed.
 - People are at the center of coordinated care and services delivered through accountable care organizations using alternative payment methodologies that shift the focus to prevention, improve health equity, and utilize person-centered primary care homes, evidence-based practices and health information technology to improve health and health care.
- An accountable care organization is a single integrated organization that accepts responsibility for the cost within its global budget and for delivery, management and quality of the full continuum of care delivered to the specific population enrolled with the ACO.
- Essential elements of an ACO include (summarized);
 - (a) Work cooperatively with community partners to address public health issues;
 - (b) Health equity is prioritized and disparities are reduced;
 - (c) Actively engages consumers in making its decisions that impact the populations served, the communities where it is located, and decisions about how integrated care is delivered;
 - (d) Person-centered, providing integrated person-centered care and services designed to provide choice, independence and dignity;
 - (e) Individuals have a consistent and stable relationship with a care team that is responsible for comprehensive care management and service delivery, including comprehensive transitional care;
 - (f) Local access to care, including use of community health workers and nontraditional settings that are accessible to families, diverse communities and underserved populations, and referral to community and social support services, with access to statewide resources when needed;

Health Systems Transformation Team
LEGISLATIVE CONCEPT
Preliminary Synopsis for Discussion Purposes

- (g) Use of health information technology links services and care providers across the continuum of care and services as feasible and appropriate;
 - (h) Strong safeguards for consumers are established;
 - (i) Prioritize working with ACO members with high needs and multiple chronic conditions, mental illness or chemical dependency to involve them in accessing and managing appropriate preventive, health, remedial and supportive care and services;
 - (j) ACO providers work are educated about the integrated approach, emphasize preventive resources, healthy lifestyle choices and evidence-based practices, shared decision-making, and communication;
 - (k) Providers work in care teams responsible for individuals, including providers and community resources appropriate to the individual's needs as a whole person, and work with the individual to develop an individual care and service plan;
 - (l) Quality indicators are used; and
 - (m) Demonstrate excellence of operations.
- Related implementation changes and key definitions
 - Use of information and confidentiality
 - Cooperation & delegation authority between OHA and DHS
 - Grant authority for demonstration on integrated services for individuals who are dually eligible
 - Authority to seek federal approvals

NOTE: This LC does not attempt to identify all possible conforming amendments, pending review and comment on the LC.

**Legislative Concept
Discussion Draft – Part 1**

GOALS AND POLICIES

AMEND current law with updated goals and findings

GENERAL PROVISIONS

414.018 Goals; findings. (1) It is the intention of the Legislative Assembly to achieve the goals of improving the lifelong health of all Oregonians, increasing the quality, reliability and availability of care for all Oregonians; and lowering or containing the cost of care so it is affordable for everyone.

Deleted: universal access to an adequate level of high quality health care at an affordable cost

(2) The Legislative Assembly finds:

(a) A significant level of public and private funds is expended each year for the provision of health care to Oregonians;

(b) The state has a strong interest in assisting Oregon businesses and individuals to obtain reasonably available insurance or other coverage of the costs of necessary basic health care services;

(c) The lack of basic health care coverage is detrimental not only to the health of individuals lacking coverage, but also to the public welfare and the state's need to encourage employment growth and economic development, and the lack results in substantial expenditures for emergency and remedial health care for all purchasers of health care including the state; and

(d) The use of integrated health care and services systems has significant potential to reduce the growth of health care costs incurred by the people of this state.

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(3) The Legislative Assembly finds that achieving its goals of improving health, increasing the quality, reliability and availability of care, and reducing costs requires an accountable and integrated health system:

(a) All health care and services are coordinated, including physical health, mental health, addictions treatment, oral health, home and community based services, and long term care services and support;

(b) Including long term care supports and services in the transformed health system promotes and encourages greater utilization of home and community based services, with nursing facility care used primarily for transition services;

(c) Services for Oregonians who are fully eligible for both Medicare and Medicaid are included within the transformed health system;

(d) People are at the center of coordinated care and services delivered through accountable coordinated care contracts using alternative payment methodologies that shift the focus to prevention, improve health equity, and utilize person-centered primary care homes, evidence-based practices and health information technology to improve health and health care;

(e) Communities and regions are accountable for improving the health of their communities, reducing avoidable health gaps among different cultural groups and managing health care and service resources; and

(f) High quality information is collected and used to measure health outcomes, quality, costs, and clinical health information.

**Legislative Concept
Discussion Draft – Part 1**

GOALS AND POLICIES

AMEND current law with updated legislative intent (from OHPB Report p. 5)
OREGON ACCOUNTABLE HEALTH CARE AND SERVICES SYSTEM

Deleted: COST CONTAINMENT

414.610 Legislative intent. It is the intent of the Legislative Assembly to develop and implement new strategies to achieve an accountable and integrated system that improves health, increases the quality, reliability and availability of care, and reduces costs by creating a system in which:

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(1) Consumers to get the care and services they need, coordinated locally with access to statewide resources when needed, by a team of health professionals who understand their culture and speak their language;

(2) Consumers, providers, community leaders and policymakers have the high-quality information they need to make better decisions and keep delivery systems accountable;

(3) Quality and consistency of care are improved and costs are contained through new payment systems and standards that emphasize outcomes and value rather than volume;

(4) Communities and health systems work together to find innovative solutions to reduce overall spending, increase access to care and improve health; and

(5) Electronic health information is available when and where it is needed to improve health and health care through a secure, confidential health information exchange.

Deleted: that promote and change the incentive structure in the delivery and financing of medical care, that encourage cost consciousness on the part of the users and providers while maintaining quality medical care and that strive to make state payments for such medical care sufficient to compensate providers adequately for the reasonable costs of such care in order to minimize inappropriate cost shifts onto other health care payers.

AMEND current statute

414.620 System established. (1) There is established the Oregon Accountable Health Care and Services System. The system shall consist of state policies and actions that make integrated care and services organizations accountable for care management and the provision of integrated health care and services for eligible persons, managed within a fixed budget by providing care better so that efficiency and quality improvements address medical inflation and, to the extent possible, caseload growth, and take these actions in a way that supports development of regional accountability for health, while maintaining the regulatory controls necessary to assure quality and affordable health services to all Oregonians.

Deleted: Cost Containment

(2) The Accountable Health Care and Services System should pay for quality while managing within a global budget. The system should hold accountable care organizations and their providers responsible for the quality and efficiency of care they provide, reward good performance and keep total spending to a global budget that limits cost increases. Within the health care system, restructured payments and incentives should reward comprehensive care coordination in new delivery models such as person-centered primary care homes.

Deleted: encourage price competition among health care providers, that monitor services and costs of the health care system in Oregon, and that

(3) Alternative payment methodologies or methods will be used, that move from predominantly fee-for-service to alternate payment methods, in order to base reimbursement on quality rather than volume of services.

Deleted: The system shall also include contracts with providers on a prepaid capitation basis for the provision of at least hospital or physician medical care, or both, to eligible persons as described in ORS 414.025.

**Legislative Concept
Discussion Draft – Part 2**

DELIVERY SYSTEM CHANGES

AMEND existing statute to describe procurement and requirements for accountable care organizations

414.725 Accountable care organization contracts; financial reporting; rules. (1)(a)

Pursuant to rules adopted by the Oregon Health Authority, the authority shall execute accountable care organization contracts for integrated health care and services funded by the Legislative Assembly. The contract must require that all health services defined in ORS 414.705(2) are provided to the extent and scope of the Health Services Commission’s report for each service provided under the contract. The contracts are not subject to ORS chapters 279A and 279B, except ORS 279A.250 to 279A.290 and 279B.235. Notwithstanding ORS 414.720 (8), the rules adopted by the authority shall establish timelines for executing the contracts described in this paragraph.

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(b) It is the intent of ORS 414.705 to 414.750 that the Oregon Health Authority use, to the greatest extent possible, accountable care organizations receiving global payments to provide integrated physical health, dental, mental health, chemical dependency, home and community based, and long term care and support services under ORS 414.705 to 414.750.

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(c) The authority shall solicit qualified providers or plans that meet the standards established in ORS 414.xxx [see new statute below] to be reimbursed for providing the integrated covered services as part of an accountable and coordinated health system. The contracts may be with hospitals and medical organizations, health maintenance organizations, managed health care plans and any other qualified public or private organization that meet the qualifications for an accountable care organization. After contracts are awarded pursuant to this section, the authority may negotiate with any successful proposal respondent for the expansion or contraction of service areas if there are potential gaps or duplications in service areas.

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Deleted: The authority may not discriminate against any contractors that offer services within their providers’ lawful scopes of practice

(d) The authority shall establish annual financial reporting requirements for accountable care organizations. The authority shall prescribe a reporting procedure that elicits sufficiently detailed information for the authority to assess the financial condition of each accountable care organization and that includes information on the three highest executive salary and benefit packages of each accountable care organization.

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(e) The authority shall require compliance with the provisions of paragraph (d) of this subsection as a condition of entering into a contract with an accountable care organization.

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(f)(A) The authority shall adopt rules and procedures to ensure that a rural health clinic that provides a health service to an enrollee of an accountable care organization receives total aggregate payments from the organization, other payers on the claim and the authority that are no less than the amount the rural health clinic would receive in the authority’s fee-for-service payment system. The authority shall issue a payment to the rural health clinic in accordance with this subsection within 45 days of receipt by the authority of a completed billing form.

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(B) “Rural health clinic,” as used in this paragraph, shall be defined by the authority by rule and shall conform, as far as practicable or applicable in this state, to the definition of that term in 42 U.S.C. 1395x(aa)(2).

**Legislative Concept
Discussion Draft – Part 2**

DELIVERY SYSTEM CHANGES

(2) The authority may contract for alternative innovative integrated health and services arrangements for the delivery of integrated services for persons eligible for health services under ORS 414.705 to 414.750 in designated areas of the state as long as the alternative innovative arrangement meets the essential qualifications in ORS 414.xxx. For purposes of this chapter, a reference to a qualified entity providing integrated services under contract with the authority pursuant to this subsection shall be a reference to an accountable care organization, to the extent the Oregon Health Authority determines appropriate.

Deleted: institute a fee-for-service case management system or a fee-for-service payment system f

Deleted: or the same physical health, dental, mental health or chemical dependency services provided under the health

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(3) As provided in subsections (1) and (2) of this section, the aggregate expenditures by the authority for integrated services provided pursuant to ORS 414.705 to 414.750 may not exceed the total dollars appropriated for integrated services under ORS 414.705 to 414.750.

Deleted: in which a prepaid managed care health services organization is not able to assign an enrollee to a person or entity that is primarily responsible for coordinating the physical health, dental, mental health or chemical dependency services provided to the enrollee. In addition, the authority may make other special arrangements as necessary to increase the interest of providers in participation in the state's managed care system, including but not limited to the provision of stop-loss insurance for providers wishing to limit the amount of risk they wish to underwrite.¶

(4) Actions taken by providers, potential providers, contractors and bidders in specific accordance with ORS 414.705 to 414.750 in forming consortiums or in otherwise entering into contracts to provide integrated services shall be performed pursuant to state supervision and shall be considered to be conducted at the direction of this state, shall be considered to be lawful trade practices and may not be considered to be the transaction of insurance for purposes of the Insurance Code.

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(5) Health care providers contracting with accountable care organizations to provide services under ORS 414.705 to 414.750 shall advise an ACO member of any service, treatment or test that is medically necessary or that could slow progression of loss of function but not covered under the contract if an ordinarily careful practitioner in the same or similar community would do so under the same or similar circumstances.

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(6) An accountable care organization shall provide information on contacting available providers to an ACO member in writing within 30 days of assignment to the accountable care organization.

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(7) Each accountable care organization shall provide upon the request of an enrollee or prospective enrollee annual summaries of the organization's aggregate data regarding:

(a) Grievances and appeals; and

(b) Availability and accessibility of services provided to enrollees.

(8) An accountable care organization may not limit enrollment in a designated area based on the zip code of an enrollee or prospective enrollee.

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NEW STATUTE to adopt "ESSENTIAL ELEMENTS" integration and accountability standards

ORS 414.xxx Essential elements for accountable care organization

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Accountable care organizations are responsible for the full continuum of care for a defined population. Each accountable care organization or alternative integrated care system shall, at a minimum, have or obtain through contractual arrangement, the following functional capacities in accordance with the standards and contracts established by the Oregon Health Authority:

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(1) Accountable care organizations improve the quality of care, lower cost, and improve health and well-being of their members.

**Legislative Concept
Discussion Draft – Part 2**

DELIVERY SYSTEM CHANGES

- (a) The organization is accountable for the overall health of children and adult members in their area, and for working cooperatively with community partners to address public health issues that affect the health of the community.
 - (b) Health equity is prioritized and disparities are reduced. ACO organizational structures must include ethnically diverse populations in the community, consumers including seniors, people with disabilities and people using mental health services, and ensure that ACO decision-making reflects the views of providers in the ACO network.
 - (c) The organization actively engages consumers in making its decisions that impact the populations served, the communities where it is located, and decisions about how integrated care is delivered.
- (2) Accountable care organizations are person-centered organizations that provide integrated person-centered care and services designed to provide choice, independence and dignity:
- (a) Individuals have a consistent and stable relationship with a care team that is responsible for comprehensive care management and service delivery that address preventive, supportive and therapeutic needs of the individual in a holistic fashion, using person-centered primary care homes and individual care plans to the extent feasible, and that provides assistance in navigating the system if needed;
 - (b) Individuals receive comprehensive transitional care, including appropriate follow-up, when entering and leaving inpatient hospital or nursing facility to other care settings or return to their home;
 - (c) Access to services and supports are geographically located as close to home as possible, including use of community health workers and nontraditional settings that are accessible to families, diverse communities and underserved populations, and referral to community and social support services, with access to statewide resources when needed;
 - (d) Use of health information technology links services and care providers across the continuum of care and services as feasible and appropriate; and
 - (e) Strong safeguards for consumers are established, including safeguards against underutilization of services and protections against inappropriate denials of services or treatments in connection with utilization of alternative payment methods or transition to a global payment system.
- (3) Accountable care organizations prioritize working with ACO members with high needs and multiple chronic conditions, mental illness or chemical dependency to involve them in accessing and managing appropriate preventive, health, remedial and supportive care and services, and reducing the use of services provided in emergency rooms and hospital readmissions.
- (4) The accountable care organization’s providers work together to develop best practices for care and service delivery to reduce waste and improve the health and well-being of individuals:
- (a) Providers are educated about the integrated approach, and how to access and communicate within the integrated system about an individual’s plan and health history.

**Legislative Concept
Discussion Draft – Part 2**

DELIVERY SYSTEM CHANGES

- (b) Providers emphasize preventive resources, healthy lifestyle choices and evidence-based practices, shared decision-making, and communication.
- (c) Providers work in care teams responsible for individuals, including providers and community resources appropriate to the individual’s needs as a whole person, and work with the individual to develop an individual care and service plan
- (d) Providers maximize use of electronic health records to assure continuity of care across the service delivery system.
- (5) Quality indicators are evaluated to assess ongoing health status of individuals, including demographic and diversity data, consistent with standard quality measures adopted by and timely reported to the Oregon Health Authority to evaluate costs, experience of care, and population health.
- (6) Accountable care organizations demonstrate excellence of operations, including best practices in financial management capabilities, including but not limited to the management of claims processing and payment functions for ACO providers, and contract management capabilities, including but not limited to network provider creation and management functions.

NEW – Language for the service delivery expectations for individuals who are dually eligible –

414.xxx Conditions for coverage for certain individuals who are dually eligible for Medicare and Medicaid (1) Accountable care organizations that meet the standards established in ORS 414.xxx [above] are responsible for providing Medicare and Medicaid services to individuals who are dually eligible, including obtaining any necessary authorization from Medicare.

(2) Care and services for individuals who are dually eligible must emphasize preventive services, and services supporting independence and continued residence at home or in their community. Services for individuals who are dually eligible must be person-centered, and provide choice, independence and dignity reflected in individual plans and assistance with accessing care and services.

(3) The Oregon Health Authority shall apply to the Centers for Medicare and Medicaid Services to seek approval of contracting procedures and blended reimbursement methods for accountable care organizations responsible for enrolled individuals who are dually eligible.

AMEND Current statute for patient-centered primary care home services –

414.760 Person centered primary care home services. (1) The Oregon Health Authority shall establish standards for implementation and utilization of person centered primary care homes and encourage their use in contracts with accountable care organizations. If practicable, efforts to align financial incentives to support person

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**Legislative Concept
Discussion Draft – Part 2**

DELIVERY SYSTEM CHANGES

centered primary care homes for enrollees in medical assistance programs should be aligned with efforts of the learning collaborative described in ORS 442.210 (3)(d).

(2) Each accountable care organization shall implement, to the maximum extent feasible, person centered primary care homes, including developing capacity for services in settings that are accessible to families, diverse communities, and underserved populations. The organization shall require its other health and services providers to communicate with the primary care home in a timely manner and participate in care coordination including use of electronic health information technology. The authority may reimburse person centered primary care homes for interpretive services provided to people in the state’s medical assistance programs if interpretive services qualify for federal financial participation.

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(3) The authority shall require person centered primary care homes receiving these reimbursements to report on quality measures described in ORS 442.210 (1)(c).

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**Legislative Concept
Discussion Draft – Part 3**

RELATED IMPLEMENTATION RECOMMENDATIONS

NEW STATUTE for coordination and delegation of authority between DHS and OHA for implementation

- (1) The Department of Human Services and the Oregon Health Authority shall cooperate with each other by coordinating actions and responsibilities necessary to implement an accountable and integrated health and service delivery system in accordance with this 2011 Act, in a manner consistent with the responsibilities of the authority for the medical assistance program pursuant to ORS 413.032.
- (2) The department and the authority may delegate to each other any duties, functions or powers that the department or the authority deem necessary for the efficient and effective operation of their respective functions for purposes of this 2011 Act.

NEW STATUTE for use of information sharing and confidentiality

414.xxx Disclosure and use of medical assistance records by ACOs limited; contents as privileged communication; exceptions. (1) A hallmark of integrated accountable care organizations' effective management and service delivery is the appropriate use of ACO member information which includes use of electronic health information and administrative data that is available when and where it is needed to improve health and health care through a secure, confidential health information exchange.

(2) ACO members must have access to their personal health information, in the manner provided in 45 CFR 164.524, so they can share it with others involved in their care and make better health care and lifestyle choices.

(3) An accountable care organization and its provider network shall use and disclose ACO member information for purposes of service and care delivery, coordination, service planning, transitional services, reimbursement, and the requirements of this chapter, in order to improve the safety and quality of care, lower the cost, and improve health and well-being of their members. Integrated whole-person care necessarily requires access to and use of information about all aspects of the person's health and mental health condition, and sensitive diagnosis information including HIV and other health and mental health diagnoses, within the accountable care organization. Such uses and disclosures by the accountable care organization and its providers for purposes of providing integrated health care and services is required by law in accordance with this section. Individually identifiable health information must be treated as confidential and privileged information subject to ORS 192.518 to 192.526 and applicable federal privacy requirements, and redisclosures outside of the accountable care organization and its providers for purposes unrelated to this section or the requirements of this chapter remain subject to any applicable state privacy requirements.

(4) For the protection of ACO members, except as otherwise provided in this section, an accountable care organization and its providers shall not disclose or use the contents of any records, files, papers or communications for purposes other than those directly connected with the administration of the ACO and the public assistance laws of Oregon, or as necessary to assist the ACO members in accessing and receiving other

**Legislative Concept
Discussion Draft – Part 3**

RELATED IMPLEMENTATION RECOMMENDATIONS

governmental or private nonprofit services, and these records, files, papers and communications are considered confidential subject to the rules and regulations of the Oregon Health Authority. In any judicial or administrative proceeding, except proceedings directly connected with the administration of public assistance or child support enforcement laws, their contents are considered privileged communications.

(5) Nothing in this section prohibits disclosure of information between the ACO and its provider network, and the Oregon Health Authority and the Department of Human Services for the purpose of administering the public assistance laws of Oregon.

AMEND – This is the state mini-HIPAA privacy law; need to amend to address privacy issues

192.519 Definitions for ORS 192.518 to 192.529. As used in ORS 192.518 to 192.529:

(2) “Covered entity” means:

- (a) A state health plan;
- (b) A health insurer;

(c) A health care provider that transmits any health information in electronic form to carry out financial or administrative activities in connection with a transaction covered by ORS 192.518 to 192.529; or

(d) A health care clearinghouse.

(e) An accountable care organization contracted with the Oregon Health Authority

AMEND current statute related to grant authority for demonstration on integrated services for individuals who are dually eligible

414.033 Expenditures for medical assistance authorized. The Oregon Health Authority may:

(1) Subject to the allotment system provided for in ORS 291.234 to 291.260, expend such sums as are required to be expended in this state to provide medical assistance. Expenditures for medical assistance include, but are not limited to, expenditures for deductions, cost sharing, enrollment fees, premiums or similar charges imposed with respect to hospital insurance benefits or supplementary health insurance benefits, as established by federal law.

(2) Enter into agreements with, join with or accept grants from, the federal government for cooperative research and demonstration projects for public welfare purposes, including, but not limited to, any project which determines the cost of providing medical assistance to individuals who are dually eligible, or to evaluates service delivery systems.

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NEW STATUTE Necessary federal approvals may be requested

(1) To promote the adoption of alternative payment methodologies and contracting with ACOs, the Oregon Health Authority shall apply to the Centers for Medicare and Medicaid Services for

**Legislative Concept
Discussion Draft – Part 3**

RELATED IMPLEMENTATION RECOMMENDATIONS

any approval necessary to obtain federal financial participation in the costs of activities described in this 2011 Act, including but not limited to:

(a) Seeking federal approvals necessary to permit Medicare to participate in Oregon’s alternative payment and integrated service methodologies. Upon obtaining federal approval for Medicare participation, such participation shall be commenced and continued and the authority shall seek extensions or additional approvals, as necessary.

(b) Seeking federal approvals necessary to support the transition to and implementation of global and alternative payment systems, and formation and utilization of ACOs in the medical assistance program.

(2) The authority shall adopt rules implementing the provisions of this 2011 Act requiring federal approval as soon as practicable after receipt of the necessary federal approval and may provide for implementation in stages in accordance with the availability of funding.

(3) Sections of this 2011 Act requiring federal approvals become operative on the later of _____, or the date on which the Oregon Health Authority receives any federal approval required to secure federal financial participation under subsection (1) of this section.

**Legislative Concept
Discussion Draft – Part 4**

KEY DEFINITIONS

AMEND current statute defining “medical assistance”

414.025 Definitions. As used in this chapter, unless the context or a specially applicable statutory definition requires otherwise:

*** [NO CHANGES IN POPULATIONS COVERED OR DEFINITIONS OF “INCOME” OR “INVESTMENTS AND SAVINGS”]

(5) “Medical assistance” is synonymous with “integrated health care and services” or “integrated services”, which means so much of the following preventive, medical, remedial and supportive care and services as may be funded by the Legislative Assembly and prescribed by the Oregon Health Authority according to the standards established pursuant to ORS 413.032, including payments made for services provided under an insurance or other contractual arrangement and money paid directly to the recipient for the purchase of medical care:

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- (a) Inpatient hospital services, other than services in an institution for mental diseases;
- (b) Outpatient hospital services;
- (c) Other laboratory and X-ray services;
- (d) Skilled nursing facility services, other than services in an institution for mental diseases, and other long term care services and supports;
- (e) Physicians’ services, whether furnished in the office, the patient’s home, a hospital, a skilled nursing facility or elsewhere;
- (f) Medical care, or any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law;
- (g) Home health care services;
- (h) Private duty nursing services;
- (i) Clinic services;
- (j) Dental services;
- (k) Physical therapy and related services;
- (L) Prescribed drugs, including those dispensed and administered as provided under ORS chapter 689;
- (m) Dentures and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;
- (n) Other diagnostic, screening, preventive and rehabilitative services;
- (o) Inpatient hospital services, skilled nursing facility services and intermediate care facility services for individuals 65 years of age or over in an institution for mental diseases;
- (p) Any other medical care, and any other type of remedial care recognized under state law;
- (q) Periodic screening and diagnosis of individuals under the age of 21 years to ascertain their physical or mental impairments, and such health care, treatment and other measures to correct or ameliorate impairments and chronic conditions discovered thereby;

**Legislative Concept
Discussion Draft – Part 4**

KEY DEFINITIONS

(r) Inpatient hospital services for individuals under 22 years of age in an institution for mental diseases; ~~and~~

(s) Hospice services;

(t) Home and community based services;

(u) Mental health services; and

(v) Chemical dependency services.

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(6) “Medical assistance” includes any care or services for any individual who is a patient in a medical institution or any care or services for any individual who has attained 65 years of age or is under 22 years of age, and who is a patient in a private or public institution for mental diseases. “Medical assistance” includes “health services” as defined in ORS 414.705. “Medical assistance” does not include care or services for an inmate in a nonmedical public institution.

(7) [OMIT DEFINITION OF MEDICALLY NEEDY – NOT CHANGED; COULD BE REPEALED, SINCE NO MEDICALLY NEEDY PROGRAM AT THIS TIME]

(8) [OMIT DEFINITION OF RESOURCES – NOT CHANGED]

(9) “Individual who is dually eligible” means an individual who is entitled to, or enrolled for, benefits under Part A of Title XVIII, or enrolled for benefits under Part B of Title XVIII, and is eligible for medical assistance under Title XIX of the Social Security Act in accordance with this chapter.

(10) “Person-centered primary care home” means a primary care team or clinic which is organized in accordance with standards as defined by the Oregon Health Authority and which incorporates the following core attributes:

(a) Access to care;

(b) Accountability;

(c) Comprehensive whole person care;

(d) Continuity;

(e) Coordination and integration; and

(f) Person and family centered care.

(10) “Accountable care organization” or “ACO” means a single integrated organization that accepts responsibility for the cost within its global budget and for delivery, management and quality of care delivered to the specific population of patients enrolled with the ACO; which operates consistent with the principles of a person-centered primary care home and satisfies the other requirements of this chapter; which has a formal legal structure to receive global payments and distribute payments and savings; and which complies with any federal requirements applicable to ACOs, however named. An ACO may include an alternative innovative integrated health and services arrangement approved by the authority in accordance with ORS 414.725.

(11) “ACO member” means an individual who receives integrated medical, remedial and supportive care and services through an accountable care organization.

(12) “Alternative payment methodologies or methods” means methods of payment that are not fee-for-service based and that are used by ACOs to compensate their providers for the provision of integrated health care and services, including but not limited to shared savings arrangements, bundled payments, episode-based payments, and

**Legislative Concept
Discussion Draft – Part 4**

KEY DEFINITIONS

global payments, as defined by rules adopted by the Oregon Health Authority. No payment based on the fee-for-service methodology shall be considered an alternative payment.

(13) “Quality measures” means objective benchmarks established in accordance with nationally accepted performance metrics and as otherwise permitted under this chapter for assessing provider and ACO performance.

AMEND current statute to define “integrated health care and services”

414.705 Definitions for ORS 414.705 to 414.750. (1) As used in ORS 414.705 to 414.750, “integrated health care and services” or “integrated services” means at least so much of medical assistance as defined in ORS 414.025, including health services, as may be prescribed by the Oregon Health Authority according to the standards established pursuant to ORS 413.032 and that are approved and funded by the Legislative Assembly. (2) “Health services” means so much of the following care and services funded by the Legislative Assembly in accordance with the prioritized list of health services under ORS 414.720:

- (a) Services required by federal law to be included in the state’s medical assistance program in order for the program to qualify for federal funds;
- (b) Services provided by a physician as defined in ORS 677.010, a nurse practitioner certified under ORS 678.375 or other licensed practitioner within the scope of the practitioner’s practice as defined by state law, and ambulance services;
- (c) Prescription drugs;
- (d) Laboratory and X-ray services;
- (e) Medical supplies;
- (f) Mental health services;
- (g) Chemical dependency services;
- (h) Emergency dental services;
- (i) Nonemergency dental services;
- (j) Provider services, other than services described in paragraphs (a) to (i), (k), (L) and (m) of this subsection, defined by federal law that may be included in the state’s medical assistance program;
- (k) Emergency hospital services;
- (L) Outpatient hospital services; and
- (m) Inpatient hospital services.

Deleted: (2) Health services approved and funded under subsection (1) of this section are subject to the prioritized list of health services required in ORS 414.720. ¶

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Addictions and Mental Health Division (AMH)

AMH Overview
Richard Harris, Assistant Director

March 8, 2011



ADDICTIONS AND MENTAL HEALTH DIVISION

AMH mission and goals

- The mission of AMH is to assist Oregonians to achieve optimum physical, mental and social well being by providing access to health, mental health and addiction services and supports, to meet the needs of adults and children to live, be educated, work and participate in their communities.
- AMH's goals are to:
 - Improve the lifelong health of all Oregonians
 - Improve the quality of life for the people served
 - Increase the availability, utilization and quality of community-based, integrated health care services
 - Reduce the overall health care and societal costs of mental health and addiction through appropriate system investments
 - Increase the effectiveness of the integrated health care delivery system
 - Increase the involvement of individuals and family members in all aspects of health care delivery and planning
 - Increase accountability of the health care system
 - Increase the efficiency and effectiveness of the state administrative infrastructure for health care

Oregon provides

- Services to prevent and/or treat the problems created by addictions, including problem gambling;
- Services to treat major mental illness such as schizophrenia, major depression, bipolar disorder and the disabling effects of childhood trauma.
- Services provided include:
 - Acute care treatment
 - Outpatient treatment
 - Residential treatment
 - Detoxification
 - Case management
 - Supportive housing
 - Supportive employment
 - Peer- and family-delivered supports

How services are delivered

- The Addictions and Mental Health Division funds services for more than 161,000 people each year through contracts with:
 - 32 community mental health programs covering 36 counties
 - Nine mental health organizations covering the entire state
 - Two state hospitals
 - Oregon State Hospital – campuses in Salem and Portland
 - Blue Mountain Recovery Center – Pendleton
- Of the total number served, 1,400 are served in the state hospitals.

Need for addictions and mental health services

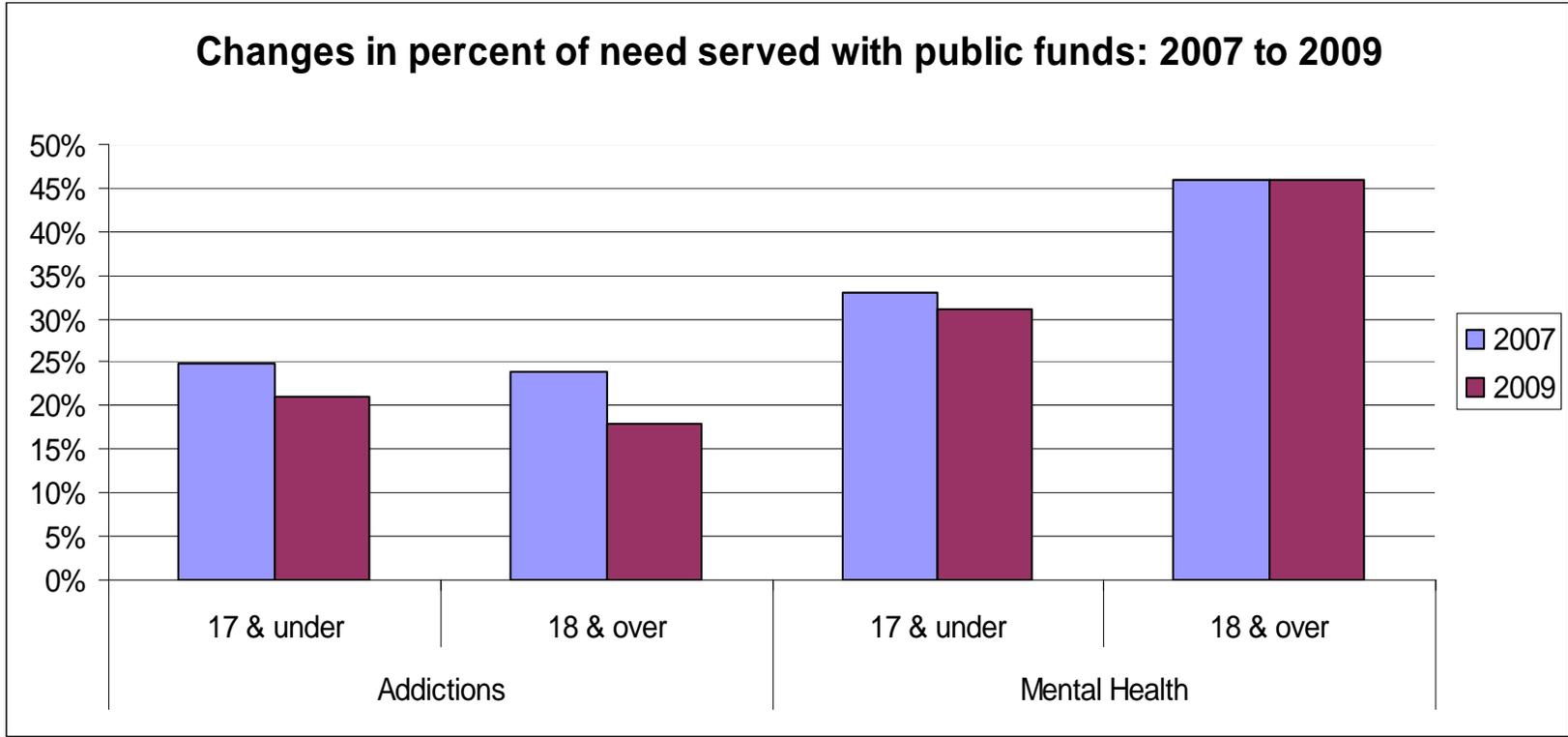
Age/Category	In need of services	People served in public system	% of need met through public system
Addiction			
17 & younger	27,592	5,663	21%
18 & older	273,895	48,445	18%
Mental Health			
17 & younger	106,124	33,243	31%
18 & older	156,962	72,207	46%
Problem Gambling			
All ages	77,486	1,756	2%

February 2011

Calendar Year 2009

Addictions and Mental Health Division





Oregon State Hospital

The Oregon State Hospital provides psychiatric treatment for people

- who suffer from severe and persistent mental illness
- whose needs are best met in an institutional setting

Civil commitments

Danger to themselves or others

- Adult treatment services
Portland campus
- Neuro/geriatric/medical
Salem campus

Forensic commitments

Court system

- Guilty except for insanity
Psychiatric Security Review Board
- Aid and assist
Competency to stand trial

Oregon State Hospital census

As of Feb. 9, 2011

2010 Census

Adult treatment (Portland) & neuro/gero/medical (combined)	153	26%	332	29%
Forensic – Guilty except for insanity	344	58%	435	38%
Forensic - Aid & assist	93	16%	382	33%
Total census	590	100%	1,149	100%

Achievements

- Centralized treatment malls
- Opened the first living units of new hospital
- Significant reductions in seclusion and restraint, aggression and self harm
- Culture change – Excellence Project
- Streamlined hiring process, reduced vacancies
- Advisory board, as requested by Legislature
- New leadership
 - new superintendent with proven track record
 - Chief of medicine
 - “Right-sizing” the cabinet

State Hospital annual cost of care

Blue Mountain Recovery Center (Pendleton)	\$251,744
Civil commitment (Portland and Salem)	\$166,484
Geropsychiatric (Salem)	\$233,695
Forensic (Salem)	\$211,926

Data Source: DHS, Institutional Cost of Care Rates, 2009-2010

Est. average cost of care in adult community residential facilities

Secure residential treatment facility	\$172,320
Residential treatment facility	\$67,800
Residential treatment home	\$101,640
Adult foster home	\$26,760

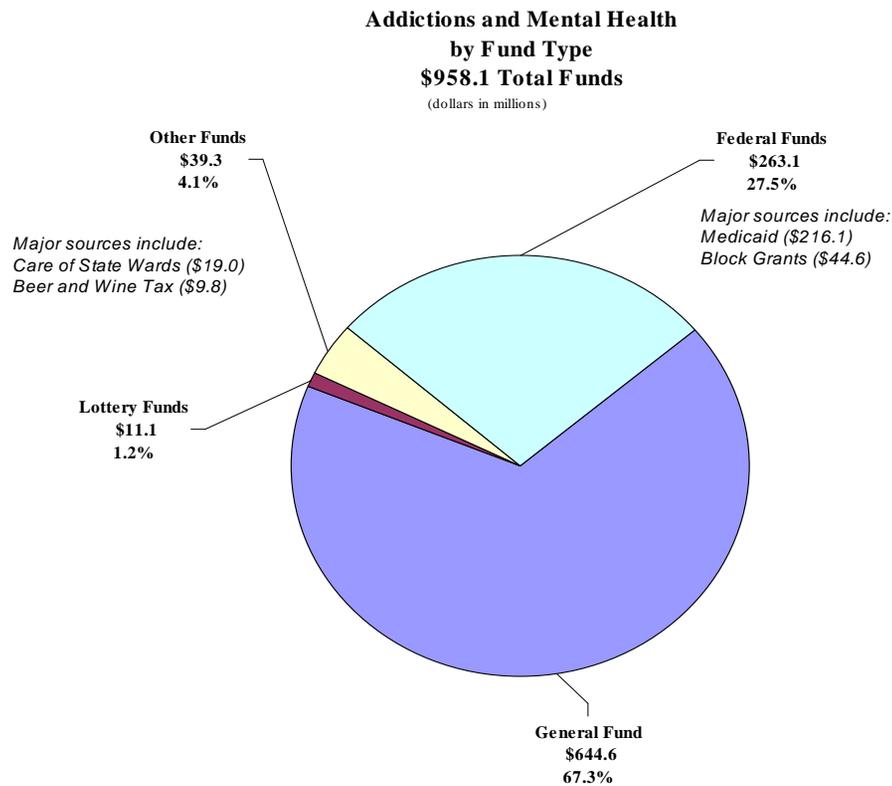
Data Source: RBASE and MMIS

2011-13 Governor's Balanced Budget

	<u>GF/LF</u>	<u>OF</u>	<u>FF</u>	<u>TF</u>
2009-11 LAB (Dec 2010 E-Board)	636.74	36.09	283.19	956.02
Less: 2009-11 Governor's Allotment Reductions	(42.00)	-	-	(42.00)
2009-11 Spending level	594.74	36.09	283.19	914.02
One-time money	26.29	-	(26.29)	-
Caseload changes (at current rates)	85.07	3.59	21.99	110.65
Subtotal	706.10	39.68	278.89	1,024.67
Administrative/ Efficiency - OSH	(36.00)	-	(4.80)	(40.80)
Administrative/ Efficiency - CMH	(7.74)	(0.42)	(5.87)	(14.03)
Benefit Reduction	(6.58)	-	(5.11)	(11.69)
*2011-13 GBB	655.78	39.26	263.11	958.15

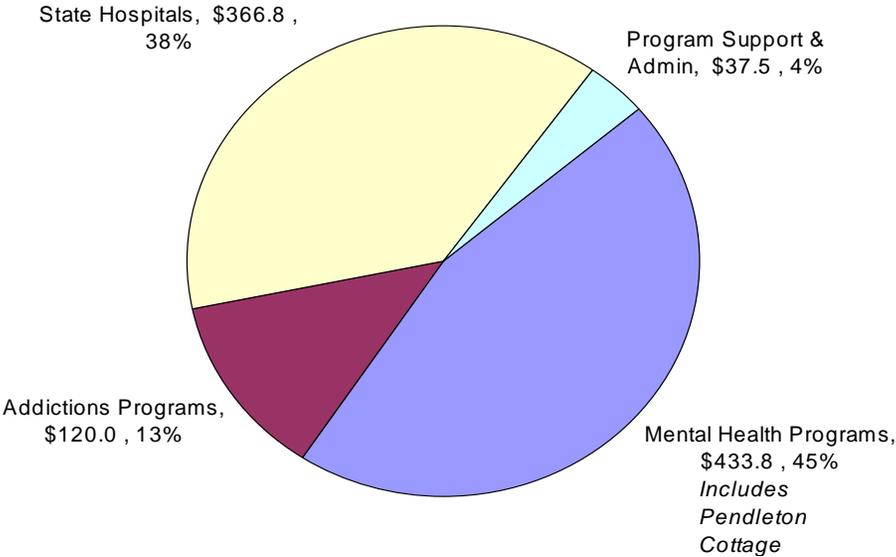
* Adjusted to correct errors in ORBITS system.

Governor's Balanced Budget by fund

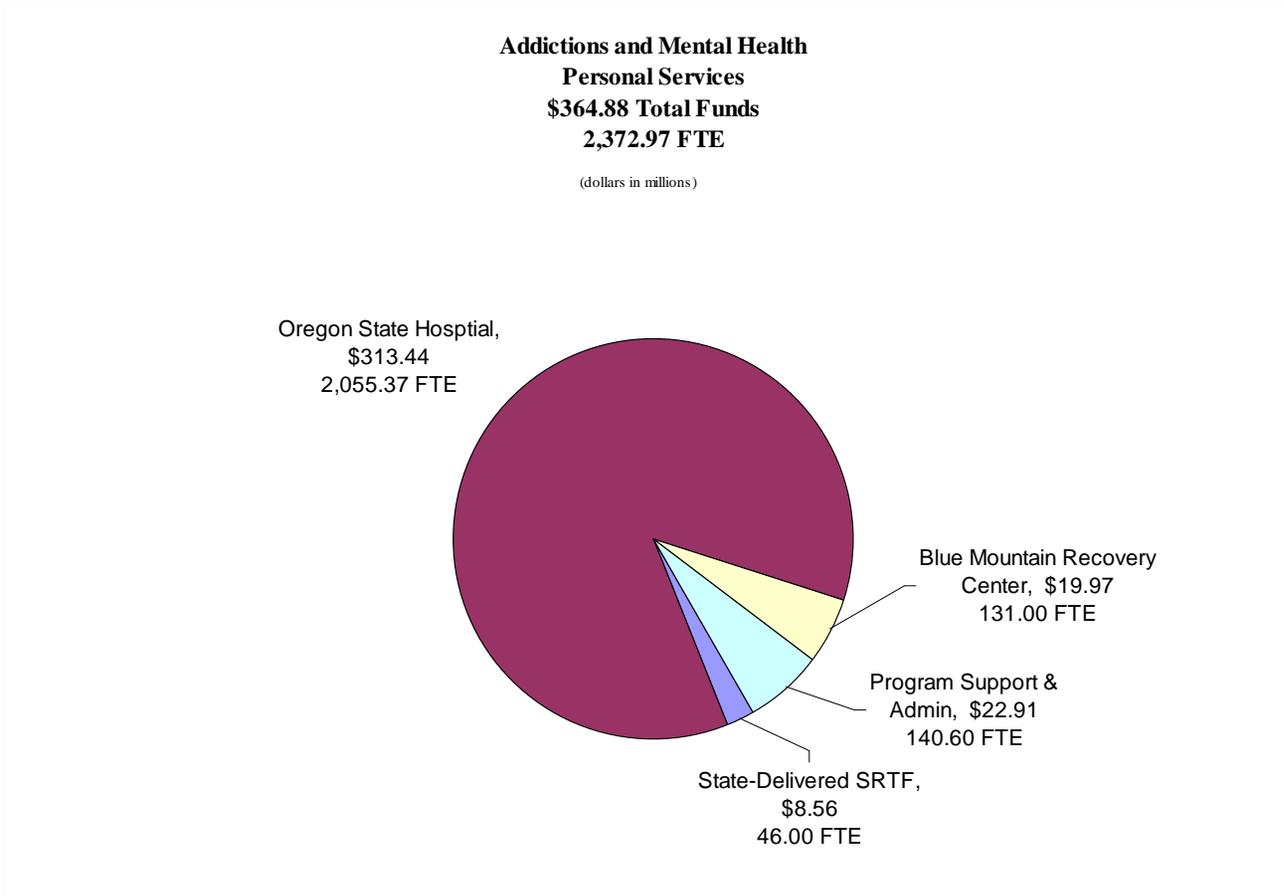


Governor's Balanced Budget by program

**Addictions and Mental Health
by Fund Type**
\$958.1 Total Funds
(dollars in millions)



Personal Services and FTE by program



System opportunities with Governor's Balanced Budget funding

- Full integration of addiction and mental health treatment and supports with physical health, dental care and long-term care;
- System of regionally managed and accountable services and supports;
- Improved access to cost-effective services and supports that work and are consumer-driven;
- Options to intervene earlier in these disorders and to increase the use of cost-effective alternative strategies such as community crisis centers, peer-delivered supports and family navigators.

Addiction services to reduce costs in child welfare

Intensive Treatment and Recovery Services

ITRS was funded by the 2007 Legislature to serve families affected by addiction. Its aim is to keep together or reunite families with children in foster care due to family substance abuse. This is accomplished by providing residential treatment, regular and intensive outpatient treatment, case management and clean-and-sober housing options.

- As of February 2011:
 - 1,803 children have been reunited with their parents who used services, providing a cost-offset to foster care of \$1.7 million per month.
 - More than 53 percent of children whose parents are or were involved in treatment are living safely with their parents.
 - More than 5,300 parents have used these services, and 1,700 are still enrolled today.

Oregon Alcohol and Drug Policy Commission

The Alcohol and Drug Policy Commission, created by statute during the 2009 legislative session, is charged with developing a blueprint for funding and effective delivery of alcohol and drug treatment and prevention services in Oregon. This includes:

- A strategy for organizing and delivering state-funded treatment and prevention services;
- Funding priorities for treatment and prevention services;
- Strategies to maximize accountability and measure performance of treatment and prevention services;
- Methods for standardizing data collection and reporting;
- A policy and funding strategy that supports a consolidated treatment and prevention system, reducing fragmentation in the delivery of services;
- A plan for sustaining focus and leadership on alcohol and drug services and for building a lasting constituency for continuing effective state action;
- A plan for evaluating the state action based on the "blueprint" in future years/biennia.

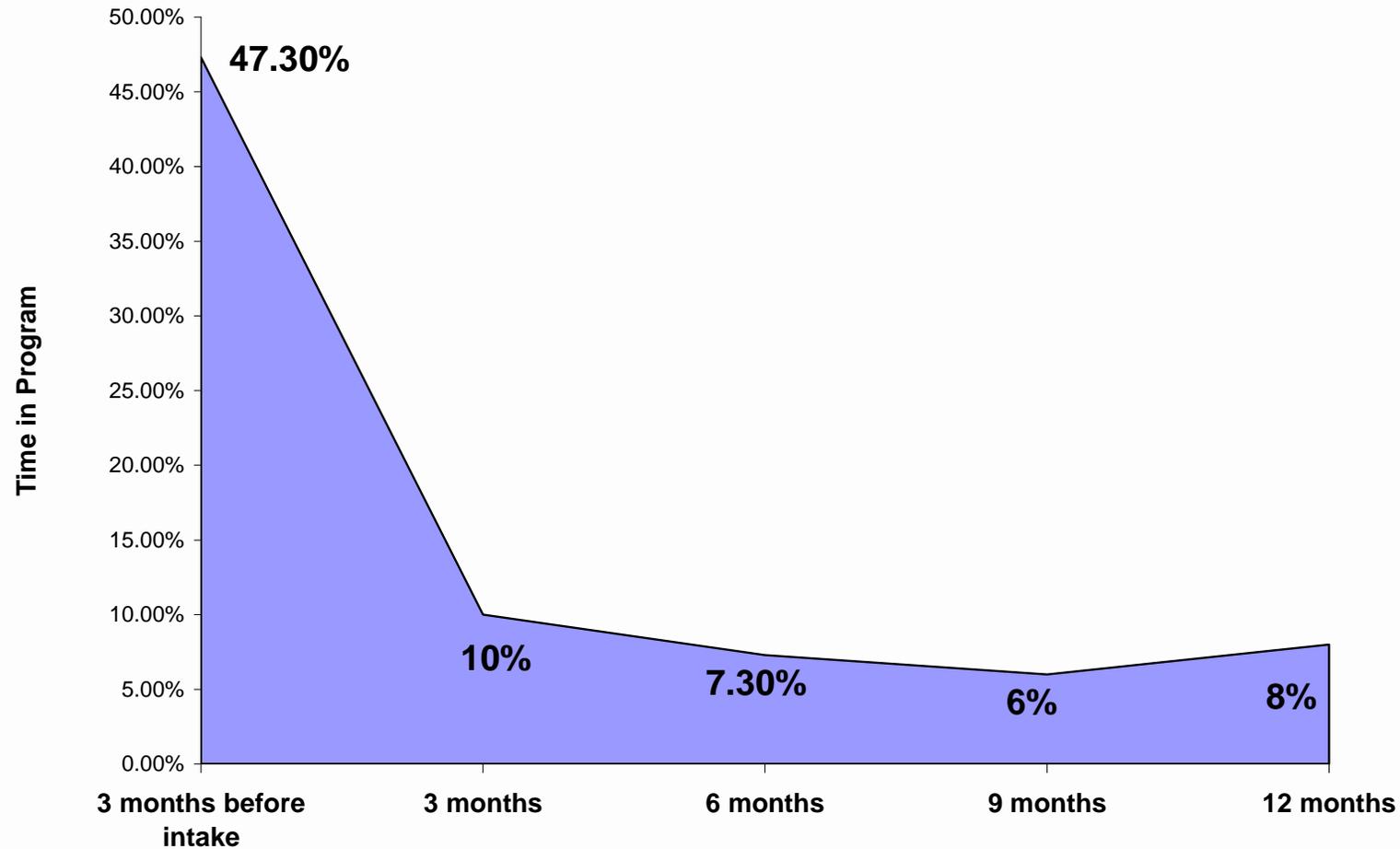
Community mental health innovations

Early Assessment and Support Alliance

The Early Assessment and Support Alliance (EASA) initiative identifies people in the early stages of schizophrenia and other psychotic disorders and ensures they and their families have the proper resources to effectively deal with the illness.

- From January 2008 through December 2010
 - 1,200 referrals were made to the programs
 - 425 individuals and families were accepted into ongoing services
 - The remaining 775 received case management and tertiary services
 - 28% of those served are under age 18
- Outcomes include
 - Increased employment (33% at nine months. vs. 19% at intake) among adults
 - 79% reduction in hospitalizations
 - Dramatic decrease in arrest or incarceration in first three months of service compared with three previous months (13% to 1.9%) among adults

Percent of EASA Clients Hospitalized by Time in Program EASA Clients in Service 12 Months (n=150)



Community mental health innovations

Adult Mental Health Initiative

- The Adult Mental Health Initiative, known as AMHI (“Aim-High”), was launched in September 2010 to promote more effective use of facility-based treatment settings, increase care coordination and accountability, and increase the quality and availability of community-based services and supports so that adults with mental illness are served in the least restrictive environment possible.
- The MHOs have helped
 - **127** individuals transition from the state hospitals
 - **100** individuals transition from licensed facilities
 - **26** diverted from the state hospitals
- Of the 253 people
 - **146** transitioned to independent living
 - **107** transitioned to licensed facilities
- AMHI does not include individuals who are
 - Under PSRB jurisdiction
 - Eligible for SPD services

Integrated Management Service Demonstrations

- A 2009 budget note directed OHA to develop two or three demonstration projects bringing together local providers and authorities to develop an integrated management and service delivery system including physical health and addictions and mental health treatment and recovery services by June 30, 2011.
- Two projects now are under way in Central Oregon and Northeast Oregon.

Oregon
Health
Authority

March 5, 2011

Dr. Bruce Goldberg
Director, Oregon Health Authority
500 Summer Street
Salem, OR 97301

Dear Dr. Goldberg:

The members of Oregon's Public Health Advisory Board (PHAB) thank and congratulate the members of Oregon Health Policy Board for the work they have done developing and completing *Oregon's Action Plan for Health*. We especially appreciate the inclusion of people with Public Health expertise in the Board's membership. Oregon Public Health supports the Plan's triple aim through the profession's well established functions of promoting population health, assuring quality of the health workforce and its services, and assuring access to health services.

Increases in longevity and population health over the past century were primarily due to Public Health interventions, yet today's children represent the first generation of Americans whose health is predicted to be worse than that of their parents. Although the Plan addresses efforts to reform clinical care and preventive medicine, it lacks sufficient attention to Public Health as well as specific strategies to provide the resources needed to establish a strong population health system, which Oregon critically needs. Increasing medical care and decreasing reimbursements alone will not achieve Oregon Health Authority's triple aim. We cannot train and fund enough medical providers to cure everyone, if the population is getting sicker because of lack of prevention that we know how to do, but which remains underfunded.

We urge you to consider several suggestions:

1. Systems change – The Plan acknowledges the cost savings of population-level (Public Health) interventions that improve health. It recommends that Public Health integrate, innovate coordinate and reduce duplication, suggesting “do better with less.” This has been tried before, and we know it will not advance the health of the population. The Plan directs resources to preventive medicine for individuals with insurance. It should be revised so that it also funds evidence-based, Public Health interventions that prevent disease among everyone regardless of their access to medical insurance.
2. Workforce – Improvements in population health depend upon a well trained, culturally competent and relevant Public Health workforce. Public Health should be included in the Plan's initiative to develop a robust and diverse health workforce for Oregon, including community health workers.

3. Environmental and Structural Determinants of Population Health – Improvements in the public’s health depend upon recognizing that “That which is around us shapes us.” Environmental and structural factors such as street connectivity, alcohol outlet density, green space, presence of food deserts, and availability of public transportation all create the essential platforms on which – or the constraints against which—health behaviors are formed, practiced and sustained.
4. Health Care Homes – The Plan should include a clear description of the integration of primary care and public health along with changes in both systems necessary to achieve the benefits of integration. Integrated health homes must coordinate externally with community-level supports (population-level health promotion interventions) that promote and improve health. Ideally, integrated health care teams will deliver person-centered care that is strengthened by community support systems, and the Plan will call for the following:
 - Health Care teams will work with Public Health through integrated Health Care Homes to create strong pipelines to community supports, including public health, mental health, dental health and social services.
 - Public Health and Primary Care are best when they work in the same continuum of patient-centered care. Multi-disciplinary team clinics need to be tested and refined within our state. We spend a lot of time trying to figure out scopes of practice focusing on what is ‘different’ among practitioners. We need to look at where different practitioners have common skills, how they can work together, and what yet undefined practitioners may be needed to provide comprehensive clinical resources to Oregonians. The least effective approach is to simply expect primary care to be responsible for disease prevention among patients.
 - Primary Care and Public Health must collaborate on the County level to be proactive in community development that ensures, for example, our communities have safe, walk-able areas and parks. They must become resources for public health information through basic prevention programs addressing immunization, nutrition, physical activity, dental and mental health. Public Health must partner with fast food services to evaluate alternatives to drive-up services and nutritional values of available products.
 - Example: Health care teams might deliver home-based, person-centered care to highest users of emergency and hospital services as a way to reduce costs (*New Yorker Magazine*, Jan. 24, 2011).
5. Public Education: Schools are our first line of defense and opportunity in building a healthy community. Children need to be taught how their bodies work, what to do to stay healthy, and how to be effective patients and self-advocates when they do need to enter the medical care system. Public Health can be an expanded resource to schools for healthy education. Education must partner with Public Health to include physical activities and education as mandatory for the development of healthy students and assume its share of responsibility for disease prevention. As recommended in the Oregon Health Improvement Plan, one proposed outcome is increased high school graduation rates and college degrees with special attention to students experiencing health disparities.

6. Health Assurance – The plan calls for clinical providers to join Public Health professionals, who by definition are responsible for the health of the whole community. The plan should address actions that will pay for Public Health to join in that shared responsibility.
7. Health Information Technology – New data systems must go beyond medical information and include health risk factor data (including environmental, social and behavioral risk data) as well as public health informatics.

All Oregonians deserve the opportunity to live healthy lives. That shared aspiration requires a Public Health system that successfully conducts community-level prevention programs addressing health disparities and the social determinants of health. Investment in Public Health is a good medical decision, because it saves lives. Investment in Public Health is a good economic decision, because it creates jobs, helps people stay at work, raise their families and succeed in school.

We encourage you to revisit Oregon's Health Action Plan and revise it to outline actions that will create the strong Public Health system necessary for the Oregon Health Authority to achieve its goals. There are many of us in Oregon's Public Health community who are keenly interested in looking at Public Health infrastructure for changes to assure Oregon has an efficient world class system of Public Health. We expect that you will call upon our individual skills. If the Public Health Advisory Board can provide information, and gather data in that process, please contact us. Thank you.

Sincerely,

Tom Eversole, DVM, MS
Chair, Oregon Public Health Advisory Board