

Oregon Health Policy Board

AGENDA

May 10, 2011

Market Square Building
1515 SW 5th Avenue, 9th floor
8:30 am to 11:30 am

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 <ul style="list-style-type: none">• Purchasers meeting update• HITOC meetings update 4-12-11 minutes	Chair	X
2	8:35	Director's Report	Bruce Goldberg	
3	8:50	PEBB/OEBB: delivery system reform	Joan Kapowich	
4	9:00	Medicaid Update: Quality results	Mylia Christensen Judy Mohr Peterson Jeanny Phillips	
5	9:30	Workforce Committee charter	Lisa Angus	X
6	9:40	Legislative Update	Amy Fauver	
7	9:55	Update on the Joint Special Committee on Health Care Transformation: HB3650.	Amy Fauver Tina Edlund	
8	10:10	Health Insurance Exchange Update	Greg Jolivette	
	10:20	Break		
9	10:30	Affordable Care Act	Attorney General John Kroger	
10	11:00	Public Testimony	Chair	
11	11:30	Adjourn		

Next meeting:

June 14, 2011

1:00 pm to 4:30 pm

Location: Market Square Building

Oregon Health Policy Board
DRAFT Minutes
April 12, 2011
Lane Community College
CENTER for Meeting and Learning
4000 E. 30th Avenue, Bldg 19, Room 104
Eugene, OR 97405
12:30 PM to 4:45 PM

Item

Welcome and Call To Order

Chair Eric Parsons called the Oregon Health Policy Board (OHPB) meeting to order. All Board members were present. Nita Werner participated by phone. Bruce Goldberg and Tina Edlund were present from the Oregon Health Authority (OHA).

Consent Agenda:

Minutes from the March 8, 2011 meeting were unanimously approved.

Director's Report – Dr. Bruce Goldberg

- Healthy Kids has enrolled over 85,000 children, and the uninsurance rate of children has decreased from 12% to 6.1%
- We are now about halfway through the legislative session. The Co-Chairs of the Ways and Means Committee have released their budget, calling for 5% cuts in human services.

This report can be found [here](#), starting on page 7.

Health Insurance Exchange (HIX) Bills Update - Nora Leibowitz and Amy Fauver

- Amy gave an update on the bills that came out of the Action Plan.

This report can be found [here](#), starting on page 9.

- The Board expressed interest in HB 3359 and suggested approaching the Incentives and Outcomes Committee with a request to speak to legislators in support of it.
- Nora presented information about the HIX Bill, SB 99, which has been passed out of the Senate Health Care Reform Subcommittee with an amendment.

A document comparing the Board's recommendations with SB 99 can be found [here](#), starting on page 13.

HSTT Update – Bruce Goldberg, Terry Coplin and Ken Provencher

- The Health System Transformation Team (HSTT) met for eight weeks to come up with a new paradigm for how health care is delivered to the Medicaid population in Oregon.
- The workgroup worked on a legislative concept that created the starting point for coordinated care organizations (CCOs) and a timeline.
- The bill will be worked in the Special Joint Committee on Health Care Transformation.
- Terry recommended that the joint committee focus on risk and how to distribute it.
- Tina Edlund updated the Board on the activities of the committees.
 - ❖ The Public Employers Health Purchasing Committee is going to hold one more meeting before they go on summer hiatus. They will wait to see what the results of the legislative session are then create a new work plan.
 - ❖ The Workforce Committee has generated a list of ideas for their charter and will bring the charter to the next Board meeting.
 - ❖ The Incentives and Outcomes Committee will charter a subcommittee that will focus on performance metrics.

BREAK

Local Community Integration Efforts – Invited Testimony

Ken Provencher – Pacific Source

Mr. Provencher spoke about the need for action at the community level, and how critical collaboration is. He said reform cannot be about making power plays, and that it has to be about bringing parties together. This has to be monitored to be sure it happens in a meaningful way. We need to create delivery system reform and make sure it is not just about reshaping governance; it should create process and structure and bring communities together.

Terry Coplin – CEO, Lane Individual Practice Association (LIPA)

Mr. Coplin discussed how LIPA has been working with Lane County Mental Health to share data and to create integration systems. He said that after we integrate physical and mental health, we need to look at integrating those with addictions, social determinants, dental and public health.

Bruce Abel – Manager, LaneCare, Lane County

Mr. Abel provided information about three committees that are working on integration.

1. Accountable Care Organization Planning Committee – This committee meets to find ways to reorganize health care, provide more prevention and early intervention services, develop alternate payment approaches, and develop primary care medical homes.
2. CEOs and Directors of Health Care Funders and Providers – This committee meets to discuss organizational development and governance.
3. Regional Health Authority – This committee focuses on planning for potential reductions in Oregon Health Plan benefits.
4. LIPA, LaneCare and Lane County Seniors and Disabled Services – This committee discusses guiding principles and structures for development of a public and private partnership that has oversight responsibility for regional Medicaid health care. The first principle is that they will maximize the funds allocated for services and minimize the creation of new organization or administrative cost centers. On the front end of the systems change they have incorporated administrative systems and implementation opportunities for integration and coordination. They are developing an integrated data set to collect, analyze and manage health performance measures that will share secure patient information and ensure cost-effective services. This project may include the development of a client health record to improve capacity for integration service coordination across diverse providers. They plan to create an integrated behavioral health benefit and understand that they must be engaged and coordinate a range of social providers.

The Board was interested in how the two systems share responsibility and risk for the patients. Mr. Able replied that sometimes there are grey areas where it is unclear who pays for the care a patient receives or who provides the aftercare, but LIPA and LaneCare work together as closely as they can to work out solutions.

Jeri Weeks – Community Health Centers of Lane County

Karen Gillette – Program Manager, Lane County Public Health

Rob Rockstroh – Director, Lane County Health and Human Services

Ms. Weeks, Ms. Gillette and Mr. Rockstroh spoke about how their organizations work together to provide better care. Mr. Rockstroh spoke about the size of Lane County and how it can be difficult to get care to the more rural areas of the county. They all spoke about the importance of preventive care and effective treatment of chronic diseases.

Medicaid Update – Judy Mohr Peterson

- Judy presented information from a report presented to the Ways and Means Committee.

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

- ↪ The Board asked for more specifics on how treatment for conditions is set up and how it is paid for. The Board also asked for information about how quickly dental care is provided for low-income housing recipients.

PEBB/OEBB Update – Joan Kapowich

- PEBB is currently going through its renewal process. They are looking at a variety of options to cut costs and provide better care next year. Some of the changes include evidence-based benefits and cost-sharing for smokers.
- PEBB will also be implementing a health engagement model. When members sign up in October, they'll be asked to sign an agreement to establish a relationship with a primary care provider, take a health assessment and participate in smoking cessation or weight management classes if needed.
- OEBB is also working through its renewal process.
- When looking at metrics, behavioral risk factors have been improving. Smoking rates have decreased, along with obesity and weight problems. Schools

- ↪ The Board asked for information about the new ideas that are emerging from the health system transformation discussion and how PEBB/OEBB are beginning to address them.

Health System Transformation Team Implications for OHPB Work Plan – Tina Edlund

Tina presented a brief timeline of activities the Board will be considering over the next few months.

That timeline can be found [here](#), on page 60.

Public Testimony

Charles Wright – Chairman, Mental Health Subcommittee of the Lane County Mental Health Advisory Committee/Local Alcohol and Drug Planning Committee

Mr. Wright spoke about how extraordinary the people behind mental health care in Lane County are and how fortunate the county is to have them. He encouraged the Board to consider it as a model for the rest of the state.

Betty Johnson – Mid-Valley Health Care Associates

Ms. Johnson urged the Board to include citizens earlier in the process of the CCOs and to keep them more involved throughout. It is important for communities to be involved.

The Board unanimously approved a motion to suggest that the health care committees of the legislature hold meetings throughout the state to collect citizen input on the formation of CCOs.

Adjourn 4:39 pm

Next meeting:

May 10, 2011

8:30 – 11:30 am

Market Square Building

1515 SW 5th Ave, 9th Floor

Portland, OR 97201

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Public Employers Health Purchasing Committee
Committee meeting: April 25, 2011

Recent committee activity: For the April 25th meeting, the Committee invited the major domestic carriers to send representatives to discuss their company's contracting policies and philosophies. The goal was to open a collaborative dialogue between the Committee and the carriers that will be beneficial as the Purchasers Committee begins to recommend more contracting language and standards. The Committee requested that the carriers come prepared to discuss the three standards that have been endorsed by the Committee to this point: adoption of uniform standards for the electronic exchange of information; adoption of patient safety language similar to that used by PEBB/OEBB; and standardization of payment methods to Medicare. Almost every carrier was able to send at least one representative. They all addressed the endorsements, revealing varying degrees of progress in implementation, though most had at least taken steps. Carriers also discussed other innovations that are being tested, discussed, or implemented like e-visits, health coaching, community health partnerships, and cultural sensitivity tracking programs.

Issue areas discussed: Committee members were able to ask a variety of questions, both general and carrier specific, regarding carrier's philosophies towards and procedures for contract negotiations. Some questions included: Is the commercial market driving change? (They are working on pilots and pilot project evaluations. One important step will be creating incentives so that providers will have a stake in reform.) How big of a group is required on the purchaser's side of the table for a health plan to consider contract changes? (Depends on what the request is, and how the request is made.) What patient safety protocols do you follow? (Varied responses.)

Next steps for the committee: This will be an ongoing relationship that will be extremely valuable in moving health reform forward in Oregon. The Committee now goes on a four month hiatus and will meet again in September after the legislative session has ended and the direction of health reform is clearer. The Committee plans at that point to develop recommendations and strategies for public purchasing entities around the state to use and aim for when negotiating contract standards with their carriers.

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**Health Information Technology Oversight Council (HITOC)
eRx Stakeholder Group Meeting, March 10, 2011**

Recent committee decisions/agreements:

Members and staff reviewed the draft e-prescribing survey of hospital pharmacies, and reached agreement on the areas that need revision, and how to do so. Staff and volunteers will revise the survey and distribute it without further review from the Group as a whole. There was agreement that more information is needed from pharmacies in order to develop accurate and useful metrics for e-prescribing success. The eRx survey of retail pharmacies will be re-distributed to Board of Pharmacies licensees, and additional questions will be developed to survey the large chain pharmacies, and the approximately 125 independent/hospital pharmacies in the state -- not registered with Surescripts.

Issue areas discussed:

- The hospital pharmacy eRx survey was reviewed. The survey will be sent out shortly via e-mail to a list of hospital pharmacy directors provided by Oregon Association of Hospitals and Health Systems (OAHHS).
- Data metrics for measuring e-prescribing adoption within the state were discussed. Identified that Surescripts population data only accounts for pharmacies that have successfully tested the e-prescribing functions of the Surescripts system, but doesn't indicate any ongoing functionality.

Meeting Outcomes:

- Staff and members will finalize the eRx survey of hospitals based on changes discussed in meeting, and send it out to the OAHHS' list of hospital pharmacy directors.
- Members decided that further information needs to be gathered from Oregon pharmacies in order to develop accurate metrics for tracking e-prescribing success. Staff and Group members will develop questions to ask the approximately 125 independent/hospital pharmacies not currently registered with Surescripts.
- Other potential sources of e-prescribing information were identified, including information reported to OEHB and PEHB by health plans.

Points of agreement:

- Further surveying of Oregon pharmacies should be pursued in an effort to develop metrics for tracking e-prescribing adoption in addition to using the Surescripts data.

Areas of contention: None at this time.

Next steps for the committee: The next meeting is on April 14, 2011. The agenda will include discussion of e-prescribing data metrics, and reviewing results from the hospital pharmacies survey.

Next steps for the Board (only if applicable):

**Health Information Technology Oversight Council (HITOC)
Laboratory Stakeholder Group Meeting, March 11, 2011**

Recent committee decisions/agreements:

Members and staff reviewed updated drafts of the Group's Work Plan and the lab results survey, and reached agreement on the areas that need revision. Staff and members will revise the Work Plan and survey questions, and will send out the survey without further review from the Group.

Issue areas discussed:

- An updated draft of the Work Plan for the group was reviewed. Timeline of deliverables will be updated with specific date targets, starting with the lab results survey. Work Plan will be kept as a working document and updated as the Group's work evolves.
- The Group reviewed an updated draft of the lab results survey for Eligible Hospital labs.

Meeting Outcomes:

- Staff and volunteer Group members will revise the Work Plan and the lab results survey. The survey will be sent out via e-mail to the consolidated list of lab managers no later than March 25, 2011 and will close April 10, 2011. Staff will draft a preliminary summary report of the results for review at the April 15 meeting of the Labs Group.

Points of agreement:

- Efforts surrounding the standardization of lab orders by the Office of the National Coordinator for Health IT (ONC) and other states should be monitored, but at this time the Labs Stakeholder Group's primary focus should be on issues surround lab results distribution.

Areas of contention: None at this time.

Next steps for the committee: The next meeting is on April 15, 2011. The agenda will include a review of the results from the lab results survey, and an initial discussion of the lab results survey for providers.

Next steps for the Board (only if applicable):

Health Information Technology Oversight Council (HITOC)
Joint HIO Executive Panel, Legal & Policy Workgroup, and Technology Workgroup Meeting,
March 17, 2011

Recent committee decisions/agreements:

Workgroup members and Panelists agreed that developing pilot programs around the state that illustrate small scale, broad benefit health information exchange (HIE) capability that could be scaled to a larger population would benefit the statewide HIE effort. Potential pilots were identified and discussed. Staff presented descriptions of two data sharing agreements, the Nationwide Health Information Network (NHIN) Data Use and Reciprocal Support Agreement (DURSA) and the Health Information Security and Privacy Collaboration (HISPC) Model Private-to-Private Data Sharing Agreement, and received feedback from Workgroup and Panel members regarding each agreement's potential use in Oregon HIE efforts. It was agreed that a data sharing agreement is necessary for the statewide HIE, and the Legal & Policy Workgroup will consider the feedback received in future discussions.

Issue areas discussed:

- Discussion of potential areas for HIE related pilot projects included the Direct Project, medication reconciliation, coordination with the VA, integration of EHR in the first response arena, case/disease management interfacing, and the integration of mental, behavioral, and physical health.
- Barriers preventing communities from embarking on health care improving initiatives identified included organizational and technical barriers, lack of vendor interest if projects aren't standards-based, statutes protecting certain health information, consent management, and marketplace uncertainty.
- The NHIN DURSA and the HISPC Data Sharing Agreements (DSA) were discussed. If the NHIN DURSA is used it would be for agreements between the State/State Designated Entity (SDE) and HIOs and between HIOs, and either a standardized HISPC DSA would be developed for use within HIOs or HIOs would use or develop their own internal agreements.

Meeting Outcomes:

- Members of the Workgroups and the HIO Executive Panel are familiar with the status of the statewide HIE technology plan (including options for "last mile" connectivity) and with potential options for standard data agreements for the HIE.
- Potential possibilities for regional collaboration, and pilot and demonstrations projects related to HIE were identified through region specific discussion groups.

Points of agreement:

- Having one common data sharing agreement for the statewide HIE covering connections between regional HIO networks and between the State/SDE and the HIOs would be good for Oregon, with the NHIN DURSA as the top prospect.

Areas of contention: None at this time.

Next steps for the committee: The next meetings are: Legal & Policy Workgroup – April 14, 2011; Technology Workgroup – April 20, 2011; HIO Executive Panel – May 19, 2011.

Next steps for the Board (only if applicable):

**Health Information Technology Oversight Council (HITOC)
Technology Workgroup Meeting, April 20, 2011**

Recent committee decisions/agreements: Staff presented updates on HITOC and the other workgroups and panels, Oregon's Health System Transformation Team, and the Direct Project, including information from the recent ONC Direct Boot Camp. The workgroup discussed Individual Level Provider Directories (ILPDs), and identified potential challenges, opportunities and strategies for implementing the statewide HIE Core Service ILPD. The group received updates from the eRx and Labs Stakeholder Groups, and then discussed content standards for exchange.

Issue areas discussed:

- The ONC HIT Policy Committee (HITPC) approved recommendations for Individual Level Provider Directories (ILPDs). In contrast to the recommendations for Entity Level Provider Directories (ELPDs), they advocated against having a national framework with heavy standards.
- Both the Labs and eRx Stakeholder Groups have surveys in the field, and following the analysis of the surveys both groups will develop action plans for increasing the adoption of electronic lab reporting and e-prescribing, respectively.
- S&I Framework Clinical Document Architecture (CDA) consolidation, transitions of care, and lab results interface initiatives are underway and addressing content standard issues that will affect HIE and HIT efforts nationwide.
- Key themes from the ONC Direct Project Boot Camp included state HIE efforts pursuing thin-layer technology infrastructures that employ Direct messaging, and states/SDEs moving away from the idea of providing all the HISP services themselves towards monitoring external HISPs.

Outcomes:

- Members are familiar with the HITPC recommendations for ILPDs, the proposed phased approach for implementing an ILPD in Oregon's statewide HIE, and the status of the Labs and eRx Stakeholder Groups.
- Members are aware of the various initiatives related to HIE and content standards that are available for participation, including the S&I initiatives and the State HIE Lab Interoperability CoP.
- Staff will draft an RFP for Oregon's statewide HIE Core Services technology.

Points of agreement:

- While Oregon's HIE Core Service ILPD, along with the ELPD, should initially be implemented as a thin-layer service with the functionality to enable routing and address discovery for HIE participants, it should have the capacity to expand in the future to provide additional services.

Areas of contention: None at this time.

Next steps for the committee: The next Technology Workgroup meeting is Thursday, May 12, 2011. The agenda will include a discussion of the technology RFP for Oregon's HIE services.

Next steps for the Board (only if applicable): none at this time.

**Health Information Technology Oversight Council (HITOC)
Consumer Advisory Panel Meeting, April 26, 2011**

Recent committee decisions/agreements: The Consumer Advisory Panel unanimously supported the following recommendation from the Legal & Policy Workgroup regarding a consent policy for health information exchange (HIE) in the case of medical emergency:

- ***If a patient opts-out of HIE, or if a patient with Specially Protected Health Information (SPHI) does not affirmatively opt-in, there will not be an exception or over-ride of this choice for the case of a medical emergency and the patient's health data will not be sent via HIE to the emergency medical provider.***

Issue areas discussed:

- Personal health records (PHRs), including recent national survey finds around rates of adoption and usage, and consumer desire to have more on-line options for managing their healthcare
- The “Direct Project”, which is a method for secure email messaging of confidential patient health information among providers and between providers and patients.
- The Legal & Policy Workgroup’s rationale for their recommended consent policy, including:
 - Creating an exception or over-ride for the opt-out choice for emergencies could inadvertently create disincentives for general participation in HIE.
 - Patients will be clearly informed about the implication of their decision to opt-out, including that it will apply across the board, including for emergency medical care.
 - Patient health data will continue to be sent via traditional methods (including fax and phone) for those patients who have opted out of HIE.
 - Patients can change their consent directive at any time, including during an emergency.
- Input was provided to Grove Insight on a draft consumer messaging survey around health information technology and HIE.

Points of agreement:

- PHRs are important and should be promoted for use in Oregon.
- The Direct Project is an important development in facilitating consumer access to their own health data and the health data of those for whom they are responsible (for example, children and elderly parents).

Areas of contention:

- Nothing to report at this time.

Next steps for the committee: The next Consumer Advisory Panel Meeting will be scheduled for July 2011, and the final version of the consumer messaging survey and the survey results will be shared with the Panel at that time.

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**Monthly Report to
Oregon Health Policy Board
May 10, 2011**

Bruce Goldberg, M.D.

PROGRAM AND KEY ISSUE UPDATES

Healthy Kids Program

Enrollment

- Through March, 2011, **85,867** more children have been enrolled into Healthy Kids for a total child enrollment of 355,940.
- This is 107.33% of our goal of 80,000 more children and a 31.79% increase in enrollment since June 2009 (baseline).
- 4,372 children are now enrolled in Healthy KidsConnect.
- *See the chart below for a more detailed look at Healthy Kids enrollment.*

Child Insurance Rate

- We anticipate releasing final Oregon Health Insurance Survey data, including the new child uninsurance rate, on May 31st.
- The Office of Healthy Kids continues to work on outreach with community partners and a refined marketing plan aimed at KidsConnect eligible families. In addition, a comprehensive review of medical eligibility systems and policies is underway for the purposes of further streamlining and improving that work.

OHP Standard

- As of March 15, 2011, enrollment in OHP Standard is now **74, 091**.
- There have now been fifteen random drawings to date. The last drawing was on April 6, 2011 for 2,500 names. The next drawing will occur on May 4, 2011 for 2,500 names.

Legislature Approves Health Insurance Exchange IT Early Adopter Grant

On Friday, April 29, the Joint Ways and Means Committee approved acceptance of the Health Information Exchange Early Innovator IT Grant. Oregon applied during the interim and was awarded the competitive grant in February, along with six other states. Oregon will receive \$48 million to begin designing and implementing the IT infrastructure needed to run a successful health insurance exchange.

Upcoming

Next OHPB meeting:

June 14, 2011

1:00 PM to 4:30 PM

Market Square Building

	OHP Net Enrollment	HKC Net Enrollment	Total Net Enrollment	Increase Over Baseline	Monthly net enrollment change	% of Goal Achieved
9-Jul	271,493	0	271,493	3,648	3,648	5%
9-Aug	276,712	0	276,712	8,867	5,219	11%
9-Sep	281,374	0	281,374	13,529	4,662	17%
9-Oct	289,015	0	289,015	21,170	7,641	26%
9-Nov	294,459	0	294,459	26,614	5,444	33%
9-Dec	298,600	0	298,600	30,755	4,141	38%
10-Jan	303,026	0	303,026	35,181	4,426	44%
10-Feb	305,785	205	305,990	38,145	2,964	48%
10-Mar	309,047	549	309,596	41,751	3,606	52%
10-Apr	312,191	923	313,114	45,269	3,518	57%
10-May	314,933	1,133	316,066	48,221	2,952	60%
10-Jun	316,891	1,338	318,229	50,384	2,163	63%
10-Jul	319,878	1,662	321,540	53,695	3,311	67%
10-Aug	322,694	1,948	324,642	56,797	3,102	71%
10-Sep	326,545	2,335	328,880	61,035	4,238	76%
10-Oct	331,837	2,700	334,537	66,692	5,657	83%
10-Nov	334,120	3,046	337,166	69,321	2,629	87%
10-Dec	337,498	3,441	340,939	73,094	3,773	91%
11-Jan	342,272	3,712	345,984	78,139	5,045	98%
11-Feb	348,660	4,081	352,741	84,896	6,757	106%
11-Mar	349,424	4,372	353,796	85,867	971	107%

INTRODUCTION

The mission of the Oregon Health Care Quality Corporation (Quality Corp) is to measurably improve health care in Oregon through community-wide collaboration. As valued stakeholders in our efforts, the State of Oregon and the Division of Medical Assistance Programs (DMAP) have helped us develop the most comprehensive system for measuring and reporting on the performance of primary care providers in our state. That system, called *Partner for Quality Care*, now includes performance information for more than 75 percent of primary care providers in Oregon.

DMAP is receiving an individualized report to provide comprehensive information about the care provided to Medicaid Fee-For-Service beneficiaries. (DMAP analysts also have received a separate full file of both Medicaid-specific and community-wide data at the medical group and provider levels from Quality Corp on April 5, 2011 via secure FTP.) In this report you will find:

- Overview of the most recent *Partner for Quality Care* data submission
- Examples of the benefits of pooling data across health plans and Medicaid Fee-For-Service
- Summary of measures
- Performance comparisons for the ten participating data suppliers
- Race and ethnicity stratification results plus preliminary analysis on selected findings
- Key demographics of the patients and providers included in *Partner for Quality Care* data

PARTNER FOR QUALITY CARE DATA OVERVIEW

Tables 1a and 1b provide an overview of Quality Corp's most recent (Round 3) health care claims data submission. The data covers the period April 1, 2006 – March 31, 2010, with a measurement year of April 1, 2009 – March 31, 2010 for the purposes of quality measurement and reporting. Statewide data results were highlighted in the February 2011 report, *Information for a Healthy Oregon*.

Key Highlights

- 10 data suppliers, including eight commercial plans, one Medicaid Managed Care plan and Medicaid fee-for-service (aggregated data also includes claims from selected Medicare Advantage plans)
- 188 million medical claims and 121 million pharmacy claims
- 3.2 million unique patients captured in claims — demonstrating the value of aggregating data

Table 1a: Quality Corp Round 3 Data Submission Summary

Measurement year	April 1, 2009 – March 31, 2010
Round 3 data coverage period	April 1, 2006 – March 31, 2010
Data submission due date	July 31, 2010
Number of data suppliers	10*
Number of unique patients in Round 3	3,290,837
Number of eligible patients as of March 31, 2010 (end of Round 3 measurement year)	1,858,687
Number of unique providers in Round 3	497,643
Total medical claim records submitted in Round 3	188.57 million
Total pharmacy claims submitted in Round 3	121.18 million

*Participating data suppliers include CareOregon, Oregon Division of Medical Assistance Programs, Health Net of Oregon, Kaiser Permanente, LifeWise Health Plan of Oregon, ODS Health Plans, PacificSource Health Plans, Providence Health Plans, Regence BlueCross BlueShield and United Healthcare

Table 1b: Quality Corp Round 3 Product Line Summary

	Oregon Total Health Insurance Enrollment 2009*	Quality Corp Member Months as of March 31, 2010	Percent of State Total of Covered Lives
Commercial—All lines	1,798,000	1,437,992	80.0
Medicare—Total	602,000	140,597**	23.4
Medicaid—Total (includes managed care and fee-for-service)	475,000	287,587	60.5
Medicaid fee-for-service	85,015	121,449	n/a***

*Oregon data derived from Department of Consumer & Business Services' *Health Insurance in Oregon*, Jan 2011 < http://insurance.oregon.gov/health_report/3458-health_report-2011.pdf > and Oregon Health Plan managed care and fee-for-service enrollment data for March 2010 http://www.oregon.gov/DHS/healthplan/data_pubs/enrollment/2010/1003/fchp1003.pdf >

**Quality Corp receives only Medicare Advantage from selected plans.

***Quality Corp's member months total includes all Medicaid FFS beneficiaries enrolled as of 3/31/2010, while the Oregon Health Plan's website reports per-day member months as of 3/15/2010 and excludes recipients eligible under the following classes: QB, QS, NP, CW and BC. Additionally, recipients retro-actively enrolled after 3/15/2010 may not be reflected in the Oregon Health Plan data. The two sources are thus not directly comparable.

DMAP Data Submission

- DMAP's beneficiaries accounted for 5.7 percent of the total patients included in *Partner for Quality Care's* quality and utilization reports.
- Primary care providers have reported the importance and usefulness of including Medicaid data in patient-level and summary quality reports

BENEFITS OF COLLABORATION

This section shows the benefits of aggregating data from multiple suppliers to produce public reports on primary care quality in Oregon. *Partner for Quality Care's* public reports include clinics that meet the following criteria: four or more primary care providers in the clinic and at least 25 patients in the individual measure being reported. The following information demonstrates that because the majority of clinics submit claims to multiple payers, *Partner for Quality Care* is able to report on more clinics than any individual data supplier could on its own.

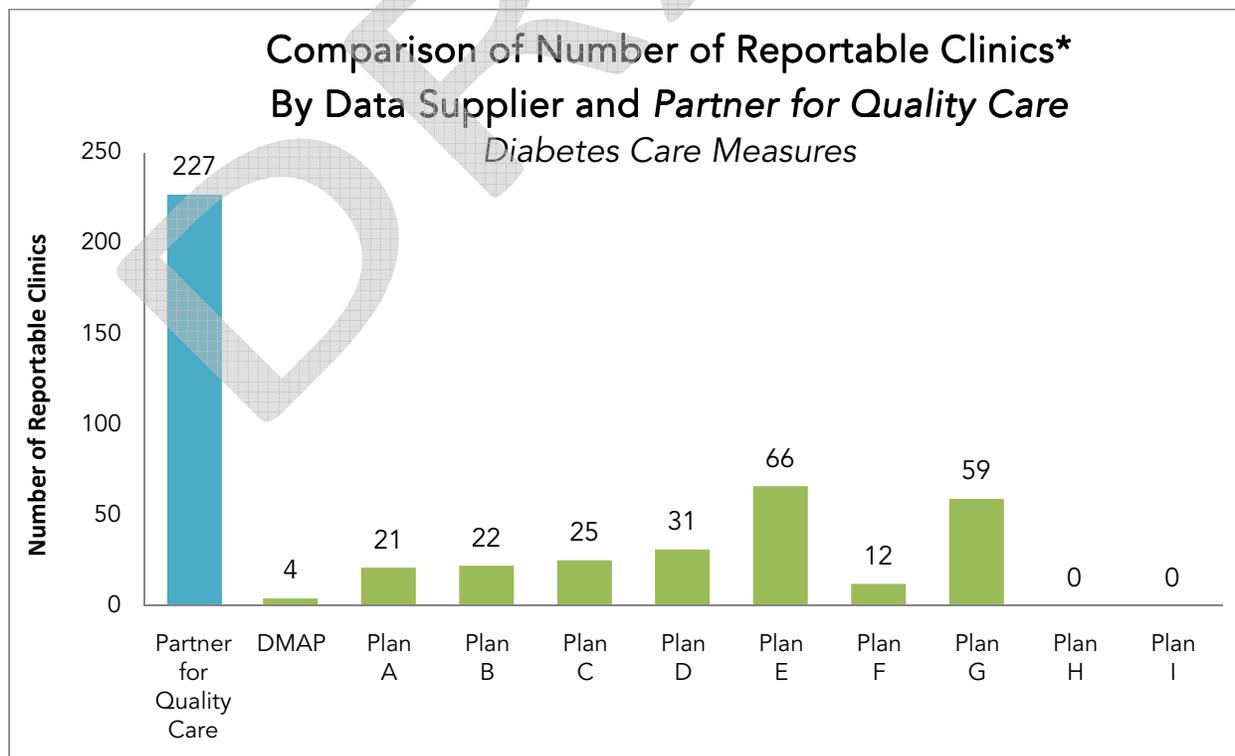
Key Highlights

- The majority of primary care clinics (80 percent) included in *Partner for Quality Care* public reports have contracts with 8-10 payers. Using their own data, data suppliers can see only a fraction of information about individual clinics. *Partner for Quality Care* reports provide payers, consumers and providers with meaningful, combined data not available elsewhere in Oregon.
- *Partner for Quality Care* reports diabetes care results for 227 Oregon clinics, while the average number of reportable clinics by a single data supplier is 24. Payers participating in *Partner for Quality Care* are able to compare clinic and medical group performance against Oregon and national benchmarks.

Table 2: Number of Clinics Submitting Claims to Multiple Payers*

	1-4 Payers Billed	5-7 Payers Billed	8-10 Payers Billed	Total
Number of Clinics	10	65	307	382
Percent of Total	2.6%	17.0%	80.4%	100.0%

*Based on billing claims during 4/1/2009 – 3/31/2010 from 10 participating payers

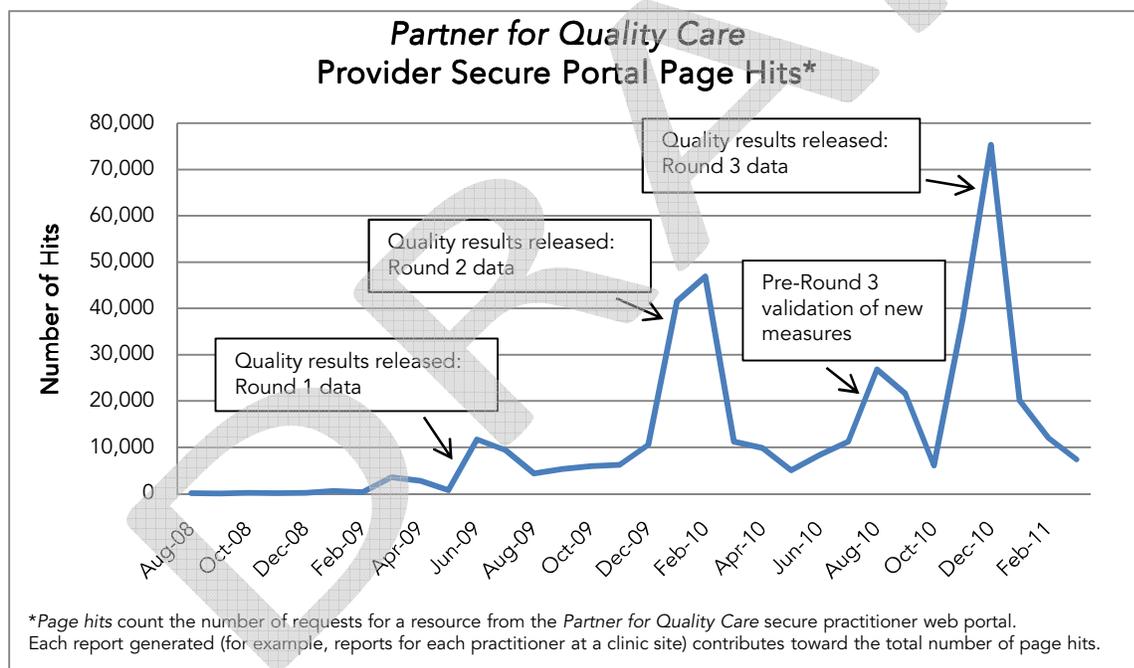


PARTNER FOR QUALITY CARE ONLINE

Partner for Quality Care hosts two websites – one for consumers and one for providers – to display relevant health care quality data¹. The consumer website, www.PartnerForQualityCare.org, lists quality scores for Oregon clinics and medical groups according to three categories: *Better*, *Average* and *Below*. The provider website is a secure portal that allows providers and medical group administrators (e.g. medical directors, quality improvement directors and clinic managers) to access their data and quality scores. Data on this website is displayed at the medical group, clinic, provider and patient levels. The graph below displays monthly page hits for *Partner for Quality Care's* secure portal since inception in August 2008.

Key Highlights

- Providers and medical group administrators make extensive use of *Partner for Quality Care's* secure online portal.
- 65 medical groups have completed a business associate agreement, which is required to access the quality reports and patient identifiable information.
- 75,335 page hits were generated in December 2010, coinciding with the latest (Round 3) data refresh.



¹ Information on how clinics, providers, health plans, purchasers and policymakers are using *Partner for Quality Care* reports are available in the latest *Information for a Healthy Oregon: Statewide Report on Health Care Quality* (release date: February 2011). More information on what data is reported publicly can be found in the Technical Appendix. Both documents are available at <http://www.partnerforqualitycare.org/publications.php>.

DEMOGRAPHICS

Partner for Quality Care's provider directory includes information for more than 75 percent of Oregon's practicing primary care providers. The directory links these providers with the clinics and medical groups where they work, allowing *Partner for Quality Care* to report on primary care quality and utilization at the medical group, clinic and provider levels.

Recognizing the unique challenges faced by small, often rural practices, the provider directory was initially developed to include medical groups with at least four providers. After three years of reporting and with multiple requests to understand the quality of care delivered by small practices in Oregon, *Partner for Quality Care* is beginning to expand its provider directory to include clinics with 1-3 providers.

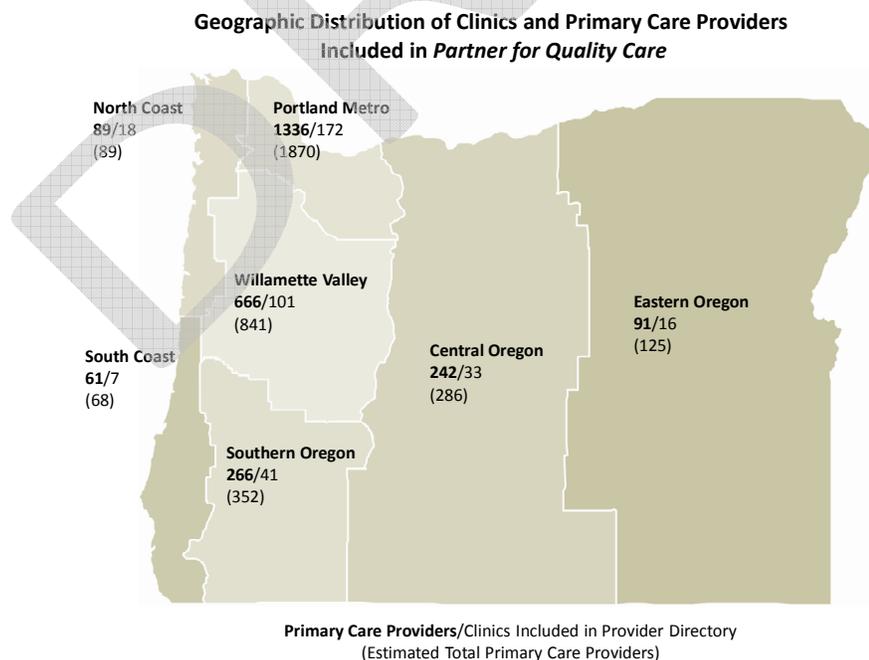
Provider Demographics

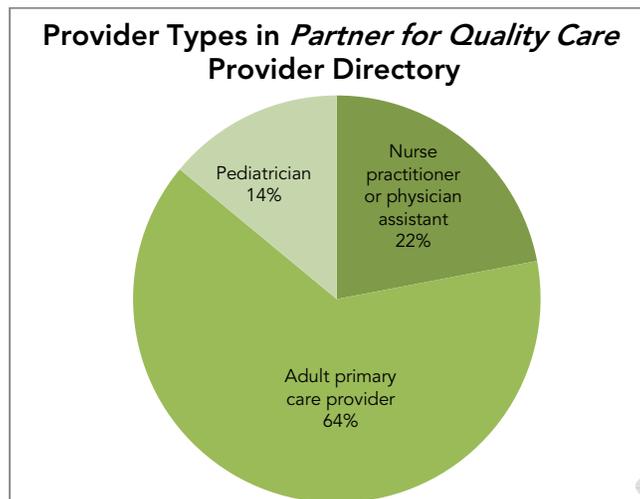
The following charts and tables illustrate the urban and rural regional distribution of Oregon clinics in *Partner for Quality Care's* provider directory, as well as the types of providers included in the data.

Key Highlights

- *Partner for Quality Care's* provider directory includes information for 2,751 primary care providers and pediatricians in Oregon. Over half (51 percent) of providers practice outside the Portland metro region.
- The majority of providers in the directory are adult primary care (family practice and internal medicine) physicians (64 percent); the initiative also includes pediatricians (14 percent), and nurse practitioners and physician assistants (22 percent).
- All providers in the directory with patients attributed to them for at least one measure receive quality reports and can access secure patient-level information for follow-up.

Map: Geographic Distribution of Clinics and Primary Care Providers Included in *Partner for Quality Care* Provider Directory





Continuous Enrollment of Patients

Partner for Quality Care reports nationally endorsed performance measures of quality and utilization primarily from the National Committee for Quality Assurance’s HEDIS set of measures. Continuous enrollment in a participating health plan or Medicaid fee-for-service is required for a patient to be included in these measures. This requirement was developed to ensure that patients are enrolled long enough to establish a relationship with a primary care provider and receive recommended care. Continuous enrollment and an allowable gap period is defined for each measure. For example, the diabetes care measures require continuous enrollment throughout the measurement year with one allowable gap in enrollment for up to 45 days. *Partner for Quality Care* was able to account for patients with insurance and Medicaid coverage from multiple health plans.

Key Highlights

- The majority of patients (77 percent) met continuous enrollment criteria for measures with a one year look-back period (e.g. diabetes, asthma and heart disease measures).
- The eligible patient populations for breast and cervical cancer screening measures were more largely affected by longer continuous enrollment requirements (64 percent and 52 percent, respectively, of total eligible patient populations).

Table 3: Effect of Continuous Enrollment Criteria* on Eligible Patient Populations

Look-Back Period for Measure	Number of Eligible Patients	Percent of Total**
One Year	1,430,885	77.0
Two Years (Breast Cancer Screening)	1,184,920	63.8
Three Years (Cervical Cancer Screening)	967,941	52.1

*Enrollment is measured across 10 participating health plans; continuous enrollment is defined as no more than one 45-day gap in enrollment during the measure look-back period

**Total eligible patients as of 3/31/2010 (end of Round 3 measurement year) is 1,858,687

This report contains national benchmarks from the voluntary HEDIS reporting system for health plans:

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SUMMARY OF PARTNER FOR QUALITY CARE MEASURES AND REPORTS

The following table displays the measures included in *Partner for Quality Care's* claims data submitted in July 2010. A subset of measures is publicly reported on the consumer website www.PartnerForQualityCare.org and all measures are privately reported to providers and medical groups for internal use and quality improvement. A clinic is considered eligible for public reporting if it has four or more practicing primary care providers and at least 25 patients in the individual measure being reported. Publicly reported measures are indicated with a "√" as are measures that adhere to NCQA HEDIS specifications or were included for the first time in the most recent (Round 3) quality and utilization reports.

Key Highlights

- Nine measures on diabetes care, women's preventive care and other chronic disease care are publicly reported.
- Two depression measures and nine new measures on utilization and pediatric care were reported privately to providers and medical groups during Round 3.
- The majority of measures are accredited by HEDIS, providing national benchmarks for comparison.

Table 4: Partner for Quality Care Round 3* Measures

HEDIS	Publicly Reported	New in Round 3	Area of Care / Measure
			<i>Women's Preventive Care</i>
√	√		– Breast Cancer Screening
√	√		– Cervical Cancer Screening
√	√		– Chlamydia Screening
			<i>Diabetes Care</i>
√	√		– Eye Exam
√	√		– Blood Sugar (HbA1c) Control Test
√	√		– Cholesterol (LDL-C) Test
√	√		– Kidney Disease Test
			<i>Other Chronic Disease Care</i>
√	√		– Asthma Medication
√	√		– Cholesterol Test for People with Heart Disease
√			– Antidepressant Medication (Short Term-12 weeks)
√			– Antidepressant Medication (Long Term-6 months)
			<i>Utilization</i>
√		√	– Appropriate Strep Tests for Children with Pharyngitis
√		√	– Appropriate Imaging for Low Back Pain
		√	– Generic Prescription Fills—NSAIDs
		√	– Generic Prescription Fills —PPIs
		√	– Generic Prescription Fills —SSRIs
		√	– Generic Prescription Fills —Statins
			<i>Pediatric Care</i>
√		√	– Well-Child Visits in the First 15 Months of Life, 5 or more
√		√	– Well-Child Visits in the First 15 Months of Life, 6 or more
		√	– Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

*Based on the measurement year 4/1/2009 – 3/31/2010

COMPARISONS OF DATA SUPPLIER RESULTS

Summary results for Providence Health Plans compared to the other nine *Partner for Quality Care* data suppliers are provided in Table 5. The results are aggregate rates (%) across each data supplier for claims data submitted in July 2010. Oregon and national (HEDIS 2009) benchmarks are also included for comparisons.

Key Oregon Highlights

- Results vary by supplier, especially for the women’s preventive care and pediatric care measures.
- Results are especially high across suppliers for diabetic eye exams compared to national HEDIS benchmarks.
- Results are especially low across suppliers for well-child visits for children ages 3-6 years compared to national HEDIS benchmarks.

Specific DMAP Highlights

- DMAP rates for diabetes care, other chronic disease care and pediatric care are generally lower than rates for other data suppliers.
- Consistent with DMAP’s extensive prescription drug programming, DMAP and contracted providers achieve higher scores than many of the other data suppliers when it comes to filled generic drug prescriptions—most notably for NSAIDs and PPIs.
- For Chlamydia screening rates, DMAP and contracted providers achieve higher scores than many other data suppliers.
- DMAP and contracted providers have far lower rates of cervical cancer screenings than other data suppliers; the DMAP rate is significantly lower than the Oregon aggregate rate by 37 percent.

Table 5: Round 3* Measurement Results for Partner for Quality Care Data Suppliers

Area of Care / Measure	DMAP	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Plan G	Plan H	Plan I	Oregon Aggregate Rate	National HEDIS Mean	National HEDIS 90 th Perc
Women's Preventive Care													
Breast Cancer Screenings	49.7	57.4	71.6	68.1	69.5	73.3	81.6	71	68.3	68.2	74.1	67.1	72.5
Cervical Cancer Screenings	37.3	63.7	70.7	74.5	74.7	75.4	84.7	74.1	73.5	76.3	74.5	74.6	79.5
Chlamydia Screenings	39.3	53	30.9	32.4	35.4	38.9	69.9	35.5	34.3	38.5	39.5	39.5	50.7
Diabetes Care													
Eye Exams	53.3	45.5	56	45.1	55.6	72.8	55.8	54.2	56.3	45.3	60.9	42.6	54.4
HbA1c Screenings	65.1	78.8	84.2	85.7	89.4	90.9	93.5	86.8	87.2	85.3	88.4	83.3	89.8
LDL-C Screenings	56.8	67.9	77.5	78.8	82.9	85.9	89.1	78	80.3	81.3	81.3	78.6	86.8
Kidney Disease Screenings	56.4	74	76.6	74.3	77.7	80.6	92.4	77.2	70.6	65.7	78.3	69.9	80.3
Other Chronic Disease Care													
Asthma Medication Mgmt	84.4	85.8	90.9	90.7	89.2	89.5	96.3	91.7	84.6	76.7	90.1	92.8	95.5
Heart Disease Cholesterol Test	62.1	66.6	86.2	86	85.1	89.1	80.3	79.8	87.5	83.5	82.9	80.2	89
Antidepression Medication- 12 weeks	56.7	62.6	68.5	62	61	64.3	75.7	62.2	63.4	65.5	65.9	63.2	69.6
Antidepression Medication- 6 months	43.5	54.8	50.7	42.3	42.7	47.5	61.9	44.2	45.7	54	49	46.4	54.3
Utilization													
Appropriate Strep Tests	63.1	65.8	68.3	75.2	77	76.1	86.4	74.1	73.9	84.2	76.8	75.5	87.1
Appropriate Low Back Pain Imaging	81.9	84.4	91	85.6	84	85.5	83.4	85.6	89.4	83.6	85.2	72.7	79.9
Generic Drug Prescriptions-- NSAIDs	91.3	97.4	85.3	84.4	84.2	87.5	--	87.3	83.2	85.8	87.7	n/a	n/a
Generic Drug Prescriptions-- PPIs	80.7	94.2	73.7	52.4	62.8	83.1	--	79.5	61.8	50.1	78.2	n/a	n/a
Generic Drug Prescriptions-- SSRIs	63.5	73.3	60	52.9	63	71.9	--	70.7	64.1	66	66.7	n/a	n/a
Generic Drug Prescriptions-- Statins	65.1	82.4	61.5	58.3	68.2	72.1	--	70	59.8	68.5	70.4	n/a	n/a
Pediatric Care													
Well-Child Visits 0-15 Months, 5+ visits	63.2	80.2	65.7	79.3	84.6	86.5	94	84.7	81.5	87	85.2	n/a	n/a
Well-Child Visits 0-15 Months, 6+ visits	44.6	62.9	45	62.7	66.8	68.3	85.2	65.5	62.4	66.7	67	71.9	82.5
Well Child Visits 3 - 6 Years	39.5	58.7	44.8	48.1	60.1	62	79.1	55.9	54.5	64.3	56.2	66	81.7

*Based on the measurement year 4/1/2009 – 3/31/2010

MEASURE RESULTS STRATIFIED BY TYPE OF COVERAGE

Table 6 provides *Partner for Quality Care* measure results by type of coverage (commercial, Medicaid and Medicare Advantage). As noted previously, the aggregated claims data does not include full coverage of Medicaid or Medicare services; however, this stratification provides a high level summary of differences in quality by product line.

Key Highlights

- Quality measure results vary by product line across all areas of care.
- Medicare Advantage plans achieve the highest rates on 9 of the 12 measures for which there is data.
- Commercial plan rates are higher than Medicaid rates on 15 of the 20 total measures.
- Medicaid plans achieve rates higher than commercial plans and Medicare Advantage plans on 3 of the 4 generic drug prescription measures.

Table 6: Stratified Measure Results by Type of Coverage*

Area of Care / Measure	Commercial Aggregate Rate	Medicaid Aggregate Rate	Medicare Advantage Aggregate Rate
Women's Preventive Care			
Breast Cancer Screenings	73.4	52.6	81.0
Cervical Cancer Screenings	77.7	51.0	--
Chlamydia Screenings	45.5	48.6	--
Diabetes Care			
Eye Exams	54.3	51.7	65.1
HbA1c Screenings	88.9	72.2	91.1
LDL-C Screenings	82.4	62.8	87.0
Kidney Disease Screenings	81.2	64.9	86.6
Other Chronic Disease Care			
Asthma Medication Mgmt	92.0	85.1	--
Heart Disease Cholesterol Test	79.5	65.3	87.6
Antidepressant Medication Mgmt- Acute Phase	67.7	60.3	75.4
Antidepressant Medication Mgmt- Cont Phase	51.4	45.8	62.8
Utilization			
Appropriate Strep Tests for Children with Pharyngitis	76.9	64.6	--
Appropriate Low Back Pain Imaging	85.7	82.8	--
Generic Prescription Fills -- NSAIDs	86.9	95.3	82.1
Generic Prescription Fills -- PPIs	73.7	89.1	80.1
Generic Prescription Fills -- SSRIs	66.1	69.1	72.4
Generic Prescription Fills -- Statins	67.3	75.7	73.2
Pediatric Care			
Well-Child Visits 0-15 Months, 5+ visits	85.7	74.8	--
Well-Child Visits 0-15 Months, 6+ visits	69.0	57.5	--
Well Child Visits 3-6 Years	61.6	53.1	--

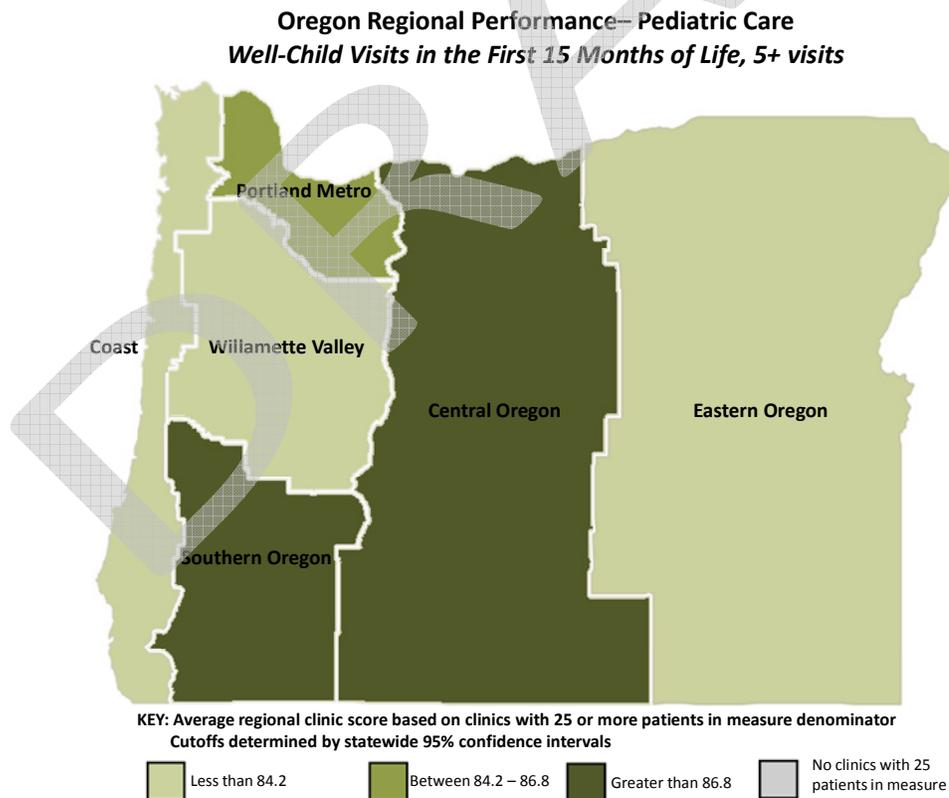
*See Table 1b for *Partner for Quality Care* Round 3 product line summary

OREGON REGIONAL VARIATION: PEDIATRIC CARE

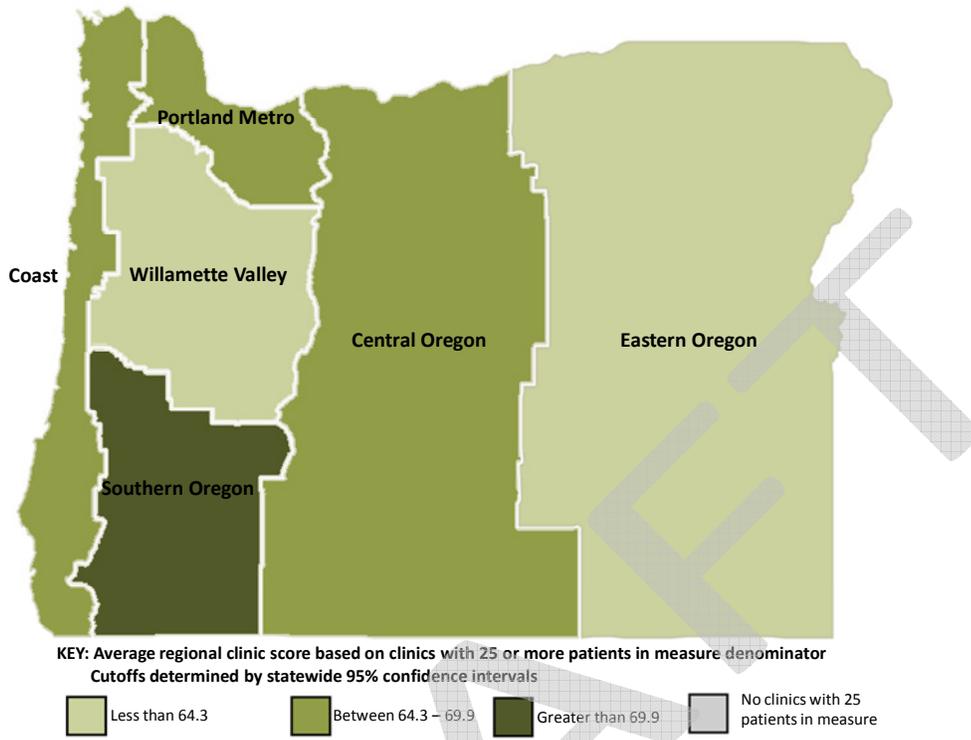
The *Partner for Quality Care* provider directory allows analysis of variation in clinic scores by geographical region. The following maps demonstrate regional variation in clinic scores on three pediatric care measures. For each measure, regional clinic rates were compared to the 95 percent confidence intervals for the Oregon clinic average. Only clinics that met *Partner for Quality Care's* public reporting criteria of four or more primary care providers and 25 patients in the measure were included. The darker a region's color, the higher it scored on a particular measure.

Key Highlights

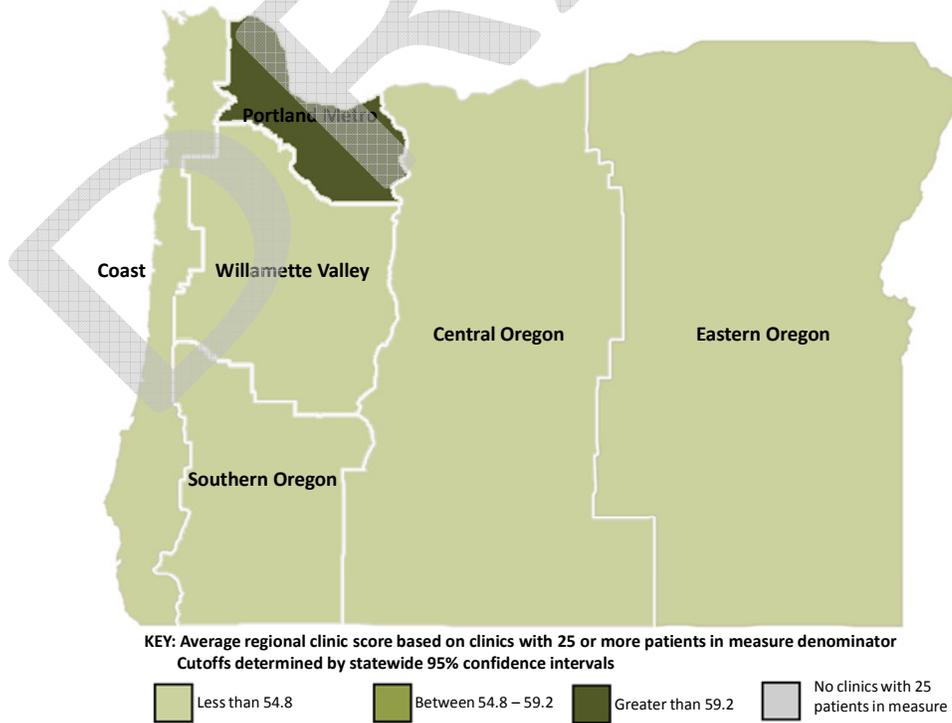
- Clinic results vary considerably by region across the set of pediatric well-child visit measures.
- Southern Oregon scored above the Oregon clinic average on both the 5+ and 6+ visit measures for children in the first 15 months of life.
- Portland metro, Central Oregon and the coast perform at or above the Oregon clinic average on at least one of the two well-child visit measures for children in the first 15 months of life.
- Portland metro is the only region to have a clinic average higher than the Oregon clinic average for the well-child measure for children ages 3-6 years; every other region has a clinic average that is less than the Oregon clinic average.
- The clinic average for Eastern Oregon is lower than the Oregon clinic average on all three well-child visit measures.



Oregon Regional Performance– Pediatric Care
Well-Child Visits in the First 15 Months of Life, 6+ visits



Oregon Regional Performance– Pediatric Care
Well-Child Visit in the Third, Fourth, Fifth and Sixth Years of Life

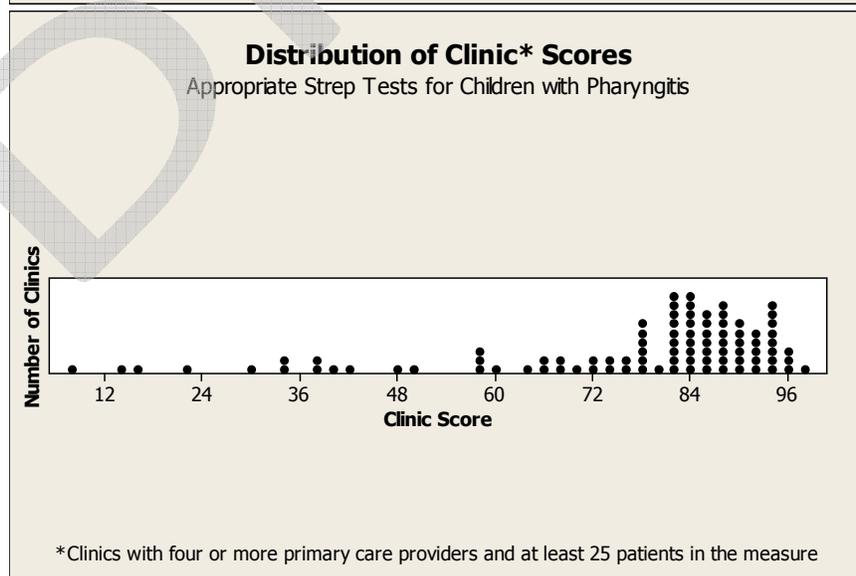
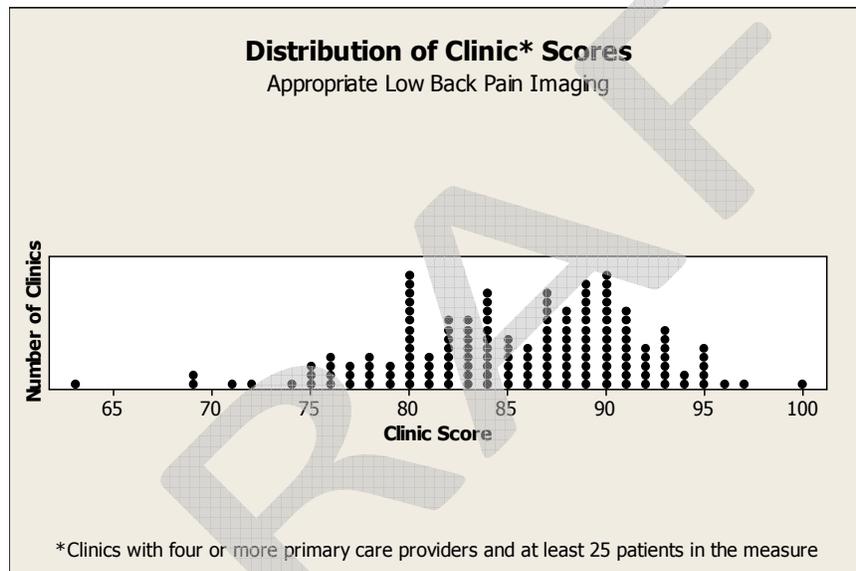


CLINIC VARIATION: UTILIZATION

The following plots demonstrate variation among Oregon clinics on two utilization measures—appropriate strep tests for children with pharyngitis and appropriate low back pain imaging. Only clinics that meet *Partner for Quality Care's* public reporting criteria of four or more primary care providers and 25 patients in the measure are included.

Key Oregon Highlights

- Oregon clinics perform well overall compared to national HEDIS benchmarks on appropriate low back pain imaging and clinic scores follow a relatively normal distribution.
- The range of Oregon clinic scores for appropriate strep tests is wide, with a low score of 7.1 percent and a high score of 97.1 percent.
- Initial contacts with some of the low-scoring clinics on the strep test measure demonstrates that some clinics use an outdated CPT code to bill for strep tests and have subsequently altered their billing practices.



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Oregon Health Care Quality Corporation Presentation to Oregon Health Policy Board

May 10, 2011

Agenda

- Overview of Quality Corp –Who are we ?
- How do we get our information ?
- Key Findings: 2011 Statewide Report
- Key Findings: DMAP FFS
- Future Directions and Opportunities

Quality Corp Mission



To measure and improve the quality of health care in Oregon through community-wide collaboration.

Quality Corp Organization

- Local, neutral, independent, not for profit
- 27 Member Board – Health Policy, Purchasers, Consumers, Providers, Health Plans
- 6 working subcommittees with over 100 volunteers
- Leadership in Quality Improvement through collaboration and relevant information

Funding Organizations

- CareOregon
- Medicaid Fee-For-Service (DMAP)
- Health Net of Oregon
- FamilyCare Inc.
- Kaiser Permanente
- LifeWise Health Plan of Oregon
- ODS Health Plans
- PacificSource Health Plans
- Providence Health Plans
- Regence BlueCross BlueShield
- UnitedHealthcare

- Robert Wood Johnson Foundation

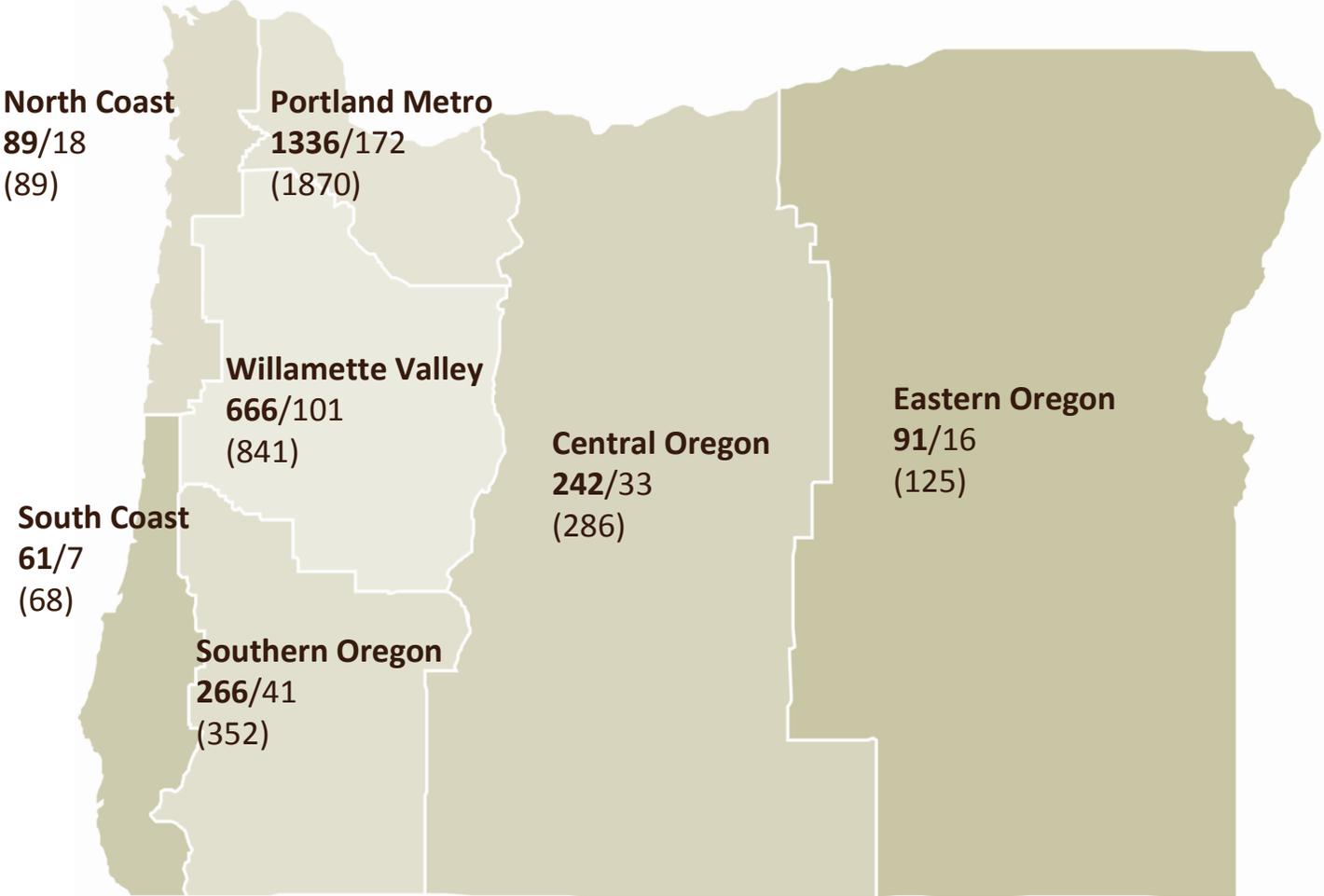


Information for a Healthy Oregon

Quality Corp Provider Directory- Data source

- Quality Corp developed and maintains the most comprehensive directory of primary care providers in the state.
- The provider directory contains information on 2,751 primary care providers currently practicing in Oregon at 388 adult primary care and pediatric clinics.
- Quality Corp's provider directory represents approximately 75% of all primary care practitioners actively practicing in Oregon
- Each provider is mapped to a clinic, which is defined as a physical doorway where patients receive care. The clinics are then mapped to medical groups.
- The provider directory contains the mailing address, phone, email address and contact at each medical group.

Geographic Distribution of Clinics and Primary Care Practitioners Included in *Partner for Quality Care*



Primary Care Practitioners/Clinics Included in Practitioner Directory
(Estimated Total Primary Care Practitioners)

Claims Data Summary

- 3.2 million unique patients captured in claims — demonstrating the value of aggregating data
- Almost half a million unique providers rendering services
- 188 million medical claims and 121 million pharmacy claims
- All providers in the directory receive quality reports with patient-level information for follow-up

Information for a Healthy Oregon

STATEWIDE REPORT ON HEALTH CARE QUALITY

FEBRUARY 2011



Partner for
Quality Care



Information for a Healthy Oregon

A project of the Oregon Health Care Quality Corporation

2011 Statewide Report

- Medical Groups
- State agencies
- Consumer groups
- Employer groups
- Public Policy Makers
- Participating health plans
- Other funders

Also available at:

www.PartnerForQualityCare.org

2011: 10 Data Suppliers & 20 Primary Care Measures

Women's Preventive Care

- Breast Cancer Screening
- Cervical Cancer Screening
- Chlamydia Screening

Diabetes Care

- HbA1c Test
- LDL-C Test
- Kidney Screening
- Eye Exam

Other Chronic Care

- Heart Disease Cholesterol
- Asthma Medication Mgmt
- Antidepressant Medication Mgmt (2)

NEW:

Utilization

- Low Back Pain Imaging
- Appropriate Strep Tests
- Generic Drug Fills (4)

Pediatric

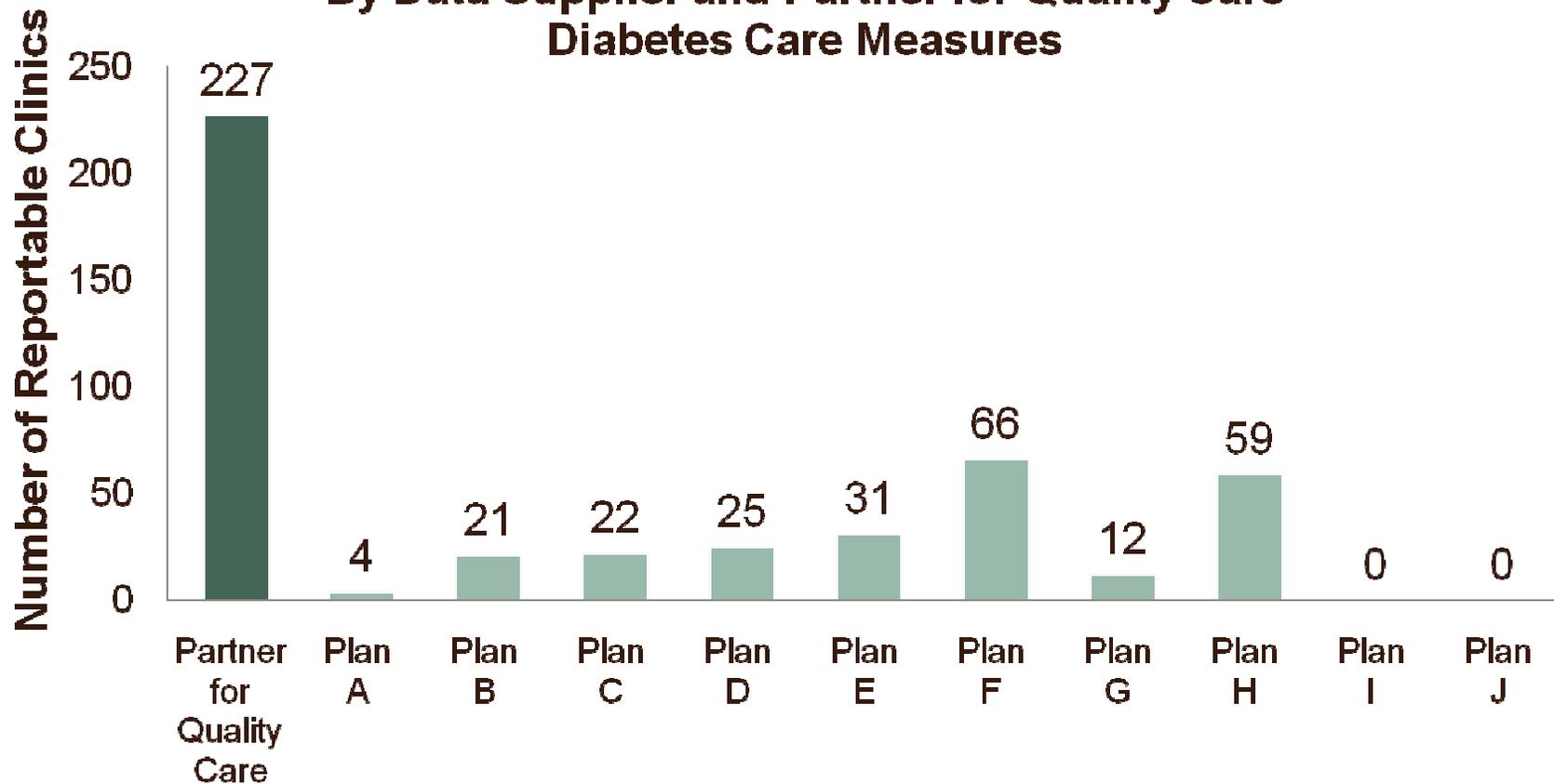
- Well-Child Visits 0-15 mths (2)
- Well-Child Visits 3-6 yrs

The Benefits of Q Corp Collaboration

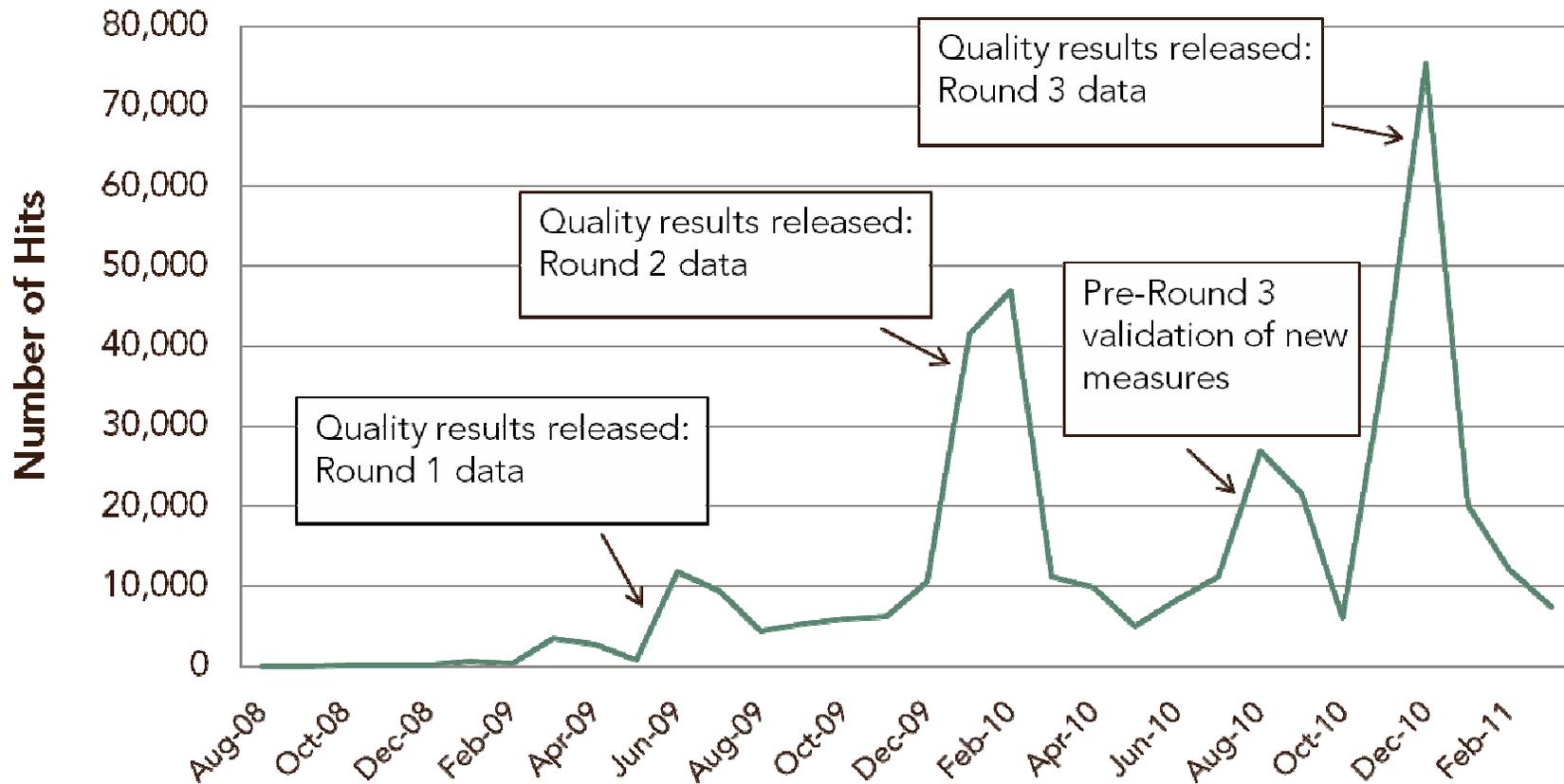
- The majority of primary care clinics (80 percent) included in *Partner for Quality Care* reports have contracts with 8-10 payers.
- Payers participating in *Partner for Quality Care* are also able to benchmark clinic and medical group performance against Oregon and national benchmarks.

Better Together

Comparison of Number of Reportable Clinics*
By Data Supplier and Partner for Quality Care
Diabetes Care Measures

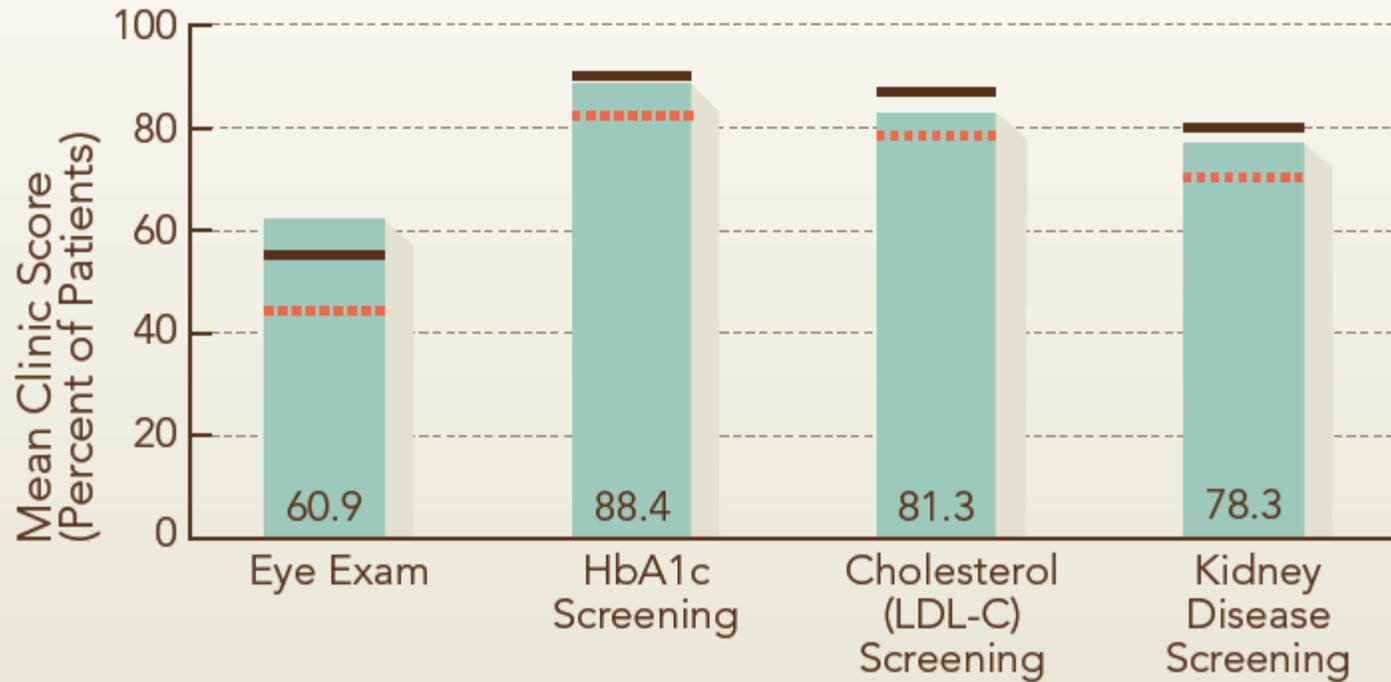


Partner for Quality Care Provider Secure Portal Page Hits*



*Page hits count the number of requests for a resource from the *Partner for Quality Care* secure practitioner web portal. Each report generated (for example, reports for each practitioner at a clinic site) contributes toward the total number of page hits.

Diabetes Care

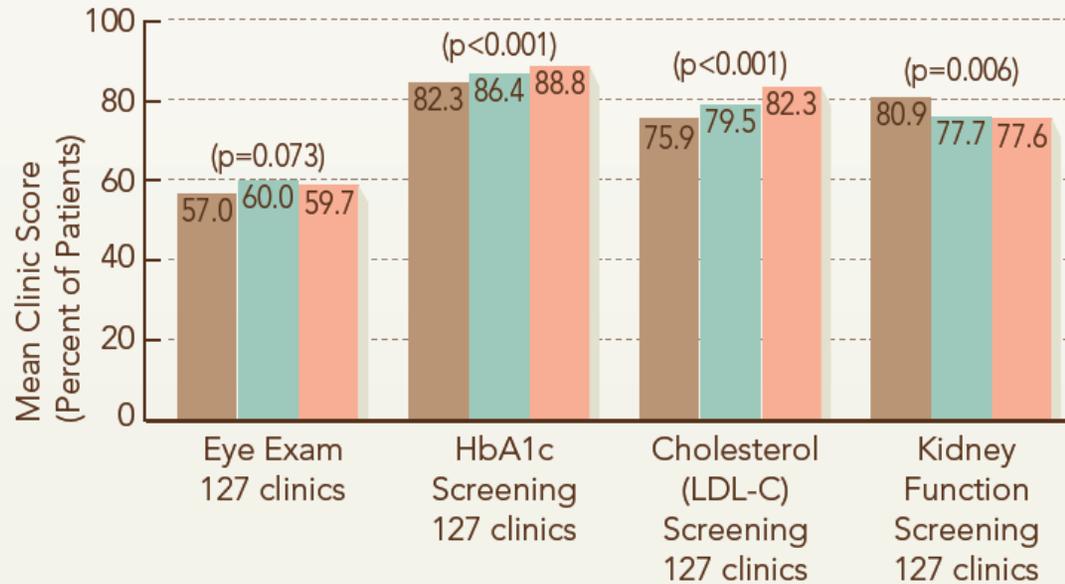


■ Measurement year Apr 2009–Mar 2010; Source data Apr 2008–Mar 2010
⋯ 2009 HEDIS national mean
— 2009 HEDIS national 90th percentile

Results for publicly-reported clinics with at least 25 patients in the measure

Three-year trends across eight common health plans

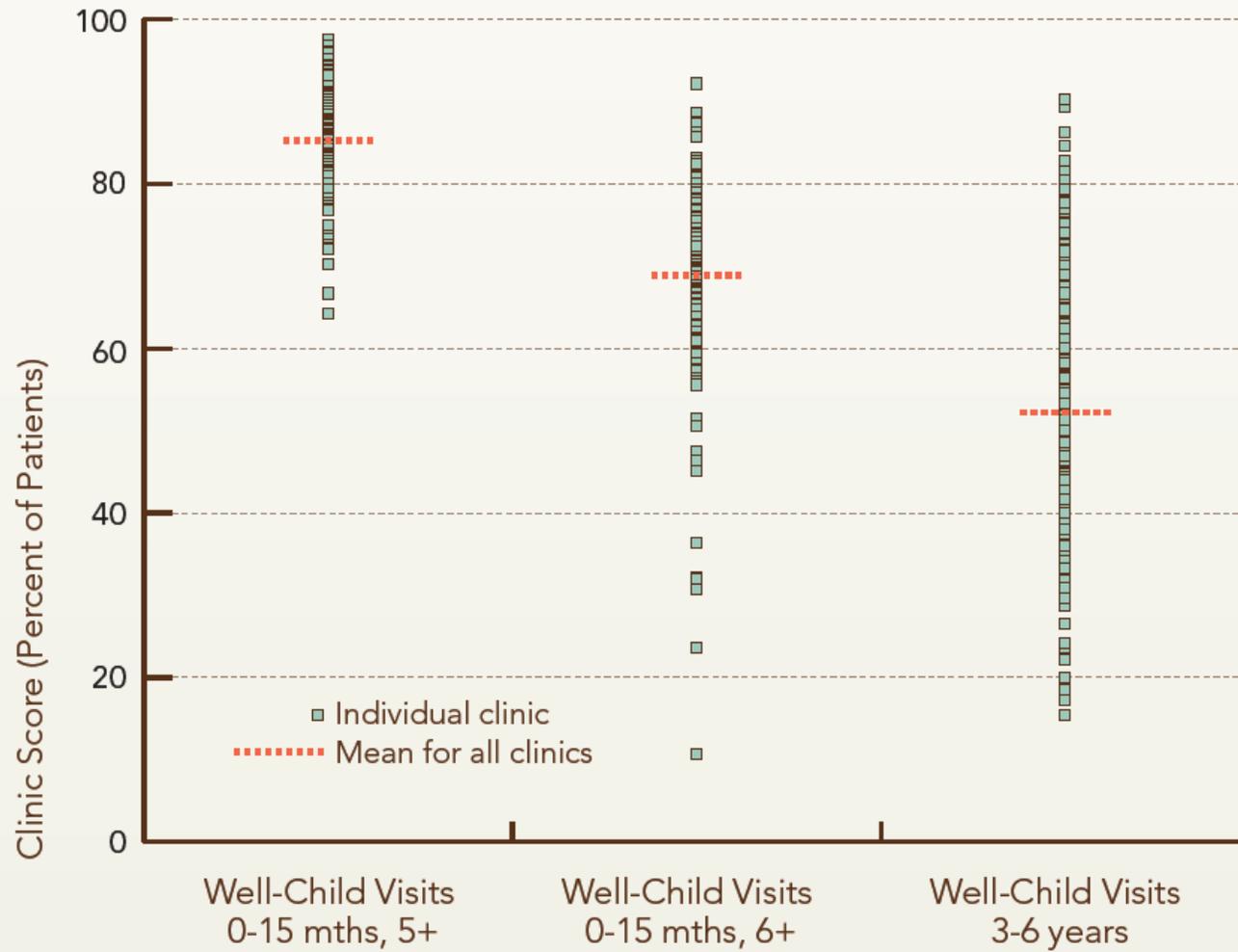
Diabetes Care



- Round 1 based on the measurement year Jan 1, 2007-Dec 31, 2007
- Round 2 based on the measurement year Apr 1, 2008-Mar 31, 2009
- Round 3 based on the measurement year Apr 1, 2009-Mar 31, 2010

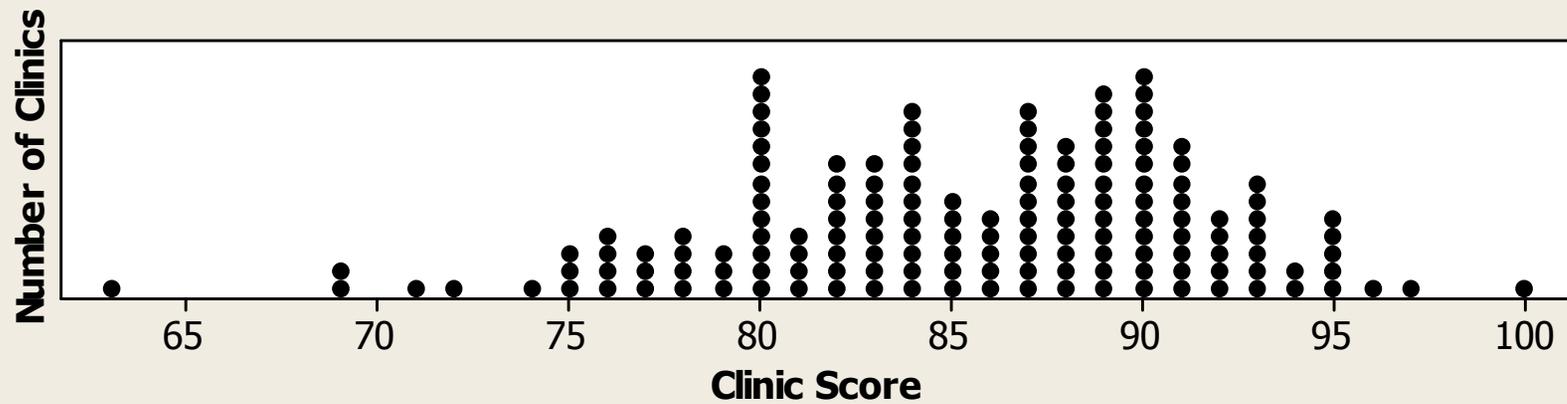
Means and linear trend analysis based on clinics with at least 25 patients in the measure denominator during Rounds 1-3, and publicly-reported in Round 3.

Variation in Pediatric Care Performance By Clinics



Distribution of Clinic* Scores

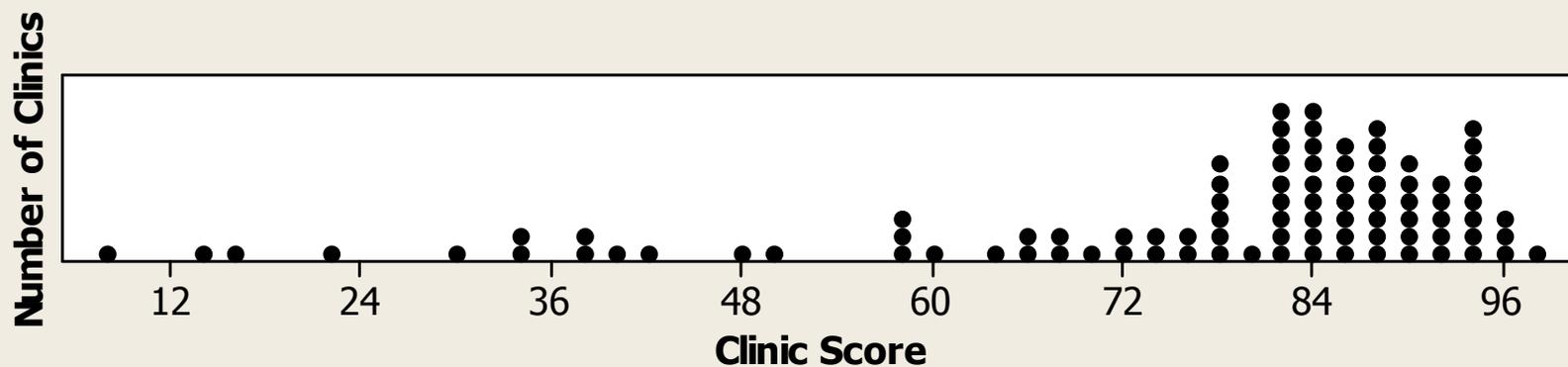
Appropriate Low Back Pain Imaging



*Clinics with four or more primary care providers and at least 25 patients in the measure

Distribution of Clinic* Scores

Appropriate Strep Tests for Children with Pharyngitis



*Clinics with four or more primary care providers and at least 25 patients in the measure

Data Conclusions from Statewide Report

- High-quality health care is happening in Oregon
- Important opportunities for improvement
- Care varies within Oregon's delivery system
- Data is more robust when stakeholders work together

Caveats:

- Claims data has limitations

Oregon Data Supplier Specific Conclusions

- Performance varies by supplier, especially for the women's preventive care and pediatric care measures.
- Performance is especially high across suppliers for diabetic eye exams compared to national benchmarks.
- Performance is especially low across measures for well-child visits for children ages 3-6 years.

DMAP FFS –Draft Observations

- Quality Corp is able to review statewide data and look at different data elements
- Data runs for all data suppliers including participating Medicaid Managed Care Plans and FFS
- Overall database includes approximately 60 % of Medicaid Population
- DMAP FFS population is 5.7 % of total patients included in reports

DMAP FFS –Draft Observations

Area of Care / Measure	DMAP	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Plan G	Plan H	Plan I	Oregon Aggregate Rate	National HEDIS Mean
Women's Preventive Care												
Breast Cancer Screenings	49.7	57.4	71.6	68.1	69.5	73.3	81.6	71	68.3	68.2	74.1	67.1
Cervical Cancer Screenings	37.3	63.7	70.7	74.5	74.7	75.4	84.7	74.1	73.5	76.3	74.5	74.6
Chlamydia Screenings	39.3	53	30.9	32.4	35.4	38.9	69.9	35.5	34.3	38.5	39.5	39.5
Diabetes Care												
Eye Exams	53.3	45.5	56	45.1	55.6	72.8	55.8	54.2	56.3	45.3	60.9	42.6
HbA1c Screenings	65.1	78.8	84.2	85.7	89.4	90.9	93.5	86.8	87.2	85.3	88.4	83.3
LDL-C Screenings	56.8	67.9	77.5	78.8	82.9	85.9	89.1	78	80.3	81.3	81.3	78.6
Kidney Disease Screenings	56.4	74	76.6	74.3	77.7	80.6	92.4	77.2	70.6	65.7	78.3	69.9
Other Chronic Disease Care												
Asthma Medication Mgmt	84.4	85.8	90.9	90.7	89.2	89.5	96.3	91.7	84.6	76.7	90.1	92.8
Heart Disease Cholesterol Test	62.1	66.6	86.2	86	85.1	89.1	80.3	79.8	87.5	83.5	82.9	80.2
Antidepression Medication- 12 wks	56.7	62.6	68.5	62	61	64.3	75.7	62.2	63.4	65.5	65.9	63.2
Antidepression Medication- 6 mths	43.5	54.8	50.7	42.3	42.7	47.5	61.9	44.2	45.7	54	49	46.4
Utilization												
Appropriate Strep Tests	63.1	65.8	68.3	75.2	77	76.1	86.4	74.1	73.9	84.2	76.8	75.5
Appropriate Low Back Pain Imaging	81.9	84.4	91	85.6	84	85.5	83.4	85.6	89.4	83.6	85.2	72.7
Generic Drug Prescriptions-- NSAIDs	91.3	97.4	85.3	84.4	84.2	87.5	--	87.3	83.2	85.8	87.7	n/a
Generic Drug Prescriptions-- PPIs	80.7	94.2	73.7	52.4	62.8	83.1	--	79.5	61.8	50.1	78.2	n/a
Generic Drug Prescriptions-- SSRIs	63.5	73.3	60	52.9	63	71.9	--	70.7	64.1	66	66.7	n/a
Generic Drug Prescriptions-- Statins	65.1	82.4	61.5	58.3	68.2	72.1	--	70	59.8	68.5	70.4	n/a

DMAP FFS –Draft Observations

Area of Care / Measure	Commercial Aggregate Rate	Medicaid Aggregate Rate	Medicare Advantage Aggregate Rate
Women's Preventive Care			
Breast Cancer Screenings	73.4	52.6	81.0
Cervical Cancer Screenings	77.7	51.0	--
Chlamydia Screenings	45.5	48.6	--
Diabetes Care			
Eye Exams	54.3	51.7	65.1
HbA1c Screenings	88.9	72.2	91.1
LDL-C Screenings	82.4	62.8	87.0
Kidney Disease Screenings	81.2	64.9	86.6
Other Chronic Disease Care			
Asthma Medication Mgmt	92.0	85.1	--
Heart Disease Cholesterol Test	79.5	65.3	87.6
Antidepression Medication Mgmt- Acute Phase	67.7	60.3	75.4
Antidepression Medication Mgmt- Cont Phase	51.4	45.8	62.8
Utilization			
Appropriate Strep Tests for Children with Pharyngitis	76.9	64.6	--
Appropriate Low Back Pain Imaging	85.7	82.8	--
Generic Prescription Fills -- NSAIDs	86.9	95.3	82.1
Generic Prescription Fills -- PPIs	73.7	89.1	80.1
Generic Prescription Fills -- SSRIs	66.1	69.1	72.4
Generic Prescription Fills -- Statins	67.3	75.7	73.2

Not shown: Three additional pediatric measures

DMAP FFS –Draft Observations

- DMAP FFS rates for diabetes care, other chronic disease care and pediatric care are generally below rates for other data suppliers. Further analysis demonstrates that rates for these measures are lower for Oregon Medicaid beneficiaries in general when compared to commercial.
- DMAP FFS and contracted providers score higher than many of the other data suppliers when it comes to filled generic drug prescriptions.
- For Chlamydia screening rates, DMAP FFS and contracted providers score higher than many other data suppliers. Further analysis shows that Medicaid beneficiaries have higher Chlamydia screening rates than commercial health plan clients.
- DMAP FFS and contracted providers have far lower rates of cervical cancer screenings than other data suppliers; the DMAP rate is significantly lower than the Oregon aggregate rate by 37 percent.

DMAP FFS - Draft Observations

- Primary care providers have reported the importance and usefulness of including Medicaid data in quality reports.
- Variations in care by race and ethnicity can be identified at the medical group and practice levels.

Looking Ahead

- DMAP Draft report feedback and next steps
- What information in the report is new and useful?
- What additional Q Corp information would be most useful?
- Other suggestions?

Looking Ahead

- Continuing reports on established quality metrics
- Reducing avoidable hospital readmissions for CHF and COPD
- Acute Low Back Pain Project (State, OHLC, OCHCP, Quality Corp, etc.)
- Patient Experience
- Improving quality and reducing cost to increase value

Looking Ahead

- Expanded new metrics to include: cost of care information, utilization reports, state baseline reports, new information for CCOs
- APAC implementation / transition
- Pilot project merging claims data and EMR data
- Evaluation of Oregon pilot projects (OHLC medical homes, imaging PA, etc.)

Thank You

- www.PartnerForQualityCare.org
- www.PartnerForQualityCareforPractitioners.org
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**Oregon Health Policy Board
Health Care Workforce Committee**

Approved by OHPB on [INSERT date]

I. Authority

The Health Care Workforce Committee is established by House Bill 2009, Section 7 (3)(a). This charter defines the objectives, responsibilities and scope of activities of the Health Care Workforce Committee. The Committee will be guided by the Triple Aim of improving population health, improving the individual's experience of care and reducing per capita costs. The Oregon Health Fund Board's final report, "Aim High: Building a Healthy Oregon," (November 2008) outlines the following ways in which training a new health care workforce addresses the triple aim:

Improves population health by:

- Ensuring an adequate numbers of health care providers in all areas in Oregon
- Improving access to primary care services by increasing the number of primary care providers

Improves the individual's experience of care by:

- Ensuring individuals have access to the providers they need in their communities
- Ensuring the diversity of Oregon's population is reflected in its provider workforce
- Ensuring providers are prepared to provide culturally competent care

Reduces per capita costs over time by:

- Ensuring providers are working at the top of their licenses
- Expanding the use of community health workers to provide cost-effective care

This charter will be reviewed annually to ensure that the work of the Committee is aligned with the Oregon Health Policy Board's strategic direction.

II. Deliverables

The Health Care Workforce Committee is chartered to coordinate efforts in Oregon to recruit and educate health care professionals and retain a quality workforce to meet the demand created by the expansion in health care coverage, system transformation and an increasingly diverse population. The Workforce Committee will advise and develop recommendations and action plans to the OHPB for implementing the necessary changes to train, recruit and retain a changing health care work force that is scaled to meet the needs of new systems of care: recommendations for patient-centered primary care homes and the implicit role of primary care in chronic care management will depend on how effectively we are able to respond to the workforce supply challenge.

One important objective of the Health Care Workforce Committee is to become the most complete resource for information about the health care workforce in Oregon by improving data collection and assessment of Oregon's health care workforce through regular analysis and reporting of workforce supply and demand. Initial efforts will focus on the health care workforce database created through HB 2009, which will include detailed demographic and practice data for the following professions: occupational therapists and certified occupational therapy assistants; physicians and physician assistants; nurses and nursing assistants; dentists and dental hygienists; physical therapists and physical therapy assistants; pharmacists and pharmacy technicians; and licensed dieticians.

The Health Care Workforce Committee will focus its work on identifying resources, needs, and supply gaps, and ensuring a culturally competent workforce that is reflective of Oregon's increasing diversity. To the extent possible, the Committee will coordinate and align recommendations of other health care workforce initiatives in its biennial recommendations to the Oregon Health Policy Board.

The Committee shall deliver to the Board the following:

- A report describing promising staffing models and/or workforce roles for Coordinated Care Organizations, Person-Centered Health Homes, or similar integrated, coordinated health care service delivery organizations.
 - The report should identify the health care workforce competencies required to implement promising models and recommend actions necessary to ensure those competencies within Oregon's health care workforce.
- Recommendations for standard administrative requirements for student placement in clinical training settings in Oregon (SB 879).
- A strategic plan for primary care practitioner recruitment in Oregon, developed in collaboration with interested parties (HB 2366).
- A brief report outlining alternatives to the current Office of Degree Administration processes for reviewing and approving new public educational programs or locations.
- Recommendations to OHA staff for metrics and/or analytical approaches to apply to the Oregon Health Care Workforce Database in order to identify emerging trends and issues related to changing workforce needs in a new delivery system.
- .

III. Timing

-
- The report on staffing models for integrated and/or coordinated care will be completed by December 2011.

- Recommendations for standard administrative requirements for student placement in clinical training settings will be completed no later than June 2012.
- The strategic plan for primary care practitioner recruitment will be completed by September 2012.
- The Committee will provide a report outlining alternatives to the current adverse impact process for public institutions by November 2011.
- Recommendations to OHA staff regarding metrics and/or analytical approaches for the Oregon Healthcare Workforce Database shall be made on an ongoing basis.

IV. Dependencies

The Health Care Workforce Committee will seek information from and collaborate with a wide range of partners including:

- a. The Oregon Workforce Investment Board and regional Workforce Investment Boards
- b. The Department of Community Colleges and Workforce Development, the Oregon University System, and other educational groups
- c. Health care professional licensure and certification boards
- d. Health care employers and providers
- e. The Oregon Office of Rural Health, the Oregon Primary Care Office, and Oregon's Area Health Information Centers (AHECs)
- f. The Oregon Employment Department

The Health Care Workforce Committee will provide draft recommendations and action plans for input to:

- a. OHA senior staff
- b. Oregon Health Policy Board

V. Staff Resources

The Oregon Workforce Institute (OHWI) will provide expert consultation to Committee leadership and staff and OHWI's Executive and Associate Directors will participate in Committee meetings and other activities alongside Committee Members.

OHA policy analyst: Lisa Angus

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Potential Projects for Workforce Committee 2011-12

Project	Key Question(s) or Request	Product	Timing
<p>Prepare workforce for CCOs and other new delivery models</p> <p>2010 Workforce Comm. re-commendation</p>	<ul style="list-style-type: none"> • What kinds of staffing or workforce models are best suited to new delivery systems? • Do we have the right people and skill sets now? If not, what paths (e.g. education, certification, standards of performance, changes in scope) are needed to get there? • How do we make sure the health care workforce reflects the kind of integration we want to see happening? 	<p>Report that:</p> <ul style="list-style-type: none"> • Identifies promising models and related health care professional competencies • Recommends steps to encourage adoption of new models and development of related competencies in current and future workforce 	<p>October 2011 – Draft report</p> <p>December 2011 – Final report</p>
<p>Develop standard admin prereqs for clinical rotations</p> <p>SB 879 and 2010 Workforce Comm. recommendation</p>	<ul style="list-style-type: none"> • OHA shall collaborate with the OWIB and a range of education and employer stakeholders to develop standard administrative requirements for student placement in clinical training settings. • At a minimum, standards must: <ul style="list-style-type: none"> • Address drug screening; immunizations; criminal records checks; & HIPAA orientation • Apply to nursing an allied health students training in hospital and ASC settings • Workgroup shall also make recommendations for implementation of the recommended standards 	<p>Report with recommended standards and steps for implementation</p>	<p>Oct./Nov 2011 – preliminary report in Workforce Committee</p> <p>March 2012 - Draft report to OHPB</p> <p>June 2012 – Report to Legislature</p>
<p>Strategic plan for primary care provider recruitment</p> <p>HB 2366-A; similar to 2010 Workforce Comm. re-commendation</p>	<ul style="list-style-type: none"> • Committee shall work with interested parties to develop strategic plan for recruiting primary care professionals to Oregon. • Plan must address: <ul style="list-style-type: none"> • Existing recruitment programs and best practices? • Role for promotional materials? • Role for a pilot visiting program? • Potential funding opportunities for coordinated recruitment? • Best entities to implement the plan? • In the interest of ensuring an adequate health care workforce for Oregon, are there improvements to be made to the current system of reviewing and approving new educational programs or sites for community colleges? 	<p>Strategic plan</p>	<p>March 2012 – preliminary report in Workforce Committee</p> <p>June 2012 - Draft report to OHPB</p> <p>Sept. 2012 – Report to Legislature</p>
<p>Clarify adverse impact policy</p> <p>2010 Workforce Comm. recommendation</p>	<ul style="list-style-type: none"> • In the interest of ensuring an adequate health care workforce for Oregon, are there improvements to be made to the current system of reviewing and approving new educational programs or sites for community colleges? 	<p>Short report with recommended changes to statute, rules, or practice</p>	<p>Oct./Nov 2011 – report to Committee</p>

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Legislative Update: Status of OHPB Bills as of 05/09/11

Changes from previous updates are in italics.

Since the last update, a major deadline has passed in the Legislature. Bills had to be passed out of the substantive committee of the chamber where the bill originated by last Thursday, April 21st, or the bill died. This deadline does not apply to bills in the Rules, Revenue, or Redistricting Committees in either chamber or to bills in the Joint Ways and Means Committee.

This deadline greatly reduced the number of active bills to track this session. However, it also means that proponents of bills which died will be looking to amend live bills with a similar “relating to” clause. The relating to clause is the first sentence of a bill, which describes the subject matter of the bill. A bill may be amended to include anything falling within that subject. Sometimes an unrelated issue fitting within a relating to clause is added to a bill that is moving to piggy back on the more popular issue. Other times the entire substance of a bill is removed and replaced with an unrelated matter fitting within the relating to clause, commonly referred to as a “gut and stuff” within Capitol.

Align Purchasing

HB 3559: Uniform payment methodologies. This bill directs OHA to establish by rule uniform methodologies for payment of hospitals and ambulatory surgery centers (ASC) and for health services that are paid based on the Medicare resource-based relative value scale (RBRVS). It also requires that OHA convenes an advisory work group to assist in developing the methodologies.

This bill was scheduled for a work session on April 20, 2011 with an amendment that Representative Kotek hoped would allow the bill to move out of committee. The bill was voted on, but did not receive the votes to move out of committee. The vote was 4-3 down party lines. Because the House is split evenly between parties, a bill must receive a majority “aye” vote by both parties to move out of committee.

Reduce Administrative Costs in Health Care

SB 94A – Administrative Simplification: This bill creates a work group within OHA to make recommendations to DCBS and OHA on administrative simplification standards which would then be codified in rule by DCBS, OHA, and DHS. This bill gives authority for DCBS to set standards for all payers, including third party administrators, managed care organizations, clearinghouses, and self-insured plans. Through discussions with stakeholders—primarily hospitals—this bill was amended to reflect that only one set of standards would be created for all payers, public and private. A federal law issue arose around a rule that requires OHA, as the single state Medicaid agency, to make its own rules for Medicaid and not be bound by another agency, such as DCBS. A compromise was made by adding language to clarify that only one set of standards will be used in the state, despite that DCBS and OHA will have separate rules, and that the two agencies will confer to ensure their rules are consistent. We also added language around what other administrative simplification issues the work group and agencies could address, including:

- Eligibility inquiry and response;
- Claim submission;
- Payment remittance advice;
- Claims payment or electronic funds transfer;
- Claims status inquiry and response;
- Claims attachments;
- Prior authorization;
- Provider credentialing; or
- Health care financial and administrative transactions.

SB94A passed out of the Senate unanimously with a 28-0 vote (two absent). A first public hearing was held on the bill on April 27th in the House Health Care Committee. Insurers, hospitals, and providers all testified in support of the bill. A work session is scheduled for May 9th..

Mission-Driven Public Corporation as Legal Entity for Oregon Health Insurance Exchange

SB 99A passed out of the Senate Health Care, Human Services, and Rural Health Policy Committee with a 5-0 vote in favor of the bill. The bill was heard on the Senate floor on Monday, April 25th, where it passed with wide bipartisan support 24-5 (1 absent). Two Democrats and three Republicans made up the “no” votes.

The bill has its first public hearing in the House Health Care Committee on May 6th and is scheduled for possible work session May 9th, 11th, and 13th.

As a reminder, the Senate’s Health Care Committee adopted the Health Reform Subcommittee’s -5 amendment. Some of the major issues ironed out by the subcommittee between the -3, -4, and -5 amendments included composition of the public corporation board, whether or not to allow industry representatives on the board (i.e. individuals employed or paid by health insurers or health care), the roll of agents and brokers, the authority of the public corporation to limit or accept plans or insurers, standards set by the exchange for health plans, and the fee charged to fund the exchange. The -5 amendment brings the bill back into alignment with OHPB’s recommendations, including:

- The committee returned to a 2-person exception for members of the board to also be employed in the health care or insurance industry (however, the ex officio position for the chair of OHPB or designee was removed, leaving two ex officio positions for the directors of OHA and DCBS, and 7 governor-appointed positions;
- The bill allows for agents/brokers to be included in accordance with the rules set by the federal government;
- The fee to fund the exchange was limited to being assessed only on plans within the exchange;
- The exchange can limit the number of plans offered in the exchange, but that limit has to apply equally to all insurers;

- The exchange cannot arbitrarily exclude an insurer from offering a qualified health plan in the exchange, but only plans which meet both federal standards as well as state standards are considered qualified. (The exchange was given broad authority to set state standards; something eventually agreed to by the health insurers so long as plans are excluded only on the basis of not meeting those standards and not for arbitrary, non-transparent reasons.)

Build Healthcare Workforce

HB 2400 – Funds the primary care loan repayment program: This bill passed the House Health Care Committee but was referred to Ways and Means because of the estimated fiscal impact of \$3.1 million in General Fund. Funding for this program was not included in the Governor’s Balanced Budget or the Co-Chairs budget. Given the current budget environment and challenges, this bill faces an uphill battle. No further hearings scheduled at this time. *Ways and Means will begin hearing policy bills in the next few weeks. If the committee is interested in moving this bill forward, it will be scheduled for a hearing during that period.*

SB 96 – Expands the workforce database: This bill allows OHA to include all health care regulatory board licensees in the Oregon Healthcare Workforce Database, which was created in 2009 by HB 2009. *Ways and Means will begin hearing policy bills in the next few weeks. We are working to have this bill scheduled. If the committee is interested in moving this bill forward, it will be scheduled for a hearing during that period.*

SB 879 – Student passport: This bill directs OHA to convene work group to develop standards for administrative requirements for student placement in clinical training settings in Oregon and report to interim legislative committee on or before June 30, 2012.

This bill passed out of the Senate Health Care, Human Services and Rural Health Policy Committee un-amended with broad-based support. It passed the Senate 29-0 (1 absent) and it passed out of the House Health Care Committee on Monday, May 2nd. It should have a floor vote in the House this week.

Two other bills affecting the work of the Health Care Workforce Committee are moving forward.

SB 225A, sponsored by Senator Monnes Anderson, requires OHA to study how other states resolve scope of practice disputes among providers and report back to a legislative interim committee on the findings. This bill passed the Senate 19-10 (1 excused). *It is scheduled for public hearing and possible work session in the House Health Care Committee on May 13th.*

SB 2366A, sponsored by Representative Nathanson, requires the Workforce Committee to work with partners to develop a strategic plan for primary care physician recruitment, and to identify the best organizations to implement the plan. The bill passed the House 58-0 (2 absent). *The Senate Health Care, Human Services, and Rural Health Policy Committee held a public hearing and possible work session on May 4th in which they*

considered an amendment to change the focus of the bill to primary care providers rather than just physicians. No action was taken on the amendment and the bill has not yet been scheduled for another work session.

OHA staff have worked closely with the sponsors and proponents on both of these bills to craft amendments which align with the bills with goals of OHPB and the *Action Plan for Health*.

Strengthen Medical Liability System

SB 95A – The bill passed out of the Senate 29-0 (1 absent). The bill was passed out of the House Health Care Committee unanimously with a “do pass” recommendation on April 27th and passed the House floor unanimously on May 5th. SB 95A is the first OHA and OHPB bill to pass both chambers and go to the Governor’s office for signature this session!

The bill:

- Ensures that an insurer cannot refuse to defend a physician being sued for malpractice because the provider disclosed an error to the patient or their family.
- Amends Oregon’s apology law to clarify that health care employers are also protected by the law.
- Current law allows the Patient Safety Commission to require reporting only of errors causing or creating a significant risk of serious physical injury or death. The measure gives the commission the flexibility to determine what serious adverse events can be addressed most productively through its reporting system.

Health System Transformation

HB 3650 – Introduced by the new Joint Special Committee on Health Care Transformation, HB 3650, is the vehicle for health system transformation. The committee has met 5 times since April 6th and is still actively working the bill. OHA submitted comments on the -3 amendment by the 5:00 PM deadline last Thursday. A -4 amendment should be available early this week. The committee plans to wrap up its work by May 18th. We anticipate the bill will move from committee to Ways and Means for further consideration as the budget is finalized.

The bill:

- *Establishes the Oregon Integrated and Coordinated Health Care Delivery System, in which Coordinated Care Organizations (CCOs) are accountable for care management and provision of integrated and coordinated health care for members within a fixed global budget.*
- *Requires the OHA to present qualification criteria for CCOs and the global budgeting process for approval by the Legislative Assembly.*

Office of Consumer Information and Insurance Oversight

**State Planning and Establishment Grants for the
Affordable Care Act's Exchanges**

Quarter II Project Report

Date: April 30, 2011

State: Oregon

Project Title: Oregon Health Insurance Exchange Planning Grant

Project Quarter Reporting Period: Quarter 2 (1/1/2011 – 3/31/2011)

Grant Contact Information

Primary Contact Name: **Nora Leibowitz**

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Website: <http://www.oregon.gov/OHA/health-insurance-exchange.shtml>

Award number: 1 HBEIE100032-01-000

Date submitted: April 29, 2011

Project Summary

During the second quarter of the planning period, Oregon utilized existing vacant agency positions to bring two new staff to respectively manage grants and contracts, and develop and analyze policy recommendations, moving Oregon forward with the creation of its health insurance exchange.

Legislation creating Oregon's Health Insurance Exchange, Senate Bill 99 (SB 99), was drafted last quarter and is currently in the process of receiving legislative hearings and work sessions, as amendments are proposed and discussed. A new House Bill, 3137, which would also establish an Exchange, was introduced in March.

Oregon signed a contract with Wakely Consulting Group to perform exchange operational development work. Members of the Wakely team travelled to Oregon for two days of meetings with the Exchange team and key stakeholders. During grant quarters three and four Wakely will deliver recommendations in the following areas: resources and needs; operations; finance; and information technology (further described below). In

February, Oregon also received notification that the state was selected to receive an Exchange IT Innovator grant award.

Core Areas

Background Research

Based on estimates of Medicaid eligibles and individual and small group Exchange participants developed previously, the Wakely Consulting Group is developing the following information to help guide Oregon's Exchange planning efforts:

- A detailed assessment of the resources and capabilities that exist in Oregon that can be used for the development of the Exchange to include infrastructure resource analysis and readiness assessment;
- A detailed needs and gaps assessment that will identify areas in which Oregon must develop or purchase resources or capabilities in order to establish the Exchange;
- Development of a financial model to project revenues and operating expenses over five years, including analysis of potential funding sources to make the Exchange self-sustaining by 2015;
- Identification of the Exchange's technical infrastructure needs and development of a plan to address those needs through the utilization of existing resources, building new capacity or outsourcing to meet resource needs in order to assist Exchange IT scoping for procurement; and
- Development of a detailed business operations plan.

Stakeholder Involvement

Internal stakeholders: The Exchange Steering Committee continues to meet monthly. In January the group discussed the draft legislation that will authorize the development, implementation and operation of Oregon's Exchange (Senate Bill 99), the IT Innovator Grant application and the contract with Wakely Consulting Group. Wakely consultants were in Oregon for the February meeting to review contract deliverables and conduct needs assessment discussions with Steering Committee members. The March meeting focused on the Establishment Grant application and a discussion of the amended SB 99.

The OHA Division of Medical Assistance Programs (DMAP), DHS Children, Adults and Families (CAF), Exchange staff, and Office of Information Services (OIS) met to discuss the technological infrastructure needs of the Exchange and eligibility and enrolment issues.

Other Stakeholder Input: The Exchange Consumer Advisory Committee met in January to discuss possible quality indicators, development of the Community Navigator component required under the Affordable Care Act and conducted a brainstorming session on outreach. The Exchange's website became operational in March, and includes a link for public comment and/or question. The Exchange Planning Grant narrative and quarterly reports are also posted on-line.

The Exchange Technical Advisory Group met once during the second quarter to discuss market design issues. Meetings are expected to resume once consultants have submitted operational planning recommendations.

In grant quarter 2 the Exchange staff arranged to present to and discuss Exchange issues with representatives of Oregon's federally recognized Tribes at the next quarterly meeting of the Tribes with the Oregon Department of Human Services and the Oregon Health Authority. This meeting will occur in grant quarter 3, at which time Exchange staff will determine what ongoing role Tribal government representatives want to have in the Exchange development process.

Program Integration

Until legislation authorizing the development of the Exchange passes and the Exchange board is appointed and confirmed, the Oregon Health Authority (OHA) is guiding and supporting the development and implementation of the Exchange. Exchange staff continues to participate in regular meetings with the leadership of the Self-Sufficiency Modernization (SSM) program, which is an effort to streamline, automate and modernize eligibility and enrollment for Medicaid and self-sufficiency programs in the state.

In February, Oregon received an Exchange IT Innovator grant. Oregon's application was based on an assessment that to meet the requirements of the Affordable Care Act, Oregon required a seamless eligibility and enrollment process that works for people who are eligible for Medicaid and for commercial insurance purchasers. Oregon was already working on an eligibility automation project and determined that coordinating the projects would be the most efficient way to proceed and provide the best solution for consumers.

The IT solution Oregon is building will improve eligibility and enrolment processing for existing public programs and allow easy transitions between Medicaid and commercial insurance. The OHA Office of Information Services is focused on a solution that will provide business applications to both DHS and OHA with a high degree of interoperability.

Resources & Capabilities

Two staff joined the Exchange team in March: a Lead Operations Analyst and a Grants and Contracts Analyst. Additional staff are helping the Exchange Executive Team focus on the legislative session, meet federal grant and contractual obligations and do the project management work necessary to keep the development of Oregon's Exchange on track. See the Personnel Changes/Updates section at the end of this report for further detail on the new hires.

Wakely Consulting Group spent two days in Oregon interviewing key stakeholders for development of contract deliverables (see Background Research section). Drafts of the first deliverables are scheduled for April, with final products are due in June and July.

Governance

As detailed in Oregon's first quarterly report, the state intends to establish its Exchange as a public corporation. A bill outlining the specifics of the Exchange (Senate Bill 99) had its first legislative hearing in February. The draft legislation establishes an Exchange

that will do more than just determine eligibility, make health plan comparisons easy and facilitate health plan enrolment. The Oregon Exchange is envisioned as a mission-driven public corporation that can help coordinate purchasing strategies for all Oregonians, starting with the individual and small group markets. The draft legislation includes significant accountability strategies, including:

- Legislative approval of an Exchange board approved business plan in February 2012;
- Development of the Exchange as a public corporation with a citizen Board appointed by the Governor and confirmed by the Senate;
- Quarterly reporting to State legislative leadership; and
- An annual financial audit and biennial performance audit.

A second bill that would authorize the creation of Oregon's Exchange, House Bill 3137, was introduced in March. This bill mirrors the Dash-2 version of SB 99, with the exception that it requires consumers wishing to use an insurance agent to pay for the service directly. Exchange staff is aware that the Affordable Care Act requires that a plan sold both inside and outside of the Exchange have the same premium, without regard to whether an agent/broker is used by the enrollee.

Finance

Last quarter's report described the fiscal analysis using enrollment estimates developed by Dr. Jonathan Gruber of the Massachusetts Institute of Technology. Based on Dr. Gruber's estimates and information on exchange costs based on the Massachusetts experience and related similar organizations, the Wakely Consulting Group will develop a financial model to project revenues and operating expenses for the Exchange over a five year period. Wakely will also recommend the funding needed for a self-sustaining Exchange by 2015, and identify sources for that funding. The final report is due in June.

Technical Infrastructure

As described in the Program Integration section, the work Oregon has undertaken to develop a system solution for the Exchange has been influenced by the state's Self-Sufficiency Modernization (SSM) effort. Oregon's Exchange will be an integrated, web-accessible portal for Medicaid and commercial coverage. During the second grant quarter Oregon continued to nurture working relationships with SSM IT staff developing high level process mapping requirements of an IT system that can meet the needs of both the Exchange and eligibility automation efforts. The state has been in contact with vendors that can develop and/or offer the software needs that meet the business purpose.

Wakely Consulting Group and its subcontractor KPMG, contracted using Exchange Planning Grant Funds, are providing assistance to the Exchange and SSM staff in preparation for the procurement of an IT software solution and system integrator that will help the state customize the software to meet eligibility automation and Exchange needs. The consultants will also help OHA and DHS choose a software vendor in grant quarter three.

Oregon originally planned to use Planning Grant funds to contract with a consultant to coordinate IT efforts between the Exchange and self sufficiency modernization efforts. Based on additional analysis of project needs, Oregon decided to hire a policy analyst who could fully integrate activities with Exchange policy, Exchange IT and SSM staff. This position will also ensure that Medicaid eligibility and enrollment issues are identified and addressed (including but not limited to issues that await further federal clarification and those that need additional state-level decisions). The position will be filled in April 2011 and additional information about the individual who fills this position will be provided in the grant quarter three report.

Business Operations

Legislation that will authorize the Exchange ensures that the organization has the needed governance structure to assure compliance with the Affordable Care Act, as well as ensure transparency and accountability to Exchange consumers, the public, and state legislature. Legislation guiding the creation of Oregon's Exchange will also outline reporting requirements to the Governor and Legislature.

The Wakely Consulting Group will deliver a draft business operations plan in May, with a final report in June. The plan will include a determination of the Exchange's needs in the following areas: customer service; government relations; communications; marketing, information and outreach; publications; contracting; appeals; policy; data; financial management (including auditing, budget and general financial management); information technology; staffing (executive, managerial and operational); human resources management; internal management and organizational structure; legal; accounting; research and analysis; procurement; facilities; and any other planning needs identified.

Regulatory or Policy Actions

As noted in the first quarterly report, the Oregon Health Policy Board submitted its recommendations regarding the formation of an Exchange to the Legislature in December 2010. Senate Bill 99, establishing the Exchange, its governance structure and functions was introduced by Governor John Kitzhaber in February 2011. The Senate Committee has heard this bill, discussing the language, proposing multiple amendments and hearing public testimony from interested stakeholders. Exchange and OHA leadership have testified on the legislation and have provided assistance to legislators on the ACA Exchange provisions. Additionally, a House Bill (HB 3137) establishing an insurance exchange was introduced in March by the House Committee on Health Care. Current drafts of SB 99 Dash-5 amendments and HB 3137 are included as appendices one and two.

Barriers, Lessons Learned, and Recommendations to the Program

Stakeholder Communications Challenges

Oregon continues to hold Consumer Advisory Group meetings. During the 2011 Oregon legislative session, Exchange staff has held discussions with all stakeholders regarding the Exchange authorizing legislation. Communication with key stakeholders has been

critical during the 2011 Legislative Session. Public hearings and/or work sessions on Exchange legislation occur on a weekly basis and as a result new amendments are regularly being drafted. Careful analysis of the amendments, and communication of the proposed changes, is a vital component in getting legislation passed.

While Exchange and other OHA staff are involved in discussions with stakeholders (including insurance carriers, consumer advocates, small business owners, insurance agents and others) the compressed timing and rapid action of the legislative session has not made it possible to gain the support of all stakeholders for all amendments to the Exchange authorizing legislation. Further, as stakeholders represent a variety of interests and positions, groups respond disparately to amendments. We have seen some successes in the process employed by the Senate Subcommittee on Health Reform, where SB 99 originated. The Subcommittee Chair asked stakeholders to submit comments and proposed amendments by a given date and then asked Exchange staff to help organize proposals for discussion by key legislators. The analysis and support of the Exchange staff allowed legislators to dig into important policy issues, including the composition of the Exchange board, the role of the Exchange, and the use of agents within the exchange. While legislators conducted negotiations and made the final decisions about amendments to the bill, staff was able to provide assistance to clarify what was federal law, what state law and what was discretionary, as well as the implications of various policy options.

While this effort was fairly successful in educating legislators and engaging stakeholders, it did not produce a bill that was satisfactory to all stakeholders. The version of the bill passed out of the Senate Health Care, Human Services, and Rural Health Policy Committee was not supported by some consumer groups, as the bill does not explicitly authorize the Exchange to negotiate rates with participating carriers and allows up to two board members to be employed by or have a financial relationship to the health insurance, insurance agent or medical industries. Lacking the support of all consumer advocates may affect the final legislation, though the full impact is not yet known.

Medicaid System Challenges

Over the past few years, Oregon has faced eligibility staffing shortages and a slow economic recovery. With DHS program and information technology staff, Exchange staff has discussed strategies to use the planned electronic system to reduce the DHS eligibility staff workload in 2014. Oregon is currently working to align Medicaid, SNAP, TANF and ERDC eligibility criteria as much as possible. A major hurdle continues to be that in 2014 Medicaid eligibility will be based on tax concepts (tax filing households and Modified Adjusted Gross Income [MAGI]) which differ from SNAP eligibility based on household numbers and income/expenses. In addition, current SNAP rules require a client interview and verification of the past 30 days of income, which limits a state's ability to automate eligibility determinations, given the absence of real-time database for certain forms of income.

Eligibility is currently determined using a paper-based process, and there is currently no comprehensive real-time database with which the Exchange could interface. This increases the work involved in the IT solution Oregon is developing, but also makes the

success of this work that much more vital. Medicaid eligibility is based on “point in time” income, and for some forms of income, there is no comprehensive real-time database showing current income; Oregon and other states are pondering the implications of this.

Exchange and Medicaid staff are starting to address how to provide outreach to the approximately 200,000 Oregonians who will become newly Medicaid eligible in 2014. Additionally, Oregon is thinking about eligibility redetermination intervals and the subsequent churning between Medicaid and Exchange products offered in the individual market, as well as how to educate newly insured people about their new insurance coverage.

Oregon is also addressing the determination of eligibility for seniors and people with disabilities, particularly the population needing long-term care (LTC), including looking at where the income limit for these populations differs from the Medicaid limit and the differing methods for calculating income. Oregon is preparing to address a variety of issues and is hoping to be assisted by additional federal guidance, including:

- Calculations involving populations subject to MAGI and non-MAGI;
- Whether the Exchange has a role for individuals seeking a long-term care eligibility determination; and
- How and at what point in the process the system should ask about needs such as the applicant’s need for help with basic activities of daily living and long-term care.

Information Technology Systems Challenges

Several discussions occurred this quarter regarding where the technology for the Exchange should “reside,” with a final decision that for at least the first several years it should reside with the Oregon Health Authority. The Exchange Development Director, policy staff and IT leadership agree that the Exchange’s programmatic and policy needs should guide technology development and that DHS and OHA applications must maintain a high degree of interoperability, including seamless real time Medicaid/self-sufficiency determination and enrollment and individual/small group insurance comparison and enrollment. Exchange staff has been actively involved in both the research leading up to the selection of a software vendor and IT process mapping. One challenge has been that the Legislature is skeptical about the state’s ability to successfully administer large IT projects. To respond to this concern, Exchange IT and policy leadership have agreed to significant reporting to and oversight by the legislature, as well to nurture a strong partnership between the Exchange IT leadership and the state’s legislative fiscal office IT lead.

Overall Implementation Challenges

Oregon is currently developing budget and staffing estimates based on existing information, recognizing new staff will face a steep learning curve regarding the Exchange’s functional capabilities. Attempting to accurately identify the internal and contracted resources needed for the Exchange will help Oregon’s Exchange ensure long-term sustainability. One of next big challenges facing Oregon will be to garner the technical expertise needed to develop a detailed understanding the current market,

enabling the state to determine structures for risk adjustment, gauge market influence and estimate small employer interest.

In addition to operational challenges, the Exchange must simplify complex provisions and issues surrounding the Exchange, in order to facilitate stakeholder communication and understanding of implications and regulatory issues.

Public Input for the Oregon Health Policy Board

April 22, 2011 – May 4, 2011

Doc #	Summary	Comment Type	Writer
1	It is crucial that you involve the Producers in the Health Insurance Exchange. They provide a highly valuable service to both the public and the business community by allowing them to make informed health care decisions.	Email Submitted 4/29/2011	Robin Ewry
2	A plea to remember those who “fall through the cracks:” people with debilitating illness and very few, if any, options for insurance. Includes a severe and traumatizing personal anecdote.	Email Submitted 5/2/2011	Peggy Burnett

From: "Robin Ewry/Cascade Associates"
<robine@cascadeassociatesnw.com>
To: <ohpb.info@state.or.us>
Date: 4/29/2011 4:56 PM
Subject: Producer involvement

Thank you for allowing me an opportunity to comment. I would like to encourage the Oregon Health Authority to allow for Producer involvement in the Insurance Exchange currently being established. I have worked as part of the produce community for 10 years and have found that producers provide a service that is highly valuable to the public, and particularly the business community. It is my sincere belief that for the exchange to work effectively produce must play a crucial role in delivering this product to the public. Many of our clients are already expressing concern about the coming changes the insurance industry. I have made it my goal to spend significant amounts of time with my clients to try and help them understand some of the coming changes. I fear that without produce involvement both individuals and businesses alike will be entirely ill-equipped to make informed decisions.

Please take these concerns into consideration, and evaluate to cost of not involving an already trained community of insurance professionals who are already plugged into the community.

Thank you,
Robin Ewry

From: "peggy burnett" <peggyburnett80@gmail.com>
To: <ohpb.info@state.or.us>
Date: 5/2/2011 6:32 PM
Subject: Current Health Initiatives Input

Please consider those of us who "fall through the cracks" : we have chronic, debilitating (but not bed-ridden) illness, and/or multiple issues like myself (i.e. uninsured, unemployed, mobility impaired, chronic pain from medical error, and PTSD from a landmark DV (domestic violence) case involving a police officer. One barrier to employment is bad enough, but multiple barriers, poor paying jobs with inadequate (or no) insurance are literally "killing" me. I fear I will be homeless and dead within a year, through no fault of my own. I do not want to be a tax burden, but am VERY scared at this point. Several of my former coworkers and friends have ended in suicide and death because of similar situations. Yes, children are important, but I provided for my son, as they should provide for theirs. If a parent can afford a mortgage, flat screen tvs, ipods, and all my son and his wife have and receive free healthcare for their children, while I suffer in silence, in a cheap studio apt., with no luxuries, worried about medication or rent, it is NOT right, and a LOT of Oregonians are in the same boat! Yes, the future is important, but many of us are extremely frightened...we don't even have a house or assets to lose, we will (and many have already) lost our modest non-asset everything due to these "cracks,"

In regards to DV "prevention" PLEASE, consider that in the time I have relocated to Oregon, due to my own DV escape, there have been an average of one police officer DV murder-suicide reported in this state (where the officer killed themselves after killing the spouse/partner). Please take partners/family of law enforcement seriously when they report, or one suspects possible DV, and pass a similar law that removes weapons and the "code of blue" from dangerous officers. They have a real advantage, when they tell the partner;"Who you gonna call??? I AM the police!" There are good and bad in all parts of society, but partners of law enforcement are especially in danger. When I was threatened, then the er doc found evidence, and stated they were a mandatory reporter, I had to BEG for 24 hrs, then decided if he was going to kill me anyway, I might as well "die talking," as I no longer had anything to lose. Fortunately for me, the abuser committed several counts of perjury in superior court, and he and his mother physically attacked me in the courtrooms in front of judges.

I still live in fear, that someday he will locate me and keep his promise, and suffer horribly from PTSD and cannot afford treatment. Due to the "greater good" the state used the perjury counts to get him to resign, after 2 yrs of testimony, and many ruined lives aside from my own. As, had they "fired" him for perfury, all the inmates in that state could have had their cases dismissed and sue that state ... etc... so one dangerous person on the loose was not as bad as prison floodgates opening on many important cases he had something to do with in any way, as an "officer of the court"

Please note, if you want further details on how one can easily "fall through cracks" I would be pleased to assist in providing succinct detailed information and/or data that can help others in our state, that can ultimately save money and improve healthcare for all, and save taxpayers money now as well as in the "long run."

Sincerely,

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"Peggy" Margaret R. Burnett