

Oregon Health Policy Board

AGENDA

July 10, 2012

Market Square Building

1515 SW 5th Avenue, 9th floor

8:30 a.m. to noon

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

#	Time	Item	Presenter	Action Item
1	8:30	Welcome, call to order and roll call Consent agenda: 6/12/12 minutes	Chair	X
2	8:35	Director's Report <ul style="list-style-type: none">• Health System Transformation<ul style="list-style-type: none">○ CCOs○ Innovator Agents• Supreme Court Decision on ACA	Bruce Goldberg	
3	9:00	CMS Waiver <ul style="list-style-type: none">• Final CMS Terms and Conditions• DSHP and the "2% test"• State and CCO Accountability	Tina Edlund	
4	9:45	Essential Health Benefit <ul style="list-style-type: none">• Board discussion and preparation for OHPB and Oregon Health Insurance Exchange Board joint meeting in August	Jeanene Smith	
	10:15	Break		
5	10:30	OHPB Workgroup on SB879: Student Passport <ul style="list-style-type: none">• Workgroup recommendations• Board discussion and next steps	Lisa Angus Terri Johanson, Ed.D.	X
6	11:00	State of the public's health in Oregon	Jean O'Connor	
7	11:45	Public Comment	Chair	
8	Noon	Adjourn	Chair	

Next Meeting:

Joint Meeting with Oregon Health Insurance Exchange Board

August 14, 2012

Market Square Bldg.

1 p.m. to 5 p.m.

Oregon Health Policy Board
DRAFT Minutes
June 12, 2012
Market Square Building
1515 SW 5th Avenue, 9th floor
1 p.m. to 4 p.m.

Item
<p>Welcome and Call To Order Chair Eric Parsons called the Oregon Health Policy Board (OHPB) meeting to order. All Board members were present.</p> <p>Bruce Goldberg and Tina Edlund were present from the Oregon Health Authority (OHA).</p> <p>Consent Agenda: The minutes from the May 24, 2012 meeting were unanimously approved.</p>
<p>Director's Report – Bruce Goldberg Bruce Goldberg gave an update about CCO Implementation. He outlined the accomplishments of the last 90 days, including the RFA, letters of intent, and the 11 provisionally certified CCOs. He spoke about the tension between innovation and accountability, and said that Oregon is doing something no one has done before. Goldberg also spoke about next steps, which included contract approval by CMS and planning how to transition members.</p> <p><i>The Director's Report can be found here, starting on page 5.</i></p>
<p>CMS Waiver – Tina Edlund Tina Edlund discussed the 1115 waiver and Oregon's commitments to CMS, including:</p> <ul style="list-style-type: none">• \$1.9 billion expenditures must be connected to CCOs and health system transformation• Creation of incentive system tied to quality metrics• Reduction of total Medicaid expenditures within OHP by two percentage points within two years.• Investment in healthcare workforce <p>Edlund said CMS is particularly interested in how we can grow at a fixed rate of growth and still meet the standards and requirements of actuarial soundness. She also said that CMS is interested in a much stronger incentive structure. Edlund said final waiver approval is expected July 1, 2012.</p>
<p>All Payer All Claims dashboard – Gretchen Morley Gretchen Morley gave an update about the All Payer All Claims dashboard. She presented slides depicting demographic information and said there is still some information that is missing from the dashboard, including Medicare Fee-for-Service, uninsured, and standalone dental and vision data.</p> <p>Morley said next steps include continuing to clean and understand the data, strategic steps to improve the data collection and analytic priority planning.</p> <p><i>The Update for All Payer All Claims Database can be found here.</i></p>
<p>Essential Health Benefits workgroup – Jeanene Smith and Lou Savage Jeanene Smith and Lou Savage gave a report on the Essential Health Benefits workgroup. Smith said after discussions surrounding affordability and the typical employer plan, the group gave a preliminary recommendation of the Pacific Source Small Group plan. Savage talked about what will be offered in the Health Insurance Exchange and said companies will be competing based on efficiencies.</p> <p>Smith said the workgroup's final recommendation will be posted for public comment through July. She also said that a summary of all public comments, workgroup discussion and the group's recommendation will be presented to the Board in August.</p> <p><i>The Essential Health Benefits Workgroup Update can be found here, starting on page 7.</i></p>
<p>Break</p>

Review of OHPB retreat feedback and next steps – Diana Bianco

Diana Bianco reviewed the OHPB work session that was held in May:

The Board wants to focus on transformation of care and community health:

Transformation of care

- Aligning purchasing
- CCO effectiveness
- Workforce
- Goals and measurements

Community health

- Public health/prevention
- Community health assessments and improvement plans
- Workforce
- Potential focus on obesity, tobacco, pregnancy
- Coordination with education (Early Learning Council)
- Education about when to use which systems
- Goals and measurements

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The Summary of Discussion on Board Roles and Workplan can be found [here](#), on page 17.

Public Comment

The Board heard testimony from two people:

Lavinia Ross, a Sweet Home resident, spoke about her personal medical journey and her experiences without medical insurance.

Betty Johnson, Mid-Valley Healthcare Advocates, commended the Board and the OHA staff for the hard work around transformation. Johnson requested access to applications for the provisionally certified CCOs as soon as possible.

John Mullins, Oregon Law Center, spoke about the need for advocates to have access to CCO applications as quickly as possible. Mullins said it's important for advocates to ensure CCOs are patient-centric.

Adjourn

Next meeting:

July 10, 2012

8:30 a.m. to noon

Market Square Building

1515 SW 5th Ave, 9th Floor

Portland, OR 97201

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850



Center for Medicaid and CHIP Services

July 5, 2012

Bruce Goldberg, MD, Director
Oregon Health Authority
500 Summer Street Northeast, E-15
Salem, Oregon 97301-1097

Dear Dr. Goldberg:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) is approving your February 29, 2012, request to amend and extend Oregon's section 1115 Oregon Health Plan Demonstration (21-W-0013/10 and 11-W-00160/10) through June 30, 2017, in accordance with section 1115(a) of the Social Security Act.

Under the demonstration, Oregon will launch new Coordinated Care Organizations (CCOs) to deliver higher-quality, coordinated care for Medicaid beneficiaries. CCOs are managed care entities that will operate on a regional basis, with enhanced local governance and provider payment structures that promote transparency and accountability; CCOs will replace the specialized managed care entities currently contracted through the Oregon Health Plan. This demonstration will test the efficacy of new approaches to care delivery through CCOs, including the use of person-centered primary care homes and non-traditional health workers. The demonstration is designed to support community-driven, innovative practices to promote evidence-based, coordinated, and integrated care that is aimed at improving the health of communities and populations, and centers on an active commitment to data and measurement.

Under the demonstration, CCOs will serve most Oregon Medicaid beneficiaries, including children and adults eligible under the state plan or through the demonstration. Individuals who are eligible for both Medicare and Medicaid or who are Native Americans will have the option to enroll but will not be required to do so. CCOs will promote administrative efficiencies by consolidating the previously fragmented care management and program administration activities for the OHP beneficiary's physical, behavioral and oral health services. Over the course of the demonstration, Oregon will transition its payment systems for the CCOs from a traditional managed care reimbursement mechanism to a system of balanced incentives that rewards improvements in outcomes. Each CCO will identify areas to target for improvement that will result in more efficient delivery of quality care, such as reducing re-hospitalization through better discharge planning and follow-up care, or improving perinatal and maternity care. Quality measurement is a key aspect of this demonstration, and common, transparent metrics will be used to compare across CCOs and compare Oregon to national performance.

Through these initiatives, the amended 1115 demonstration aims to achieve a 2 percentage point reduction in the growth rate of Medicaid spending on a per person basis, without reducing eligibility or benefits. Progress will be measured both by reviewing the State and Federal cost of purchasing care for individuals enrolled in CCOs and by assessing data to ensure that CCOs simultaneously improve quality of care and access for the Medicaid population.

Working together, the federal government and the State will carefully monitor progress toward the demonstration's goals and evaluate its success. A series of clear program benchmarks will enable the State, with CMS' technical assistance, to ensure progress toward lower cost and improved quality and access. The demonstration authorizes expenditures on certain Designated State Health Programs (DSHP), and in order to align incentives and support progress, if demonstration goals are not realized after appropriate interventions have been pursued, CMS will reduce DSHP funding.

CMS approval of this section 1115 Demonstration amendment is subject to the limitations specified in the approved waiver and expenditure authorities. The State may deviate from the Medicaid State plan requirements only to the extent those requirements have been specifically listed as waived or not applicable to the expenditure authorities. All requirements of the Medicaid program as expressed in law, regulation, and policy statement not expressly waived or identified as not applicable shall apply to the Oregon Health Plan Demonstration.

The CMS approval of the Oregon Health Plan Demonstration amendment and extension is conditioned upon continued compliance with the enclosed set of STCs, waivers and expenditure authorities defining the nature, character, and extent of anticipated Federal involvement in the project. The award is subject to our receiving your written acknowledgement of the award and acceptance of these STCs, waivers and expenditure authorities within 30 days of the date of this letter.

Your project officer is Ms. Terri Fraser. She is available to answer any questions concerning your section 1115 demonstration. She may be reached as follows:

Ms. Terri Fraser
Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-5573
Facsimile: (410) 786-5882
Email: terri.fraser@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Fraser and to Ms. Carol Peverly, the Associate Regional Administrator in our CMS Seattle Regional Office. She may be contacted as follows:

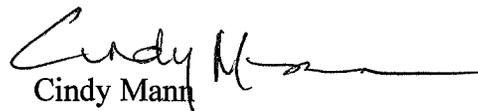
Ms. Carol Peverly
Associate Regional Administrator
Centers for Medicare & Medicaid Services
Division of Medicaid and Children's Health Operations
2201 Sixth Avenue

MS RX-43
Seattle, WA 98121
Telephone: (206) 615-2515
Facsimile: (206) 615-2311
Email: carol.peverly@cms.hhs.gov

If you have questions regarding this approval, please contact Ms. Victoria Wachino, Director, Children and Adults Health Programs Group, Center for Medicaid and CHIP Services, at (410) 786-5647.

The health system transformation that Oregon is pursuing is ambitious, and we look forward to continuing to work with you and your staff to ensure that the Demonstration achieves its goals. We appreciated your partnership throughout the review process, and look forward to continuing to work with you and your staff.

Sincerely,


Cindy Mann
Director

Enclosures

cc: Carol Peverly, CMS Seattle Regional Office
Wendy Hill Petras, CMS Seattle Regional Office
Victoria Wachino, CMCS
Terri Fraser, CMCS

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July 6, 2012

On July 5, 2012 the Centers for Medicaid and Medicare (CMS) approved Oregon's 1115 Medicaid Waiver that was necessary to implement health system transformation. Waivers of this size and scope usually take years to negotiate. The ability to finish so rapidly is a testament to both the importance of this waiver and to an effective federal and state partnership. A very brief summary of the key issues follow:

- **Establishment of Coordinated Care Organizations (CCOs):** Establishes CCOs as the delivery system for Medicaid. Language in the waiver that describes CCOs mirrors that in our legislation.
- **Flexibility in use of federal funds:** State has ability to use Medicaid dollars for flexible services e.g. non-traditional health care workers. All flexible services will have to be used for health related care; however, the CCO will have broad flexibility in creating the array of services necessary to improve care delivery and enrollee health. Flexible services will be accounted for in what is paid to CCOs and utilization assumptions for use of these services will be applied. The state and CMS have 120 days to develop the appropriate methodology for accounting for flexible services and their utilization.
- **Federal Investment:** Calls for federal investment of ~\$1.9 billion over 5 years (Year 1: \$620 million, Year 2: \$620M, Year 3 \$290M, Year 4: \$183M, Year 5: \$183M). This funding comes through the Designated State Health Programs (DSHP). Penalties apply as noted below.
- **Savings:** State agrees to reduce per capita medical trend by 2 percentage points by the end of the second year of the waiver. There is a ramp up to achieve this. During this year, there is no reduction. Second year must average a 1 percentage point reduction, but again the state must be at a 2 percentage point reduction by the end of the second year. The reduction is from an assumed trend of 5.4% as calculated by OMB and based on the President's budget. Base expenditure is calendar year 2011. Penalties for not achieving this are significant. Ranging from \$145 million for not achieving the second year goal, to \$183 million in Years 4 and 5.
- **Quality:** There are strong criteria around quality. CMS want to assure that cost savings are not realized by either withholding needed care, degrading quality or by cutting payment rates. As such there is a requirement that CCOs meet a number of quality metrics and that there is a financial incentive for achieving performance benchmarks. The state and CMS have 120 days to work with national experts on creating the appropriate metrics and incentives. There is a requirement by CMS for a 1% withhold

beginning in Year 2 for timely and accurate data submission. A bonus incentive pool is also required in Years 2 and beyond.

- **Transparency:** CMS requires assurance that in the interest of advancing transparency and providing Oregon Health Plan enrollees with the information necessary to make informed choices, the state shall make public information about the quality of care provided by a CCO.
- **Workforce:** To support the new model of care within CCOs will require changes in the health care workforce. As such Oregon will establish a loan repayment program for primary care physicians who agree to work in rural or underserved communities in Oregon and training for 300 community health workers by 2015.
- **OHP Medical Benefits:** Current OHP medical benefits will be maintained (there will be no reduction to lines covered on the prioritized list).

Q & A about Designated State Health Programs (DSHP)

As part of its Medicaid waiver amendment, Oregon identified a number of state-funded programs, called Designated State Health Programs (DSHP) that provide health services to low-income, vulnerable populations for which CMS agreed to provide Federal support. Under DSHP, the Federal government will provide funding up to \$1.9 billion over 5 years to Oregon for specific, approved expenditures:

Demonstration Year	DSHP
Yr 1: 2012	\$620 million
Yr 2: 2013	\$620 million
Yr 3: 2014	\$290 million
Yr 4: 2015	\$183 million
Yr 5: 2016	\$183 million

Oregon has agreed to several special terms and conditions as part of this funding support. The state is required to:

- Use funds only to support health system transformation;
- Reduce the inflation of Medicaid per member health care costs by 2 percentage points within 2 years;
- Establish a primary care provider loan repayment program in the second year of the program;
- Train an additional 300 community health workers by December 2015; and
- Hold Coordinated Care Organizations (CCOs) accountable for quality and efficiency through robust public reporting of metrics and a system of incentives and penalties.

How does DSHP work?

DSHP funds come into the state only as expenditures are made in the approved programs. Under DSHP, the Federal government provides support to the state in a two-step process:

- When an expenditure is made in one of the approved programs, the Federal government will pay for 60% of the cost and the state pays 40% where it previously paid 100%. This frees up the 60% previously paid by the state to be used for health system transformation.
- The dollars that are freed up with the new federal investment in DSHP programs will then be invested in Medicaid health system transformation and matched with federal funds. In Oregon, the federal Medicaid match is approximately \$1.69 for every state or local dollar spent in Medicaid.
- Through this two-step process, the Federal government's DSHP investment of \$704 million over 5 years translates into approximately \$1.9 billion in total Federal financial support.

When will the Federal dollars begin coming into the state?

- Expenditures made in approved programs can begin to draw down Federal dollars from the date of waiver approval, or July 5, 2012.

What kind of quality metrics will CCOs be held accountable to?

- Quality metrics required by CMS include (all to be reported by race and ethnicity), but are not limited to, measures such as:
 - Member satisfaction
 - Health status
 - Rate of tobacco use
 - Obesity rate
 - Avoidable ED visits
 - Hospital readmissions
 - Follow-up after hospitalization for mental illness
 - Developmental screening for children by 36 months

MEMO

DATE: July 3, 2012
TO: Oregon Health Insurance Exchange Corporation Board
Oregon Health Policy Board
FROM: The Essential Health Benefits Workgroup
RE: Essential Health Benefits Workgroup Final Recommendation

Dear Oregon Health Insurance Exchange Corporation Board and Oregon Health Policy Board Members:

After several meetings involving detailed discussions, the Essential Health Benefits (EHB) Workgroup is pleased to present their final recommendation for Oregon's EHB Benchmark plan that will be required as the basis for individual and small group health plans in and out of the Exchange. This letter outlines the Workgroup's recommendation and explains the discussions involved in the process.

Action Item:	Request for endorsement of the Workgroup's final recommendation.
Recommendation:	<p>The recommended benchmark plan is the <u>PacificSource Preferred CoDeduct small group plan</u>. Missing benefit categories were supplemented as follows:</p> <ul style="list-style-type: none">• Pediatric Vision – The federal BlueVision “High Plan” package was defined as the required supplement to be used for these services.• Pediatric Dental – HealthyKids dental package.• Prescription Drug Benefits – Default to the Regence Innova package.• Habilitative Services – For this supplement, Oregon prefers to work on defining “parity” in terms of developing a habilitative services package similar to that of rehabilitative services packages.
Key Decision Points:	<p>The Workgroup discussed the impact of certain benefits on the overall cost of a benchmark plan and its impact on the small group and individual market. Key decision points include the following:</p> <ul style="list-style-type: none">• Using decision-making principles focused on federal requirements, health equity, and limiting disruptions in the marketplace.• Considering the overall affordability of the benchmark plans and the relative impacts to premiums• Comparing the benchmark plans with plans currently offered in the individual market, the Oregon Medical Insurance Pool, and the Oregon Health Plan.• Understanding the initial EHB benchmark plan can be re-evaluated.

Background

Beginning in 2014, individual and small group health plans will be required under the Affordable Care Act to offer an EHB package. According to a bulletin released by the United States

Department of Health and Human Services (HHS) in December 2011, EHBs must include ten statutory-required benefit categories and be defined using a benchmark approach reflecting a “typical employer plan.” Outlined by HHS, Oregon’s benchmark plan options included three of the largest small group plans in the state, three of the largest state employee health plans, the three largest federal employee health plans, and the largest health maintenance organization (HMO) plan offered in the state’s commercial market by enrollment. These plans are listed in the attached EHB Benchmark Plan Comparison Chart.

Established by Governor Kitzhaber and chartered by the Exchange Corporation’s Board and the Oregon Health Policy Board (OHPB), the EHB Workgroup was charged to recommend one of these ten EHB benchmark plans and ensure the inclusion of all statutory-required benefit categories. Over the last few months, the Workgroup reviewed and compared details of these plans as identified in the attached EHB Benchmark Plan Comparison Chart and decided on the PacificSource small group benchmark plan as their recommendation. In addition, decisions on needed supplements to the benchmark plan were made and are also included in the recommendation. Below is a summary of the Workgroup’s discussions.

Workgroup Discussions

After the initial EHB Workgroup meeting that included an overview of the EHB process, the Workgroup began discussing the impact of certain benefits on the overall cost of a benchmark plan and its impact on the small group and individual market, noting that plans could offer riders or potentially substitute within federal restrictions those services not in the benchmark to fit market needs or add competitive value. Concerns were raised about whether those benefits are essential. The Workgroup noted that while these expensive benefits are extremely valuable to some, lowering costs while still providing access to “essential” services will optimize participation in and outside the Exchange. Revisiting the benefit benchmark in two years, as suggested by HHS, will allow the State to re-evaluate if the chosen benchmark plan remains essential or needs to be updated in a transforming health delivery system. The Workgroup’s decisions are summarized as follows:

- The Workgroup felt that while bariatric surgery, adult dental, and alternative medicine are important benefits, the high cost associated with these benefit cautioned against including them in Oregon’s EHB benchmark plan. It was noted that while these particular benefits have the potential to result in long-term savings for health plans, the Workgroup focused on the immediate premium impacts, and the plans offering these benefits were considered too costly for many Oregonians. Health insurers may still offer these benefits in their more comprehensive benefits packages or as riders to Oregonians that need them. Oregon should consider a process to analyze the long-term impacts for these types of benefits and provide that information to stakeholders for consideration.
- Federal employee health plans were first eliminated due to the richness of the plans (e.g., the inclusion of alternative medicine, adult dental, bariatric surgery and fewer limitations) making them more costly, and because the plans were missing a few Oregon mandated benefits.
- The Kaiser largest HMO was then eliminated as an option due to its similarity to the Kaiser small group plan option with the exception of bariatric surgery not being covered by the small group plan.
- The Public Employee’s Benefit Board (PEBB) Providence Choice and the Kaiser Small Group Deductibles plans were both eliminated mainly due to the added cost related to

alternative medicine and because the coverage of infertility assisted reproductive technology coverage was not considered an essential benefit. The Providence Choice plan was also eliminated because of the added cost related to bariatric surgery coverage.

- The Oregon Educator's Benefit Board (OEBB) ODS plan was eliminated because of the extra coverage of certain benefits determined by the Workgroup as not being essential in an EHB package.
- Providence Statewide was eliminated due to the inclusion of some additional costly benefits (e.g., hearing aids, infertility coverage, and alternative care) having an immediate impact on premiums.
- The RegenceInnova plan, while very similar to the PacificSource plan, was not chosen due to the inclusion of infertility treatment plus greater limitations on other services. The PacificSource plan had fewer or more generous limitations in many areas that the EHB Workgroup felt were more important in choosing an EHB benchmark plan.

With the PacificSource Preferred CoDeduct small group plan left as the preliminary benchmark plan recommendation, the Workgroup had to ensure supplements were made for any of the ten statutory-required benefits that were missing using a predefined process outlined by the HHS. Missing benefit categories under the PacificSource plan included pediatric vision and dental, prescription drugs, and habilitative services. Supplement options for these benefits were discussed at the June 22, 2012, EHB Workgroup meeting as outlined below:

- Pediatric Vision – As defined by the HHS, the default for a supplemental vision package was the BlueVision “High Plan,” which is the FEDVIP vision plan with highest enrollment.
- Pediatric Dental – Options for a supplemental dental package included Oregon's HealthyKids dental package and a federal Metlife Dental PPO package. The group determined that the HealthyKids package is the best option since it is already utilized in Oregon and would provide seamless coverage for children without much disruption in the delivery of these services in the Oregon marketplace.
- Prescription Drug Coverage – Outlined by HHS, the default for prescription drug coverage is the Regence small group plan's prescription drug package. However, future federal guidance may develop in the coming months that may alter the default package. The Workgroup has listed Regence's package as the appropriate supplement until additional federal guidance is received.
- Habilitative Services – While these services have not yet been defined, as a transitional approach the December 2011 bulletin indicated that they may be selected using the same services used for rehabilitative needs and offering them at parity, *OR* they can be decided by the plans and approved by the HHS. The Workgroup felt that the former option was most feasible due to the complexities that may be involved in obtaining HHS approval for each plan. However, they also felt that the term “parity” would need to be discussed in order to ensure rehabilitative services limitations would not hinder the treatment successes resulting from habilitative services.

While supplements would also need to be made to ensure that all Oregon mandated benefits were included in the selected benchmark plan, this was unnecessary because the PacificSource small group plan already includes coverage for all of Oregon's current mandates.

Public Comment

All EHB Workgroup meetings were open for the public to attend and provide public comment. The EHB website also provided opportunity for individuals or groups to submit public comment electronically. In addition, public comment and testimony were also welcome at the Exchange Corporation's Board and the OHPB's meetings or through their respective public comment processes. A summary of all public comment received is attached for your review and generalized below:

- While not within the decision parameters of the EHB Workgroup, many comments were focused on the details of administering particular benefits. Specific inquiries involved the administration of benefits such as tobacco cessation and transplants (especially regarding waiting period restrictions). We are awaiting guidance from the federal government as to whether the medical management of EHB must mirror that of the chosen benchmark plan or if flexibility will be allowed.
- Several advocate groups voiced concern regarding the prescription drug formulary that will be included under EHB. Because the PacificSource plan did not cover prescription drug, largest small group plan's (Regence Inova) prescription drug package was submitted by default. However, a required class list for prescription drugs is still forthcoming and may only specify that at least one drug per class be covered. Due to individual responses to medication, the EHB Workgroup acknowledges that having multiple prescription drugs available for each condition will be extremely important.
- Several commenters noted that alternative pain medications and treatments such as pain medication lotions and acupuncture or chiropractic therapy can be less costly and also provide less invasive treatment options for individuals with chronic pain.
- Several commenters expressed concern with affordability of the EHB benchmark plan. The selection of a group benchmark plan may have a negative impact, particularly on the individual health insurance market, as group plans typically have richer benefits. The cost of meeting the EHB benchmark may make health care less affordable for Oregonians.
- Several commenters responded negatively to the exclusion of family, marital, and sexual therapy and alternative medicine. Many individuals and organizations feel these are benefits are essential and prevent other ailments or increase the positive health outcomes for patients. This was also the case for bariatric surgery and adult dental benefits.
- Some advocacy groups and EHB Workgroup members voiced concern regarding the churning of Medicaid members in terms of the need to ensure some type of consistency between the commercial market's EHB package and the EHB package for Medicaid. Medicaid members should not be encouraged to remain on Medicaid due to enhanced coverage and they should also not be affected by inadequate care transitions when moving to commercial coverage, both inside and outside the Exchange.

In Summary

The final benchmark plan recommendation, inclusive of all supplemental benefits chosen, is attached for your review. At this point, the EHB Workgroup asks you to review this information and the summary of public comments to determine whether to endorse the recommendation and forward it on to Governor Kitzhaber for communication to the HHS.

Thank you for the opportunity to be part of the selection of essential health benefits for Oregonians. For more information, please visit the Essential Health Benefits website by visiting www.oregon.gov/OHA/OHPR/EHB/index.shtml.

State of Oregon
Illustration of Total Essential Health Benefits
 Grouped into the 10 categories of Essential Health Benefits required by the ACA

Benefit	Coverage Details	Source Plan
1. Ambulatory patient services		
a. Primary care to treat illness/injury	√	Small Group - PacificSource Preferred CoDeduct
b. Specialist visits	√	Small Group - PacificSource Preferred CoDeduct
c. Outpatient surgery	√	Small Group - PacificSource Preferred CoDeduct
d. Acupuncture	NC (optional rider)	Small Group - PacificSource Preferred CoDeduct
e. Chiropractic	NC (optional rider)	Small Group - PacificSource Preferred CoDeduct
f. Naturopath	NC (optional rider)	Small Group - PacificSource Preferred CoDeduct
g. Chemotherapy services	√	Small Group - PacificSource Preferred CoDeduct
h. Radiation therapy	√	Small Group - PacificSource Preferred CoDeduct
i. Infertility treatment services	NC	Small Group - PacificSource Preferred CoDeduct
j. Sterilization	√	Small Group - PacificSource Preferred CoDeduct
k. Home health care	√	Small Group - PacificSource Preferred CoDeduct
l. Telemedical services	√	Small Group - PacificSource Preferred CoDeduct
m. Foot care	√ medical conditions only	Small Group - PacificSource Preferred CoDeduct
n. Medical contraceptives	√	Small Group - PacificSource Preferred CoDeduct
o. TMJ services	NC	Small Group - PacificSource Preferred CoDeduct
p. Dental - diagnostic & preventive	NC	NC
q. Dental - basic	NC	NC
r. Dental - major	NC	NC
2. Emergency services		
a. Emergency room - facility	√	Small Group - PacificSource Preferred CoDeduct
b. Emergency room - physician	√	Small Group - PacificSource Preferred CoDeduct
c. Ambulance service - ground and air	√	Small Group - PacificSource Preferred CoDeduct
3. Hospitalization		
a. Inpatient medical and surgical care	√	Small Group - PacificSource Preferred CoDeduct
b. Organ & tissue transplants	√ limited to organs specified \$5000 limit for travel expenses	Small Group - PacificSource Preferred CoDeduct
c. Bariatric surgery	NC	Small Group - PacificSource Preferred CoDeduct
d. Anesthesia	√	Small Group - PacificSource Preferred CoDeduct
e. Breast reconstruction (non-cosmetic)	√	Small Group - PacificSource Preferred CoDeduct
f. Blood transfusions	√	Small Group - PacificSource Preferred CoDeduct
g. Hospice / respite care	√ respite limit 5 consecutive days / 30 days	Small Group - PacificSource Preferred CoDeduct
4. Maternity and newborn care		
a. Pre- & postnatal care	√	Small Group - PacificSource Preferred CoDeduct
b. Delivery & inpatient maternity services	√	Small Group - PacificSource Preferred CoDeduct
c. Newborn child coverage	√	Small Group - PacificSource Preferred CoDeduct
d. Nonprescription elemental enteral formula	√	Small Group - PacificSource Preferred CoDeduct
5. Mental health and substance use disorder services, including behavioral health treatment		
a. Inpatient hospital - mental/behavioral health	√ limit 45 days / yr for residential treatment	Small Group - PacificSource Preferred CoDeduct
b. Outpatient hospital - mental/behavioral health	√	Small Group - PacificSource Preferred CoDeduct
c. Inpatient hospital - chemical dependency	√	Small Group - PacificSource Preferred CoDeduct
d. Outpatient hospital - chemical dependency	√	Small Group - PacificSource Preferred CoDeduct
e. Detoxification	√	Small Group - PacificSource Preferred CoDeduct
f. Counseling or training in connection with family, sexual, marital, or occupational issues	√ NC	Small Group - PacificSource Preferred CoDeduct
6. Prescription drugs		
a. Retail	√	Small Group - Regence Innova (HHS default)
b. Mail order	√	Small Group - Regence Innova (HHS default)
c. Generic	√	Small Group - Regence Innova (HHS default)
d. Brand	√	Small Group - Regence Innova (HHS default)
e. Specialty	√	Small Group - Regence Innova (HHS default)
f. Insulin/needles for diabetics	√	Small Group - Regence Innova (HHS default)
g. Tobacco cessation drugs	√	Small Group - Regence Innova (HHS default)
h. Contraceptives	√	Small Group - Regence Innova (HHS default)
i. Fertility drugs	√ NC	Small Group - Regence Innova (HHS default)
j. Growth hormone therapy	√ medical conditions only	Small Group - Regence Innova (HHS default)
7. Rehabilitative and habilitative services and devices		
a. Inpatient rehabilitation	√ limit 30 days / yr additional 30 days for head/spinal cord injury	Small Group - PacificSource Preferred CoDeduct
b. Physical, speech & occupational therapy (outpatient)	√ limit 30 visits / yr additional 30 visits / condition for specified conditions	Small Group - PacificSource Preferred CoDeduct
c. Massage therapy	√ NC	Small Group - PacificSource Preferred CoDeduct
d. Durable medical equipment	√ limit \$5000 for non-essential DME	Small Group - PacificSource Preferred CoDeduct
e. Prosthetics	√	Small Group - PacificSource Preferred CoDeduct
f. Orthotics	√	Small Group - PacificSource Preferred CoDeduct
g. Vision hardware	√ NC	Small Group - PacificSource Preferred CoDeduct
h. Hearing aids - adults	√ NC	Small Group - PacificSource Preferred CoDeduct
i. Cochlear Implants	√	Small Group - PacificSource Preferred CoDeduct

State of Oregon
Illustration of Total Essential Health Benefits
 Grouped into the 10 categories of Essential Health Benefits required by the ACA

Benefit	Coverage Details	Source Plan
j. Skilled nursing	√ limit 60 days / yr	Small Group - PacificSource Preferred CoDeduct
k. Habilitative services (not currently defined)	Recommend to be in parity with rehabilitative services. Must define "parity."	Small Group - PacificSource Preferred CoDeduct
8. Laboratory services		
a. Lab tests, x-ray services, & pathology	√	Small Group - PacificSource Preferred CoDeduct
b. Imaging / diagnostics (e.g., MRI, CT scan, PET scan)	√	Small Group - PacificSource Preferred CoDeduct
c. Genetic testing	√ medically necessary	Small Group - PacificSource Preferred CoDeduct
9. Preventive and wellness services and chronic disease management		
a. Preventive care	√	Small Group - PacificSource Preferred CoDeduct
b. Immunizations	√	Small Group - PacificSource Preferred CoDeduct
c. Colorectal cancer screening	√	Small Group - PacificSource Preferred CoDeduct
d. Screening mammography	√	Small Group - PacificSource Preferred CoDeduct
e. Routine eye exams (separate office visit)	NC	Small Group - PacificSource Preferred CoDeduct
f. Routine hearing exams (separate office visit)	√ medically necessary	Small Group - PacificSource Preferred CoDeduct
g. Nutritional counseling	√ limit 5 visits / lifetime	Small Group - PacificSource Preferred CoDeduct
h. Diabetes education	√	Small Group - PacificSource Preferred CoDeduct
i. Smoking cessation program	√	Small Group - PacificSource Preferred CoDeduct
j. Allergy testing & injections	√	Small Group - PacificSource Preferred CoDeduct
k. Diabetes - medically necessary equip. & supplies	√	Small Group - PacificSource Preferred CoDeduct
l. Screening pap tests	√	Small Group - PacificSource Preferred CoDeduct
m. Prostate cancer screening	√	Small Group - PacificSource Preferred CoDeduct
10. Pediatric services, including oral and vision care		
a. Preventive care - physician services	√	Small Group - PacificSource Preferred CoDeduct
b. Immunizations	√	Small Group - PacificSource Preferred CoDeduct
c. Metabolic formula & low protein food for inborn errors of metabolism	√	Small Group - PacificSource Preferred CoDeduct
d. Vision - Eye Exam (separate office visit)	√ limit 1 / yr	FEDVIP - BlueVision High Plan (HHS default)
e. Vision - Lenses	√ limit 1 pair / yr	FEDVIP - BlueVision High Plan (HHS default)
f. Vision - Frames	√ limit 1 / yr \$150 allowance	FEDVIP - BlueVision High Plan (HHS default)
g. Vision - Contact Lenses	√ limit 1 / yr \$150 allowance in lieu of eyeglasses (\$600 for medically necessary)	FEDVIP - BlueVision High Plan (HHS default)
h. Routine hearing exams (separate office visit)	√ medically necessary	Small Group - PacificSource Preferred CoDeduct
i. Hearing aids	√ limit \$4000+CPI / 4 yrs	Small Group - PacificSource Preferred CoDeduct
j. Dental - Class I - Clinical oral examinations	√ limit 2 / yr	CHIP - OHP Plus (under age 21)
k. Dental - Class I - Radiographs	√ limit 1 / yr for bitewings, limit 1 / 5 yrs for complete intraoral or panoramic	CHIP - OHP Plus (under age 21)
l. Dental - Class I - Dental prophylaxis	√ limit 2 / yr	CHIP - OHP Plus (under age 21)
m. Dental - Class I - Fluoride treatments	√ limit 2 / yr	CHIP - OHP Plus (under age 21)
n. Dental - Class I - Sealants	√ limit aged 15 and under limit 1 / permanent molar / 5 yrs	CHIP - OHP Plus (under age 21)
o. Dental - Class I - Space maintainers	√	CHIP - OHP Plus (under age 21)
p. Dental - Class I - Counseling	√ smoking cessation only	CHIP - OHP Plus (under age 21)
q. Dental - Class II - Amalgam, silicate, acrylic or plastic restorations	√ limit resin based to anterior teeth	CHIP - OHP Plus (under age 21)
r. Dental - Class II - Endodontics - pulp capping, pulpotomy and root canal therapy	√ root canal therapy limited to first and second molars on primary teeth	CHIP - OHP Plus (under age 21)
s. Dental - Class II - Periodontics - surgical services	√ limited to gingivectomy/ gingivoplasty	CHIP - OHP Plus (under age 21)
t. Dental - Class II - Periodontics - non-surgical services	√ limit 1 / 2 yrs	CHIP - OHP Plus (under age 21)
u. Dental - Class II - Periodontics - maintenance	√ limit 2 / yr	CHIP - OHP Plus (under age 21)
v. Dental - Class II - Maintenance prosthodontics (adjustments)	√	CHIP - OHP Plus (under age 21)
w. Dental - Class II - Maintenance prosthodontics (repair)	√	CHIP - OHP Plus (under age 21)
x. Dental - Class II - Maintenance prosthodontics (rebase/reline)	√ limit 1 / 3 yrs	CHIP - OHP Plus (under age 21)
y. Dental - Class II - Simple extractions	√	CHIP - OHP Plus (under age 21)
z. Dental - Class II - Oral Surgery	√	CHIP - OHP Plus (under age 21)
aa. Dental - Class II - General anesthesia	√	CHIP - OHP Plus (under age 21)

State of Oregon

Illustration of Total Essential Health Benefits

Grouped into the 10 categories of Essential Health Benefits required by the ACA

Benefit	Coverage Details	Source Plan
ab. Dental - Class III - Crowns - single restorations	√ limit aged 16 and over limit 4 / 7 yrs	CHIP - OHP Plus (under age 21)
ac. Dental - Class III - Installation of prosthodontics - complete or partial dentures, bridge pontics and abutment	√ limit aged 16 and over 1 or more missing anterior or 4 or more missing posterior teeth/arch replacement 1 / 10 yrs resin partials only	CHIP - OHP Plus (under age 21)
ad. Dental - Orthodontics	√ cleft palate or cleft lip only	CHIP - OHP Plus (under age 21)

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Essential Health Benefits

Final Recommendations from
the Essential Health Benefits Workgroup

July 2012



The Essential Health Benefits Workgroup is chartered jointly by the Oregon Health Insurance Exchange Corporation Board and the Oregon Health Policy Board and is staffed by the OHA's Office of Health Policy and Research (OHPR) led by Jeanene Smith and the Oregon Insurance Division (OID) led by Lou Savage.

Overview of ACA's Essential Health Benefits

- Beginning in 2014, individual and small group health plans will be required under the Affordable Care Act to offer an essential health benefits (EHB) package.
- This applies to both inside and outside the new Health Insurance Exchanges.
- States are required to define their EHB that will serve as the "reference plan" in their state's market and Exchange.
- Cost sharing and Actuarial value based on federal requirements will be applied to the "reference plan."
- A separate set of choices & process remains to determine the Medicaid expansion benchmark.

2

First Step Towards the Full EHB Package

- Determining the state's reference plan is the first step in how plans will be designed for the market and in the Exchange.
- Directed to have it reflect a "typical employer plan."
- This "reference plan" sets the coverage for services, not its cost sharing structure.
- It must include the 10 essential elements of an EHB.
- If selected choice doesn't include all 10, then must augment from the other choices, based on specific federal guidelines.

3

The 10 Statutory Categories required for an EHB

EHBs must include items and services in 10 categories identified by the Affordable Care Act (ACA):

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment (to comply with federal mental health parity)
6. Prescription drugs
7. Rehabilitative *AND* Habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management and
10. Pediatric services, including oral and vision care

4

Still to Come: Cost Sharing

- Once the reference plan is selected, the other components will build on top of it. This includes:
 - Specified levels of actuarial value (Bronze, Silver, Gold)
 - Cost-sharing requirements (deductibles, co-insurance, etc.)
- Specific details on Cost sharing and actuarial value will be provided by the federal government, but we do know:
 - There will be no annual or lifetime dollar limits on EHBs
- SB 91 rules process underway to set Oregon's base bronze & silver plan cost-sharing.

5

Essential Health Benefits Workgroup

- The EHB Workgroup was established by the Governor and chartered by the ORHIX Board and the OHPB in April 2012.
- The Workgroup included representation from the following:
 - Majority of the major commercial health plans
 - Insurance agents/brokers
 - Mental Health care representative
 - Dental care representative
 - County representative
 - Consumer advocates
 - Small business owners
 - Liaisons from the OHPB and the Exchange Corporation Board.

6

Essential Health Benefits – HHS Guidance

- EHBs must be decided using a benchmark approach reflecting a “typical employer plan.”
- HHS defined 10 benchmark plans for Oregon:
 - Three largest small group plans – Regence Innova, Kaiser Deductible Plan, and PacificSource Preferred CoDeduct.
 - Three largest state employee plans – PEBB Providence Statewide, OEBB ODS, and PEBB Providence Choice.
 - The largest commercial non-Medicaid HMO – Kaiser.
 - Three federal employee plans – BCBS Plan Standard, BCBS Plan Basic, and GEHA Plan Standard.
- Supplements for missing benefit categories were also predefined options provided by HHS guidance.

7

Benchmark Plan Analysis

- Wakely, an actuarial consulting firm working with the Insurance Division, conducted the plan analysis and provided a side-by-side comparison.
- Highlighted to the Workgroup the major differences in benefit coverage, primarily those that would impact premium costs.
- Provided Relative cost comparisons to estimate premium impacts.
- Included, by Workgroup request, comparison with Oregon’s High-risk Pool, most common individual plan, and OHP Standard.

8

HHS Guidance on Missing Benefits

Missing benefits to be supplemented:

- Pediatric Vision – The default is the BlueVision “High Plan,” which is the FEDVIP vision plan with highest enrollment.
- Pediatric Dental – Oregon’s HealthyKids dental package and a federal Metlife Dental PPO package were both options.
- Prescription Drug Coverage – The default for prescription drug coverage is the Regence Innova small group plan’s Rx plan.
- Habilitative Services – Transitional approach is to use the same services used for rehabilitative needs and offer them at parity, OR allow plans to determine services and obtain HHS approval.

9

Other Caveats

- Oregon’s SB 91 directs the rulemaking process that will help determine actuarial value for health plans sold in Oregon’s individual and small group markets, based on the reference plan. Will allow consumers to directly compare plans.
- Federal guidance may still be forthcoming to clarify prescription drug benefit requirements, and to define habilitative services.
- No clear direction on the flexibility of administering particular benefits, only described currently as coverage “*substantially similar*” to the reference plan.

Workgroup’s Final Recommendation

Request for endorsement of the EHB Workgroup’s final recommendation as highlighted below.

The recommended benchmark plan is the PacificSource Preferred CoDeduct small group plan. Missing benefit categories were supplemented as follows:

- **Pediatric Vision** – The federal BlueVision “High Plan” as it was the required supplement to be used for these services.
- **Pediatric Dental** – HealthyKids dental package.
- **Prescription Drugs** – Default to Regence Innova Rx plan.
- **Habilitative Services** – Workgroup prefers to work on defining “parity” in terms of developing a habilitative services package similar to that of rehabilitative services packages.

So how did the Workgroup make this decision?

Workgroup Discussions

The EHB Workgroup discussed the impact of certain benefits on the overall cost of a benchmark plan and its impact on the small group and individual market. Key decision points included:

- Using decision-making principles focused on federal requirements, health equity, and limiting marketplace disruptions.
- Considering the overall affordability of the benchmark plans and the relative impacts to premiums.
- Comparing the benchmark plans with plans currently offered in the individual market, the Oregon Medical Insurance Pool, and the Oregon Health Plan.
- Understanding the initial EHB benchmark plan can be re-evaluated in two years.

13

Workgroup Decision Process

The Workgroup focused on balancing cost versus “essential” when comparing plans' coverage:

Weighing the Federal Plans options:

- Federal plans were first to be eliminated due to the richness of the plans (e.g., the inclusion of adult dental and fewer limitations).

Looking at the Largest HMO:

- The Kaiser HMO was eliminated due to added costs of its coverage of bariatric surgery and its similarity to the Kaiser small group plan.

14

Workgroup Decision Process, *Continued...*

Weighing the State Employee Plans Options:

- The PEBB Providence Choice was eliminated due to added costs of alternative medicine, infertility assisted reproductive technology coverage, and bariatric surgery coverage.
- The OEBS ODS plan was eliminated because of the added cost due to coverage of alternative medicine, unlimited mental/behavioral health inpatient hospitalization, and hearing aid benefits.
- Providence Statewide were also not chosen due to the inclusion of additional costly benefits (e.g., hearing aids and infertility coverage).

15

Workgroup Decision Process, *Continued...*

Weighing other small group options:

- The Kaiser Small Group Deductibles plan was also eliminated due to the added costs of alternative medicine and infertility coverage, with additional coverage for hearing aids.
- The Regence plan was also not chosen due to the inclusion of additional costly benefits (e.g., hearing aids and infertility coverage).

Addressing Balance Across the Benefits

- *Bariatric surgery, adult dental and alternative medicine benefits were felt to be important and have the potential to result in long-term savings for health plans.*
- *However, the Workgroup focused on the immediate premium impacts, and the plans offering these benefits were considered too costly for many Oregonians.*
- *It is recommended that Oregon assess potential long-term impacts and provide that information to stakeholders for future consideration.*

Public Comment Opportunities

The EHB Workgroup's final recommendation is currently out for public comment through July 30, 2012. Opportunities for public comment were available during the Workgroup process:

- EHB Workgroup meetings were open for public attendance.
- Public comment was submitted via the EHB Workgroup website or submitting it to staff.
- Public comment and testimony were also welcome at the Exchange Corporation Board's and the OHPB's Board's monthly meetings or through their respective processes.

Public Comment to Date

The following is summarized public comment received to date:

- Individual concerns regarding the administration of particular benefits, such as tobacco cessation and transplant waiting periods.
- Advocate groups voiced concern regarding prescription drug benefits, stating also that the formulary needs to be flexible.
- Alternative treatments such as pain medication lotions and acupuncture or chiropractic services can be less costly and less invasive treatments for chronic illnesses/pain.
- Selection of a “group” benchmark plan may have negative impacts on the individual plan market as group plans tend to be more costly.

Public Comment to Date, *Continued...*

- Family, marital, and sexual therapy and alternative medicine should be considered essential as they prevent other ailments or increase positive health outcomes.
- Positive health outcomes was also raised as reason to consider plan choices that included bariatric surgery and adult dental benefits.
- Comments also suggested the need to ensure some type of consistency between the commercial market’s EHB package and the EHB package for Medicaid to avoid inadequate care transitions when moving to commercial coverage, both inside and outside the Exchange.

In Summary...

- Within the confines of federal guidance, nine of the benchmark plans were mainly eliminated due to the premium impacts of some of their benefits when weighed with what is most essential.
- *Accessibility* and *Affordability* was considered by the Workgroup.
- PacificSource Preferred CoDeduct was selected as the reference plan with the following supplements:
 - Pediatric Vision – The federal BlueVision “High Plan.”
 - Pediatric Dental – HealthyKids dental package.
 - Prescription Drugs – Default to Regence Innova Rx plan.
 - Habilitative Services – Noting a need to work on defining “parity” in terms of developing a package similar to rehabilitative services.
- The EHB Workgroup’s final recommendation is currently out for public comment through July 30, 2012.

Questions?

Additional information regarding Essential Health Benefits can be found by visiting <http://health.oregon.gov/OHA/OHPB>.

**Oregon Health Care Workforce Committee
SB 879 Workgroup**

**Recommendations for the
Oregon Health Policy Board**

June 30, 2012

I. Introduction

In its 2010 report to the Oregon Health Policy Board, the Healthcare Workforce Committee (Workforce Committee) recommended standardization of student background requirements for clinical training (drug testing, criminal background check, HIPAA training, etc.). [SB 879](#) (2011) directed the Oregon Health Authority, in collaboration with the Oregon Workforce Investment Board, to convene a workgroup to develop these standards and to report back to the Oregon Health Policy Board and the Legislature. A copy of SB 879 is included with this report.

SB 879 specified that:

- The standards must apply to students of nursing and allied health professions, at a minimum, and may apply to students of other health professions;
- The standards must pertain to clinical training in settings including but not limited to hospitals and ambulatory surgical centers;
- The workgroup shall make recommendations for standards and for initial and ongoing implementation of those standards. The authority [OHA] may establish by rule standards for student placement in clinical training settings that incorporate the standards developed under this section and approved by the Oregon Health Policy Board.
- The Oregon Health Authority must report to an interim legislative committee related to health on workgroup progress on or before June 30, 2012.

Over the past several months, the Workforce Committee convened three large stakeholder meetings to identify what is currently working well and what is not, to develop a draft list of standard requirements, to consider options for implementing the standards, and to develop a system to track compliance with the standards. Participants in those meetings included representatives from:

- Universities, community colleges, and proprietary schools with healthcare professional educational programs;
- Hospitals and health systems (student placement or residency coordinators as well as legal or risk management departments);
- A wide range of disciplines including nursing, medicine (physician and physician assistant programs) PT, OT, lab and imaging technology, and medical assisting;
- Other interested parties such as licensing boards, the Oregon Center for Nursing, and the Oregon Primary Care Association.

See Appendix A for a full list.

A preliminary set of recommendations was produced in May and presented to the Senate Health, Human Services, and Rural Health Policy Committee during interim legislative days in that month. In late May and early June, stakeholders who had participated in the workgroup process were asked to review the material and to solicit feedback from their colleagues and their organizations' leadership. Many groups responded and their comments have been

incorporated into this report as part of the recommendations or--in the case of specific operational details--as notes of issues to be finalized in implementation.

This brief report describes the issue and key questions related to standardization and outlines the workgroup's recommendations for a set of common requirements and their implementation. The final section addresses the next steps that the Workforce Committee believes are necessary to move the standards forward.

II. Background and Approach

The Workforce Committee initially recommended that clinical placement requirements be standardized because the inconsistencies that currently exist across health care organizations increase students' education expenses and create costly inefficiencies for schools and clinical sites. The demand for clinical experiences already threatens to exceed the supply, so streamlining the process for everyone involved would help to increase capacity. Testimony provided while the bill was being considered in the Legislature expressed the urgent need for and benefits of standardization:

“Because educational institutions enter into contractual agreements with each clinical site, sometimes for each program at each clinical site, we are obliged to manage literally hundreds of contracts that may have differing pre-placement requirements for students in need of clinical training. One year we reviewed a clinical education contract that involved 4 health professions programs. We began to review the contract 4 weeks in advance of the expiration date. Pre-placement requirements (trainings, immunizations, drug screenings, etc.) were among the issues that required review and negotiation. It took 4 months to resolve the pre-placement requirements issue and involved 37 email threads, 3 faculty members, 5 staff members, 1 director of legal affairs and 1 executive dean.” **Ann E. Barr PT, DPT, PhD Executive Dean and Vice Provost at Pacific University**

From a student's perspective, the varied requirements are confusing and often frustrating. Students wait from one to six months and spend between \$100 to \$200 on the appropriate set of immunizations, drug tests, and background checks in order to become eligible to attend clinical training at one hospital or clinic. Then, when a student is rotated to another site, he or she once again could wait one to six months and possibly spend another \$100 to \$200 on another set of required checks and tests. Each time, a student moves, the process begins again.” **Ann Malosh, M.Ed, Dean, Business, Healthcare, and Workforce, Linn Benton Community College**

“This bill has the potential to not only reduce administrative costs across Oregon's health care system by eliminating duplication, but it will also contribute to laying the necessary groundwork to expand Oregon's training capacity, which is an essential

*aspect of meeting Oregon's future healthcare workforce needs." Mark A. Richardson
MD, MBA, Dean of OHSU School of Medicine*

The workgroup formed to address these issues agreed that ensuring patient and student safety should be the priority. In undertaking their task, the workgroup's approach was to value simplicity and to attempt to develop efficient solutions that would benefit all three constituencies: students, schools, and clinical facilities.

III. Key Questions and Recommendations

In the course of their meetings, participants in the SB 879 workgroup process addressed four questions:

- What should the standards be?
- To whom should they apply?
- How should the standards be implemented?
- How should students' compliance with the standard requirements be tracked?

Key considerations and the Workforce Committee's recommendations on each are described below.

Standards

➤ The recommended standards address immunizations, screenings, training, and other topics (liability, health insurance, etc.), as well as the timing for these standards. See Table 1 for the specific recommendations in each area.

As noted in the Table, some operational details remain to be finalized, e.g. the particular list of sources that should be checked and types of offenses that should be considered as part of a criminal background check. Workgroup participants suggested the Department of Human Services' criminal background check process as the best starting point, but this and a few other details should be settled during planning for implementation of the standards (see *Implementation* below).

In addition to trying to identify specific standards that would be broadly acceptable, participants in the workgroup process wrestled with the key question of whether the standards should be considered a floor or a ceiling. Setting standards as a floor would allow each clinical facility to add their own requirements on top; many stakeholders felt strongly that this would replicate the problem the group was trying to solve. On the other hand, several noted that setting the standards as a ceiling could put clinical sites in a difficult situation if updated guidelines are subsequently issued by regulatory and accrediting agencies.

➤ The recommendation of the Workforce Committee is that the standards be implemented as a ceiling for the relevant professions and settings (see *Applicability* below) but that a process be developed to update the standards in a timely manner in response to significant changes. This

process may include an automatic incorporation of guidance issued by The Joint Commission (TJC), the Centers for Disease Control and Prevention (CDC), or other relevant bodies (see *Implementation* below).

Applicability

SB 879 specifics that, at a minimum, the standards should pertain to nursing and allied health students doing clinical placements in hospitals and ambulatory surgical center settings. However, the bill allows the standards to apply more widely and the draft recommendations were developed by a much broader range of stakeholders.

➤ The Workforce Committee recommends that the standards apply to any student with clinical or therapeutic contact with patients in a healthcare setting. Specifically, the standards should apply to students of these professions (whose clinical placement meets the definition above):

- Medicine (including Physician Assistants)
- Nursing
- Physical and Occupational Therapy
- Pharmacy
- Dentistry and Dental Hygiene
- Mental health and addictions treatment
- Allied health (e.g. respiratory therapists, phlebotomists, medical assistants, etc.)

And the standards should apply to students working in the following settings, when their work/internship involves clinical contact:

- Hospitals
- Ambulatory care centers and offices
- Long term care settings, including but not limited to nursing facilities, assisted living, and residential care
- Hospice

Note that Department of Veterans' Affairs (VA) facilities are explicitly excluded from this list because their standards for student clinical placement are set at the federal level. However, representatives from the Portland VA participated in the SB 879 workgroup and the proposed standards are largely consistent with the VA's requirements.

➤ Based on stakeholder input, the Committee recommends that the standards allow for exceptions when students are placed in a facility or setting where the employed professionals do not have similar requirements. The need for this was raised in the context of behavioral health professions students (e.g. social work, psychology), whose level of clinical patient contact varies, but the exception may be relevant for others as well.

➤ The Committee is *not* suggesting that the proposed standards extend to students who will not have direct patient contact as part of their internship or placement. Under most circumstances, this would include students in programs for health management or administration, clinical informatics, research, and medical transcription, among others. While

some facilities may require students from these fields to meet one or two of the prerequisites (e.g. a background check), the standards were not developed with non-clinical students in mind. Similarly, the standards are not intended to apply to research or medical services settings (e.g. a clinical research laboratory or a blood bank). Finally, the standards are not intended to supersede requirements that apply to specialty services (e.g. requirements set by the Nuclear Regulatory Commission for students involved in radiosurgery).

In more than one meeting, workgroup participants discussed to what extent the standards should apply to students enrolled in out-of-state training programs who do clinical placements in Oregon. These students include Oregon residents enrolled in online programs or attending schools just across state lines in Washington, Idaho, or California, as well as non-Oregon residents who want to come to Oregon for clinical rotations. The question is an important one because distance learning programs are growing rapidly and are creating additional demand for limited clinical placement sites in Oregon. Anecdotally, participants in the workgroup process relayed that some distance programs do not assist their students to obtain clinical placements or supervise them adequately while they are in place.

➤ The Workforce Committee recommends that the standards apply to *all* students seeking clinical placements in Oregon, including those enrolled in out-of-state schools or distance training programs. This consistency should benefit both host facilities and students. The question of how to incorporate verification and tracking for out-of-state students is one that should be addressed during implementation planning.

Implementation

The third key question addressed by the workgroup was how to secure agreement with and use of the proposed standards. Stakeholders discussed a range of options, from voluntary adoption to compliance enforced via statute. In general, the group felt that voluntary adoption would not address the problem effectively and that statutory enforcement would be unnecessarily heavy-handed.

➤ The Workforce Committee recommends that the standards be articulated in administrative rule by OHA, as provided by SB 879. The effective date of the rules should be far enough in the future that training programs and clinical sites have time to amend their entry requirements and contracts as needed (e.g. effective for students admitted as of September 2014). As emphasized under *Applicability* above, the administrative rules must include a process by which the standards can be re-considered and updated in a timely manner when regulatory or accrediting bodies issue new guidance. This process may include an automatic incorporation of guidance issued by TJC, the CDC, or other relevant bodies.

Tracking

Documenting and communicating that each student has satisfied the prerequisites for clinical placement currently creates a significant workload for students, schools, and clinical sites.

Many schools and institutions employ full-time placement coordinators to facilitate the process. In some areas, systems have been developed to centralize this tracking and facilitate scheduling of clinical placements, such as StudentMAX in the Portland metro area for nursing students (now expanding beyond nursing) or the Student Health Professional Scheduler offered by the Area Health Education Center of Southwest Oregon. Participants in the SB 879 workgroup process debated the merits of a range of tracking options and identified two primary candidates:

1. A common format checklist or other high-level paper document (e.g. a “passport”) that attests to students’ good standing; or
2. A passport along with a centralized, web-accessible database that allows students and schools to upload relevant source documents (e.g. proof of immunization). The database would have to be built with appropriate safeguards for information security and only allow clinical sites to view source documents with students’ permission.

The benefits of a centralized database are many: it would reduce the exchange of paperwork between schools and clinical sites; facilitate access to the primary source documentation that clinical sites are increasingly demanding; and would allow students who transfer between schools or who continue on to a second degree to preserve their information. Many workgroup participants argued that a centralized database would be essential for an effective system. It was widely acknowledged, however, that the cost of creating and maintaining a centralized database, even one built on top of an existing system, was a significant logistical barrier. A centralized database has the potential to create savings in the long term by simplifying contractual negotiations, facilitating communication, and reducing duplication but would require an up-front investment and an ongoing operating budget. Cost aside, some participants also expressed concern about the security of confidential information and how to incorporate students coming from out-of-state programs.

➤ While recognizing the value of a centralized database and urging stakeholders to conduct a financial feasibility study, the Workforce Committee recommends a simpler, paper-based “Passport” tracking system initially. Schools would continue to verify source documents and would issue a common format passport to students in good standing. With the student’s permission, schools could release copies of the source documentation to clinical sites upon request.

IV. Next Steps

The Healthcare Workforce Committee respectfully submits the draft recommendations in this report to the Oregon Health Policy Board for review and feedback. If the Board agrees with the substance of the recommendations, the Committee would suggest the following as next steps:

1. OHA convenes a Rules Advisory Committee and develop the administrative rules necessary to implement the common standards. As noted, the effective date of the standards should allow all constituencies adequate time to prepare. The rules should

address the details that were not finalized by the SB 879 workgroup (e.g. particular elements of a criminal background check) and specify when and how the standards can be updated in response to national and regional guidelines or issues identified by Oregon institutions.

By default, the process of administrative rule development includes notification of interested parties and opportunities for public comment. The Committee suggests that these be expanded in this case to encourage participation from stakeholders who may not have engaged in the SB 879 workgroup.

2. Stakeholders commission a small feasibility study for a self-sustaining, centralized database to track and document students' satisfaction of the prerequisites. The study should estimate the expenses incurred now by students, schools and clinical sites, the degree to which use of common standards and a centralized database could be expected to reduce those expenses, and the cost of building and maintaining a database.

Table 1. Standards that health professions students should meet before clinical placements
Developed for the Oregon Health Policy Board by the Oregon Healthcare Workforce Committee
June 2012

Standard	Timing	Notes
Immunizations (documented receipt of vaccine or documented immunity via titer or valid history of disease)		
Hepatitis B (Hep B)	Per CDC guidelines	
Measles, mumps and rubella (MMR)		
Tetanus, diphtheria, pertussis (Tdap)	Per CDC guidelines	
Varicella		
<i>Recommended</i> -- Influenza (seasonal flu)		Follow state law requirements ¹ /recommend mask or other precaution if not immunized
<i>Recommended</i> -- Polio		CDC recommends for health care workers with special conditions (i.e., pregnant, diabetic, etc.)
Screenings		
Tuberculosis (TB)	Before first placement; after that only in case of known exposure	Facility choice of skin test or Quantiferon Gold
Substance Abuse - 10-panel drug screen as minimum, <i>unless profession requires more (e.g. BOP intern license)</i>	Matriculation contingent on acceptable drug screen results; subsequent screens only for cause	School/training program should verify that screening is performed by a reputable vendor
Criminal Background Check - E.g. local and national criminal search, OIG provider exclusion list, sex offender registry, etc.	Matriculation contingent on acceptable criminal background check results	Elements of check should be standardized (see at left) and check should be performed by a reputable vendor, criteria TBD.
Training		
Basic Life Support (BLS) for healthcare providers	Before first placement; maintain current certification during placement	Recommend American Heart Association training
Bloodborne Pathogen training (OHSA)		
<i>Site-specific</i> privacy and confidentiality practices	With <i>each</i> placement	
<i>Site-specific</i> orientation (facility-specific protocols for safety, security, standards of behavior, etc.)		
Other		
Professional liability	Prior to clinical rotation	Students are typically covered by school
General liability		Students are typically covered by school
Non-disclosure agreement		
Current health insurance (or coverage via Workers' Compensation insurance extended to students by school)		

Appendix A Stakeholders Consulted

Participated in one or more meetings:

Lucy Andersen	Northwest Permanente, P.C.
Jen Baker	Oregon Nurses Association
Jo Bell	Department of Community Colleges and Workforce Development
Jana Bitton	Oregon Center for Nursing/Student Max
Peg Bodell	Legacy Good Samaritan
Debra K. Buck	Oregon State Board of Nursing
Michelle Cooper	Portland VA Medical Center
John Custer	Legacy Health Systems
Denise Dallman	Carrington College
Marcia Decaro	OHSU
Jennifer Diallo	Oregon Student Assistance Commission
Deb Disko	Oregon Institute of Technology
Amy Doepken	Legacy Health Systems
Michelle Eigner	OHSU
Mark H Ellicott	Portland VA Medical Center
Vicki Fields	OHSU
Jesse Gamez	FamilyCare
Leslie Gonzales	Carrington College
Jalaunda Granville	Oregon Primary Care Association
Weston Heringer, Jr.	Oregon Dental Association
Felicia Holgate	Oregon Occupational Therapy Licensing Board
Kim Ierian	Concorde Career College
Joy Ingwerson, RN	Oregon State Board of Nursing
Jo Johnson	Office of Rural Health
Carlie Jones	Sumner College
Julie Kates	Portland State University
Jenny Kellstrom	Oregon Institute of Technology
Troy Larkin	Providence Health & Services
Donna Larson	Mt. Hood Community College
Ann Malosh	Linn-Benton Community College
Linda Meyer	OHSU

Teresa Moeller	Breckenridge School of Nursing
Judy Ortiz	Pacific University
Skip Panter	Samaritan Health Services
Sandra Pelham Foster	Pacific University
Launa Rae Mathews	OHSU
Juancho Ramirez	OSU/OHSU
Rebecca Reisch	Pacific University
Mary Rita Hurley	Oregon Center for Nursing
Pamela Ruona	Oregon Health Care Association
Karan Serowik	Heald College
Leslie Soltau	Samaritan Lebanon Community Hospital
John Thompson	Providence Health & Services
Kirt Toombs	Eastern Oregon Center for Independent living (EOCIL)
Linda Wagner, RN, MN	Rogue Community College
Greg White	Oregon Workforce investment Board
Anne Wilson	Legacy Health Systems
Saydee Wilson	Pioneer Pacific College
Marina L. Yu	Legacy Health Systems

Received meeting materials, summaries, and other review material

Ann Barr	Pacific University
Nancy Bensen	Tuality Healthcare
Alisa Beymer	Sacred Heart Medical Center
Jan Brooke	PeaceHealth
Genevieve Derenne	Providence Health & Services
Julie Ebner	Providence Health & Services
Coleen Fair	Samaritan Lebanon Community Hospital
Ilene Gottesfeld	ITT Technical Institute
Jennifer Hanson	Kaiser Foundation Health Plan
Connie Hector	Douglas County Educational Service District
Diana Kimbrough	Providence Health & Services
Linda Lang	Oregon Association of Hospitals and Health Systems
Karen MacLean	Oregon Board of Pharmacy
Susan Mahoney	Tuality Healthcare
Sue Naumes	Rogue Community College

Patty O'Sullivan
Matthew Schmoker
Elaine Seyman
Roxanne Stevens
Judy Tatman
Amparo Williams

Oregon Association of Hospitals and Health Systems
Carrington College
Everest College
Pioneer Pacific University
Providence Health & Services
Providence Health & Services

Enrolled
Senate Bill 879

Sponsored by Senators MONNES ANDERSON, WINTERS

CHAPTER

AN ACT

Relating to administrative requirements for student placement in clinical training settings; and declaring an emergency.

Be It Enacted by the People of the State of Oregon:

SECTION 1. (1) **The Oregon Health Authority, in collaboration with the State Workforce Investment Board, shall convene a work group to develop standards for administrative requirements for student placement in clinical training settings in Oregon. The work group may include representatives of:**

- (a) State education agencies;**
 - (b) A public educational institution offering health care professional training;**
 - (c) Independent or proprietary educational institutions offering health care professional training;**
 - (d) An employer of health care professionals; and**
 - (e) The Health Care Workforce Committee established under ORS 413.017.**
- (2)(a) The work group shall develop standards for:**
- (A) Drug screening;**
 - (B) Immunizations;**
 - (C) Criminal records checks;**
 - (D) Health Insurance Portability and Accountability Act orientation; and**
 - (E) Other standards as the work group deems necessary.**

(b) The standards must apply to students of nursing and allied health professions. The standards may apply to students of other health professions.

(c) The standards must pertain to clinical training in settings including but not limited to hospitals and ambulatory surgical centers, as those terms are defined in ORS 442.015.

(3) The work group shall make recommendations on the standards developed under this section and the initial and ongoing implementation of the standards to the Oregon Health Policy Board established in ORS 413.006.

(4) The authority may establish by rule standards for student placement in clinical training settings that incorporate the standards developed under this section and approved by the Oregon Health Policy Board.

SECTION 2. **The Oregon Health Authority shall report on the progress of the work group convened under section 1 of this 2011 Act to an interim legislative committee related to health on or before June 30, 2012.**

SECTION 3. **Section 2 of this 2011 Act is repealed on January 1, 2013.**

SECTION 4. This 2011 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2011 Act takes effect on its passage.

Passed by Senate April 5, 2011

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Robert Taylor, Secretary of Senate

.....
Peter Courtney, President of Senate

Passed by House May 11, 2011

.....
Bruce Hanna, Speaker of House

.....
Arnie Roblan, Speaker of House

Received by Governor:

.....M,....., 2011

Approved:

.....M,....., 2011

.....
John Kitzhaber, Governor

Filed in Office of Secretary of State:

.....M,....., 2011

.....
Kate Brown, Secretary of State

Oregon Health Care Workforce Committee

SB 879 (Student Passport) Workgroup Recommendations

Oregon Health Policy Board Meeting
July 10, 2012



The problem

Inconsistencies in requirements for student clinical placement create costly inefficiencies for students, schools, and clinical sites.

Because educational institutions enter into contractual agreements with each clinical site, sometimes for each program at each clinical site, we are obliged to manage literally hundreds of contracts that may have differing pre-placement requirements for students in need of clinical training." Ann E. Barr PT, DPT, PhD Executive Dean and Vice Provost at Pacific University



SB 879 Workgroup

- SB 879 called for a workgroup to develop standard requirements for student clinical placement
- Participants in the process included:
 - Healthcare professional educational programs (many disciplines)
 - Hospitals and health systems
 - Other interested parties (e.g. licensing boards)
- Priorities: patient and student safety
- Goal: find viable solutions that benefit students, schools, and sites



Recommended Standards

Standard	Timing	Notes
Immune status (documented receipt of vaccine or documented immunity via test or valid history of disease)		
Hepatitis B (HBsAg)	per CDC guidelines	
Measles, mumps and rubella (MMR2)		
Tetanus, diphtheria, pertussis (Tdap)		
Varicella		
Recommended - Influenza (seasonal/flu)	per CDC guidelines	Follow state law requirements/contractual needs in other jurisdictions if not introduced
Recommended - Polio		CDC recommendations for health care workers with special conditions (i.e., pregnant, diabetic, etc.)
Screening		
Tuberculosis (TB)	Before first placement, after that only in case of known exposure	Facility choice of skin test or Quantiferon Gold
Substance abuse - 10-panel drug screen as minimum, unless profession requires more (e.g. ADP screen required)	Pre-employment contingent on acceptable drug screen results; subsequent screens only for cause	Screening program should verify that screening is performed by a reputable vendor
Criminal Background Check - E.g. local and national criminal search, DIC provider excludes TSA, sex offender registry, etc.	Pre-employment contingent on acceptable criminal background check results	Elements of check should be standardized (see article) and check should be performed by a reputable vendor, criteria TBD
Training		
Basic life support (BLS) for healthcare providers	Before first placement; recertification certification during placement	Recommended American Heart Association training
Advanced Pediatric Training (APAT)		
Site specific policies and confidentiality practices (e.g. weight measurement for the specific purposes for safety, security, standards of behavior, etc.)	With each placement	
Other		
Professional liability		Students are typically covered by school
Current liability		Students are typically covered by school
Non-disclosure agreement		
Current health insurance for coverage via Workers' Compensation insurance extended to students by school	Refer to school website	



Key Question 1

Should standards be set as a floor or a ceiling?

Considerations:

- Allowing each clinical facility to add its own requirements on top of the standards would replicate the problem that SB 879 is intended to solve
- Clinical sites need flexibility so they are not caught between Oregon regulations and mandates from regulatory and accrediting agencies

Workforce Committee Recommendation:

The common standards should be implemented as a ceiling but a process must be developed to update the standards in a timely manner in response to issues or new guidance from regulatory or accrediting bodies.



Key Question 2

To whom should the standards apply?

Considerations:

- SB 879 specifies nursing and allied health professions, hospitals and ASCs at a minimum
- Broader applicability would go further toward addressing the underlying problem

Workforce Committee Recommendation:

The standards should apply to any student who will have clinical or therapeutic contact with patients in a healthcare setting (with some specific exceptions).



Key Question 3

How should the standards be implemented?

Considerations:

- Options range from voluntary compliance to enforcement via statute
- Mechanism should support statewide adoption of the standards but must be flexible enough to allow for changes when needed

Workforce Committee Recommendation:

The standards should be implemented via administrative rule, as SB 879 suggests. The effective date of the rules should provide training programs and clinical sites with ample advance notice (e.g. effective for students admitted as of September 2014).



Key Question 4

How to track students' requirements across placements?

Considerations:

- Centralized online system or a common-format physical passport issued to students by their training programs?
- Important factors include: access to timely information and to source documents (e.g. proof of immunization); privacy and security concerns; cost and administration of a centralized system

Workforce Committee Recommendation:

Centralized, web-accessible database should be the long-term goal but stakeholders should assess financial feasibility. Start with a paper-based "Passport" initially.



Next Steps

- Feedback and direction from OHPB
- Pending OHPB approval, development of administrative rules with input from a rules advisory committee.
- Stakeholder exploration of the financial and operational feasibility of a centralized database.

