

Basic Health Program (BHP) Stakeholder Group

AGENDA

October 8th, 2015

8:00 – 10:00 a.m.

Lincoln Building, 7th Floor Suite 775
421 SW Oak Street
Portland Oregon 97204

Call-in number: 888.398.2342

Participant code: 3732275

Webinar registration: <https://attendee.gotowebinar.com/register/4437643593036369922>

Time	Item	Presenter
8:00am	Welcome and introductions	OHA Staff
8:10am	Review requirements of HB 2934 and revisit timeline <ul style="list-style-type: none">Summarize key decision points from Sept. 16th meeting	OHA Staff
8:20am	Oregon Marketplace <ul style="list-style-type: none">Eligibility for QHPs and federal subsidies	D'Anne Gilmore, DCBS
8:35am	Stakeholder group <ul style="list-style-type: none">Review list of advantages and disadvantagesReview and finalize key design principlesAssess straw proposals	Stakeholder Group
9:50am	Wrap up, next steps	OHA staff

Materials

1. Agenda
2. HB 2934 enrolled
3. September 16th meeting summary
4. Cost-sharing reductions brief, DCBS
5. Draft presentation for Oct. 8th
6. Summary of Oregon Coordinated Care Model (CCM)

Next meeting: none scheduled/tbd.

Enrolled
House Bill 2934

Sponsored by COMMITTEE ON HEALTH CARE

CHAPTER

AN ACT

Relating to access to health care; and declaring an emergency.

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

SECTION 1. (1) The Oregon Health Authority shall convene a stakeholder group consisting of:

- (a) Advocates for low-income individuals and families;**
- (b) Advocates for consumers of health care;**
- (c) Representatives of health care provider groups;**
- (d) Representatives of the insurance industry; and**
- (e) Members from the House of Representatives and the Senate appointed by the chairs of the legislative committees related to health care.**

(2) The first meeting of the group shall occur no later than 30 days after the effective date of this 2015 Act.

(3) The group shall provide recommendations to the Legislative Assembly regarding the policy, operational and financial preferences of the group in the design and operation of a basic health program, in accordance with 42 U.S.C. 18051 and 42 C.F.R. part 600, in order to further the goals of the Legislative Assembly of reducing the cost of health care and ensuring all residents of this state equal access to health care.

(4) The group shall, in its deliberations, consider the findings from the independent study commissioned under section 1, chapter 96, Oregon Laws 2014.

(5) The authority shall report the recommendations of the group to the interim legislative committees related to health care no later than December 1, 2015.

SECTION 2. Section 1 of this 2015 Act is repealed December 31, 2015.

SECTION 3. This 2015 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2015 Act takes effect on its passage.



Passed by House April 20, 2015

.....
Timothy G. Sekerak, Chief Clerk of House

.....
Tina Kotek, Speaker of House

Passed by Senate May 26, 2015

.....
Peter Courtney, President of Senate

Received by Governor:

.....M,....., 2015

Approved:

.....M,....., 2015

.....
Kate Brown, Governor

Filed in Office of Secretary of State:

.....M,....., 2015

.....
Jeanne P. Atkins, Secretary of State

HB 2934: Basic Health Program (BHP) Stakeholder Group

Meeting: [September 16th](#), 2015, 3:00pm – 5:00mm, 421 SW Oak Street, PDX 97201

[Members](#) in attendance: Rep. Keny-Guyer, J. Bauer, V. Demchak, A. Hess, Amanda Hess, Staff. Senator Shield; D. Gilmore, R. Moody, H. Rosenau, J. Santos-Lyons (phone), D. Sobel, and M. Taylor.

Meeting Synopsis:

- Consensus achieved around developing a high-level framework based on key design principles. The group agreed that an important outcome of their work will be to submit a recommendation regarding the BHP to the legislature that addresses the financial realities facing Oregon.
- Design preferences identified by the group to date: (1) provider reimbursement, although not unanimous, general level of agreement the reimbursement rate should be somewhere between Medicaid and commercial, (2) BHP should adopt the principles of Oregon's Coordinated Care Model (CCM), (3) Coordinated Care Organization (CCOs) and commercial plans should compete to offer BHP plans, and (4) adopt a sustainable rate of growth to control costs.
- Group did not reach consensus on the type of delivery system: Medicaid vs. Marketplace.

General Summary: Representative Keny-Guyer opened the meeting by offering several observations for the group as it works towards a recommendation: (1) prioritize scenarios that address remaining uninsured in terms of coverage and affordability for those under 200% of the federal poverty level (FPL): (2) identify approaches in the design of a BHP that will be most effective in reaching the remaining uninsured in terms of CCOs, qualified health plans (QHPs), or other alternative coverage/delivery models, and (3) consider the impact of the group's final recommendations on the Marketplace, both short and long term.

Courtney Westling, OHA Legislative Director, informed the group there are no additional resources available to rerun the BHP model by updating the actuarial results produced by Wakely Consulting for the [report](#) submitted to the Oregon Legislature in 2014. A question was raised as to whether outside funding could support additional econometric or actuarial modeling? Staff confirmed external stakeholders are encouraged to utilize private funding to support additional work deemed critical to informing the conversation around BHP moving forward. A concern was expressed by a member of the group regarding the lack of clarity on OHA's priorities for addressing Oregon's remaining uninsured. Courtney confirmed that health equity and addressing the remaining uninsured remain a priority for the agency.

OHA staff summarized key discussion points raised during the August 13th meeting (see [meeting materials](#)). Staff provided a brief overview of the preferences identified in the last BHP stakeholder meeting, which focused on Scenario 1. This scenario is based on a Medicaid provider reimbursement rate but incorporates a graduated premium scenario per the preferences expressed by the group. Staff summarized the projected deficit if a BHP were

implemented in 2016 as modeled by Wakely and Urban (see [slides](#) 16-17). Staff also briefly walked through four potential scenarios for designing a BHP in Oregon (see [slide](#) 18).

The group had a robust discussion on the preferences identified in August and reached a consensus that it's more suitable and pragmatic for the final recommendations to identify a set of principles and general framework for designing an implementation strategy for BHP.

Key Discussion Points and Considerations: Summarized below are main discussion points raised at the September 16th meeting including preliminary recommendations put forth by the stakeholder group.

Oregon Marketplace: D'Anne Gilmore, staff with Oregon Department of Consumer and Business Services (DCBS), provided a brief overview of Oregon's Marketplace. D'Anne's presentation focused on premiums and Advanced Premium Tax Credits (APTC) for a one person household. She also shared 2015 enrollment data for Oregon's Marketplace by plan type below 200% of the federal poverty level (FPL) (see [slides](#) 12-13).

- Approximately 21,592 individuals are enrolled in an adult dental plan in the Marketplace. However, it's unknown what percentage of this population falls below 200% of FPL.
- Several questions were asked about the number of Oregonians currently eligible for federal subsidies yet not enrolled in the Marketplace. Approximately, 75,000 Oregonians are eligible but not enrolled as of 2015.¹
- Revisited the dynamics of removing a portion of Oregon's Marketplace. Concern was expressed about the magnitude in terms of impact to the Marketplace by removing a significant portion of eligible individuals for QHP coverage into a BHP program.
- Agreement reached about the difficulty in determining the precise impact to Oregon's Marketplace outside of the results available in the 2014 BHP report by Wakely and Urban. The challenge with using estimates from the 2014 report is Oregon's Marketplace is projected to continue to grow, so the exact magnitude in terms of impact the BHP would have on the Marketplace in 2017 or 2018 is unknown.

Oregon Health Plan (OHP): several considerations summarized below.

- Pregnancy coverage: moving pregnant women b/w 138-185% FPL out of Medicaid into BHP. Group would like to know what percentage of women within this Medicaid coverage category could potentially qualify for BHP coverage based on historical OHP enrollment data.
- Existing pregnancy related coverage policy in Oregon. As of 2015, an individual enrolled in Marketplace coverage between 138-185% of FPL is given the option to stay enrolled in their QH plan and continue receiving premium tax credits, or enroll in Medicaid, but they cannot be enrolled in both. If an individual opts to stay enrolled in a QHP plan, they are responsible for any out-of-pocket costs.

¹ Estimate based on analyses by State Health Access Data Assistance Center, University of Minnesota, School of Public Health and McKinsey Center for US Health System

- Mixed family coverage: parents with children currently in Medicaid between 138-200% of FPL with Marketplace coverage could potentially be covered by the same carrier and provider network—if the BHP was available through CCOs.

Delivery system consideration: an important question in designing the BHP is whether to offer coverage through a traditional insurance product or use a CCO like-design, specifically, Oregon’s principles for a coordinated care model (CCM). As demonstrated by CCOs, Oregon’s CCM is making progress by bending the cost curve and has demonstrated measurable improvement in quality and integration of services. Another design consideration would be to incorporate a sustainable rate of growth that mirrors Oregon’s federal waiver with CMS for CCOs, and is now also a requirement in PEBB and OEBB. Several other observations offered by the group:

- Create long-term cost savings, use control factor.
- CCOs are a “noun” vs. “adjective” (i.e. the CCM).
- Issue of plan choice recognizing that the majority of Oregon is only served by a single CCO.
- BHP thru CCOs potentially creates an access issue, particularly in rural Oregon.

Financing: The group discussed the importance of trying to ensure the BHP is budget neutral for the State. Consequently, the group is opting to develop a framework with principles that will inform how best to design a BHP for Oregon. It was agreed that the issue of having to pencil out the costs of a BHP in Oregon beyond 2016 will need to be addressed by the legislature.

Reimbursement Rate: the group identified the likelihood of significant concerns among providers if a BHP were offered with rates considerably lower than current commercial rates. It was acknowledged that offering a BHP based on Medicaid rates would possibly limit provider and/or carrier participation, creating an access issue for BHP enrollees.

- A mid-point between Medicaid and commercial reimbursement rates, for example a Medicare rate would be a preferred choice among providers compared to lower Medicaid reimbursement rates in Oregon as of 2015.

Consumer affordability: consensus that co-pays should not be included in the BHP due to administrative complexities and concerns with potentially creating a barrier to care among enrollees. Group agreed to move forward with no-cost sharing below 138% of FPL and apply a graduated cost-sharing structure for those between 139-200% FPL (similar to New York’s BHP model). Focus should be on premiums rather than co-pays and use of cost-sharing to deter non-urgent utilization of emergency services.

Benefit package: no clear universal consensus was achieved on whether to include adult dental acknowledging that dental is the largest and most costly benefit when comparing Medicaid to Marketplace coverage. One suggestion was to mirror OHP coverage to help foster continuity of coverage between Medicaid and BHP and decrease the impact of transitioning between Medicaid and BHP. Another suggestion is to recommend dental coverage to be included in the

future -- if federal or state funding becomes available. A third suggestion offered is to allow for individuals enrolled in BHP to purchase standalone dental coverage.

Administrative considerations: The group requested additional information about administrative complexities and costs with offering multiple benefit packages in Medicaid, possibly, pulling historically data from OHP *Plus* and Standard (pre-ACA implementation). It's unknown whether any such data is available from OHA. There was a general agreement among the group not to include a recommendation on enrollment policy, specifically 12-month continuous eligibility in terms of program design due to its impact on overall costs.

Advantaged and Disadvantages of a BHP: In July, Rep. Greenlick posed a fundamental question: What's the issue that the BHP is attempting to address in Oregon? In response, at each meeting the group has reviewed potential advantages and disadvantages with a BHP. At the September meeting, participants identified two new potential advantages:

- (1) If offered through CCOs, opportunity to address issue of mixed family coverage for parents with children in OHP between 139-200% of FPL, and
- (2) Reduce the rate of pregnancy related churn between Medicaid and the Marketplace.

The two potential advantages ultimately are dependent upon how the BHP is designed, if implemented.

Initial Set of Key Principals in Designing a BHP in Oregon: the intent in developing a general framework is to summarize for the legislature the "how" and "why" a BHP would enhance Oregon's goals around health reform, and to identify key program design elements, including design preferences that impact the overall financing of the program in a way that's budget neutral. In developing a framework, the following "concepts" have been discussed among the group as potential principles.

- Adopt Oregon's Coordinated Care Model (CCM) as part of the high-level framework for designing a BHP. Six principles are: best practices to manage and coordinate care, shared responsibility for health, transparency in price and quality, measuring performance, paying for outcomes and health, and a sustainable rate of growth.
- Establish a provider reimbursement rate somewhere between current Medicaid and commercial. Medicare was identified as a potential rate, but there wasn't unanimous agreement on whether that would be an acceptable rate for health care providers impacted by the program.
- Level of benefit coverage should be based on available funding, with a preference to mirror Medicaid coverage but ultimately determined by overall program costs.
- Recommend earliest possible implementation of 2017 or 2018. OHA would need to request federal approval and authority depending on the design of the program and complexity, and complete an IT feasibility assessment among federal and state officials. Of critical importance is to determine necessary eligibility programming among one or more IT systems to implement the BHP, specifically Oregon's ONE Medicaid eligibility system and/or the federal hub (or federally-facilitated marketplace, FFM).

Follow-up and next steps:

- Provide the group with pregnancy related in the Oregon Health Plan (OHP).
- Determine whether there's any historical data on administrative related costs created by churn in Medicaid in Oregon.
- Staff with DCBS will prepare written clarifications as requested by the group. Specifically, estimated the number of remaining uninsured between 0-200% of FPL in Oregon.
- Next steps:
 - Determine key design principles and review straw proposals based on preferences identified by the group to date from July-September.
 - Revisit list of "advantages & disadvantages."
 - Review list of constraints identified through this process that the legislature would need to be aware of in terms of federal permissibility.

DRAFT

Cost-Sharing Reductions

While tax credits get most of the attention for helping to reduce the cost of premiums, cost-sharing reduction (CSR) variations of qualified health plans can reduce the costs of copays, coinsurance, deductibles and maximum out-of-pocket (MOOP) costs for people with household incomes up to 250% of the federal poverty level (FPL).

CSR variations plans increase the actuarial value of a silver plan to silver plus, gold, and platinum levels, depending on the household income and the amount of subsidy.

Insurers may take different approaches to creating CSR variants of the silver metal level plans, the *only* metal level that qualifies for CSR.

In 2016 filings, most insurers in Oregon chose to reduce copays, coinsurance, deductibles and maximum out-of-pocket (MOOP). One insurer kept copays and coinsurance at the same level, but reduced deductible and MOOP.

The federal government directly reimburses insurers for the CSR plans.

Example of 2016 Cost Sharing Reduction Plans with Reduced Copays, Coinsurance, Deductible and Maximum Out-of-Pocket						
1-person Household	Required Annual Contribution to Premium	Deductible	Maximum Out-of-Pocket	Primary Care Copay	Generic Drug Copay	In-Patient Coinsurance
133% FPL - 94% AV	\$318	\$100	\$750	\$10	\$5	10%
150% FPL - 87% AV	\$719	\$850	\$1,500	\$15	\$10	10%*
200% FPL - 73% AV	\$1,509	\$2,500	\$4,300	\$35	\$15	30%*

*After deductible

HB 2934: Basic Health Plan Stakeholder Group

**October 8th, 2015
Oregon Health Authority**

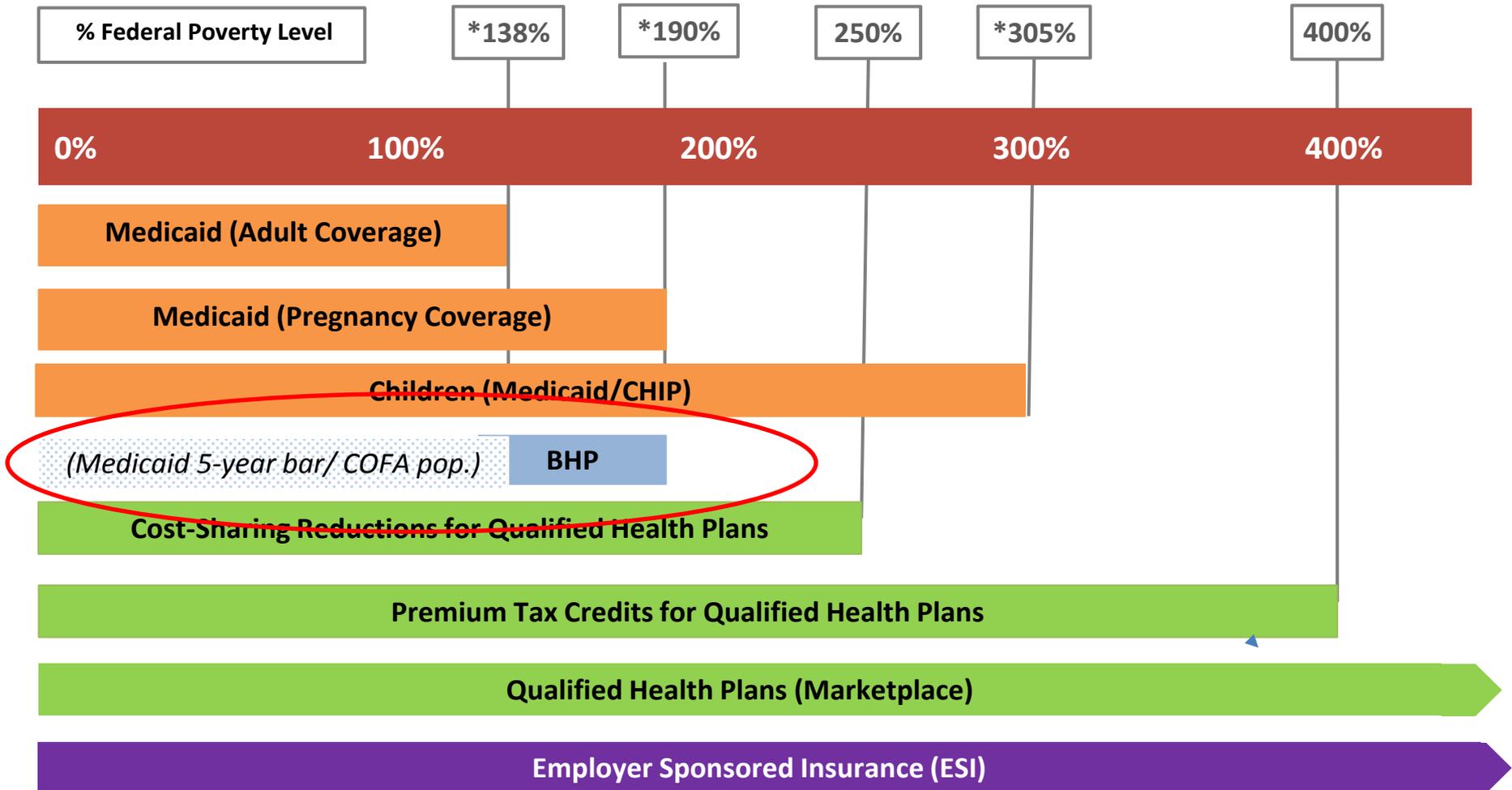
Presentation Overview

- Summarize discussion from September 16th
- Oregon Marketplace presentation
- Introduce principles framework
- Review straw proposals
- Identify key considerations for the Oregon Legislature

Basic Health Program (BHP) Overview

- The Affordable Care Act (ACA) gives states the option to establish a BHP for:
 - Individuals above 138% FPL up through 200% FPL who are ineligible for Medicaid or CHIP, and who do not have access to affordable employer coverage; and
 - Individuals at or below 138% of FPL who are ineligible for Medicaid due to immigration status.
- Federal government gives states 95% of what would have been spent on tax credits in the marketplace.
- Must offer two health plans; plans must include all essential 10 health benefits (EHB).
- Monthly premiums and cost sharing cannot exceed the amount the individual would have paid for coverage in the marketplace.

How BHP Could Fit into Oregon's Coverage Landscape

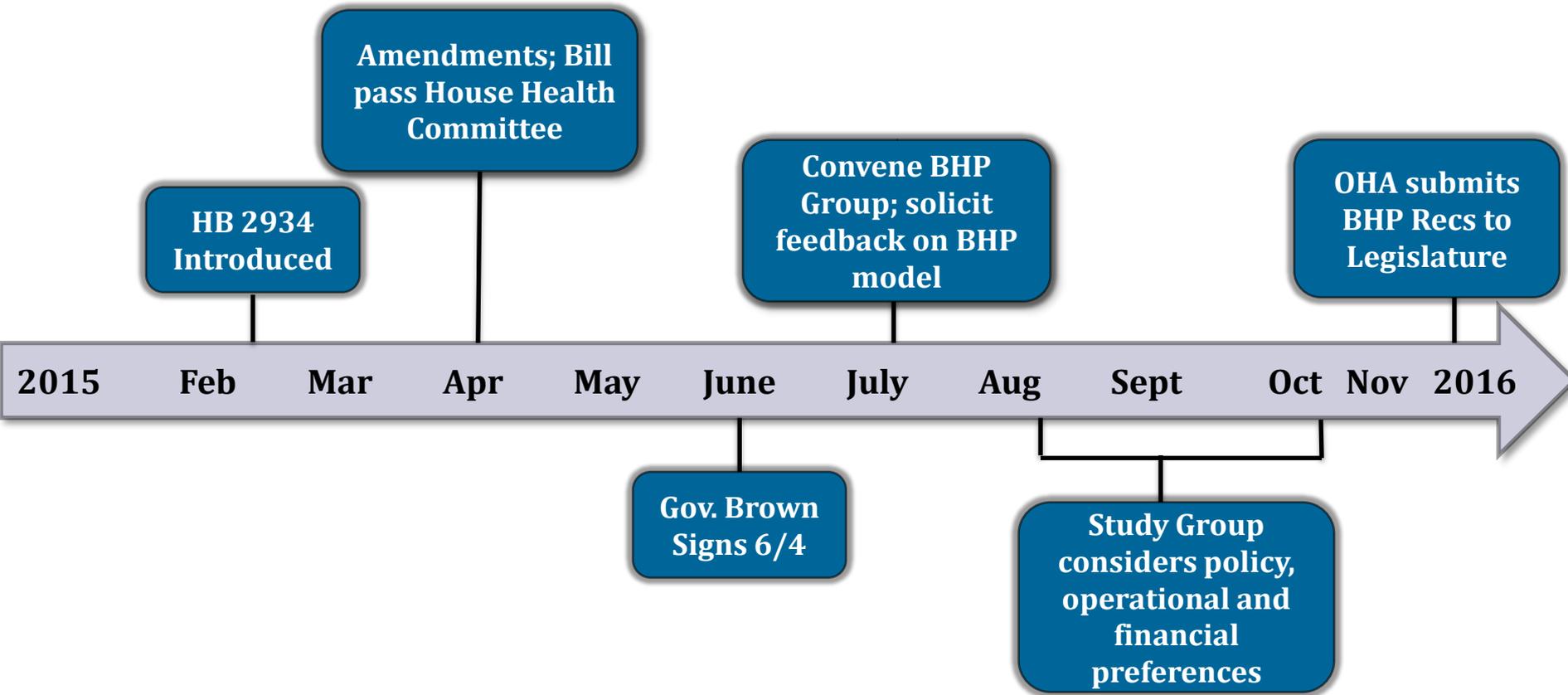


*Indicates the 5% across-the-board income disregard in Medicaid and CHIP. (Illustration adapted from the Washington State Health Care Authority.)

Requirements of HB 2934

- Requires OHA to convene a stakeholder group to provide recommendations to Legislative Assembly concerning the BHP.
- OHA must report recommendations to interim legislative committees no later than Dec. 1, 2015.
- Recommendations need to address “the policy, operational, and financial” preferences of the group in the “design and operation” of a BHP.
- Recommendations should further the goals of the Legislative Assembly of “reducing the cost of health care and ensuring all residents” of Oregon have equal access to health care.

Timeline: HB 2934 BHP Stakeholder Group



Revised Work plan/Timeline

Stakeholder group: four meetings

- **July 2nd** — initial convening of stakeholder group; outlined key findings from 2014 BHP study.
- **July 29th** — review federal guidance related to the BHP; consider consumer affordability, premium and cost-sharing options for BHP, and level of benefit coverage.
- **Aug. 13th** — review potential delivery systems, contracting and provider networks, and provider reimbursement.
- **September 16th** — review operational and financing considerations; identify initial design preferences
- **Oct 8th**— finalize recommendations.

Revised Work plan/Timeline (cont.)

Report submission

- **October** — OHA staff finalize written recommendations for Legislature
- **November** — OHA submits recommendations to the Legislature
- **January (2016)** — presentation to House Committee on Health – Interim Legislative Days (**tentative*)

Scope of Recommendations: HB 2934

○ Program Design

Consumer Preferences

- Premiums and out-of-pocket costs
- Level of benefit coverage

Delivery System and Fiscal Preferences

- Plan offerings, procurement and contracting
- Provider reimbursement
- Network adequacy

Operations

- Enrollment period
- Disenrollment procedures for non-payment of premium
- Administrative financing (i.e. collection of premiums)
- Federally-facilitated Marketplace - feasibility
- Coordination of insurance affordability plans (IAPs)
(OHP/Marketplace)

Scope of Recommendations: HB 2934 (cont.)

Additional Considerations

- **Federal requirements***
 - Ensure two standard health plans from at least two offerors (consumer choice); *possibility of federal exemption*
 - Competitive contracting process for selecting standard health plans; *no federal exemptions allowed*
- **Financing**
 - Potential need for state general fund to support program
 - Administrative expenditures
 - Volatility in Marketplace (premiums)
 - Carrier and provider participation
- **IT Systems – eligibility , enrollment and renewal**
 - Federally-facilitated Marketplace – federal feasibility
 - Oregon’s ONE Medicaid eligibility system
 - Ability to monitor cost-sharing compliance

BHP: Advantages and Disadvantages*

Potential Advantages

- Affordability: More low-income individuals able to afford coverage by reducing premiums and cost sharing for low-income individuals
- Expand coverage to remaining uninsured 0-200% FPL
- Reduce churn: may smooth transitions as incomes fluctuate at 138% FPL
- BHP as a policy to spread coordinated care model (CCM)
- Offer additional benefit coverage; encourage appropriate use of primary and preventive care (e.g. removing copays)
- Address mixed eligibility for public coverage for families and children (<200% FPL)

Potential Disadvantages

- Federal funding may not cover cost of plans; State may have financial exposure
- Funding for start-up and ongoing administrative costs
- Exchange volume will decline; potential impact unknown beyond 2016

Oregon Marketplace

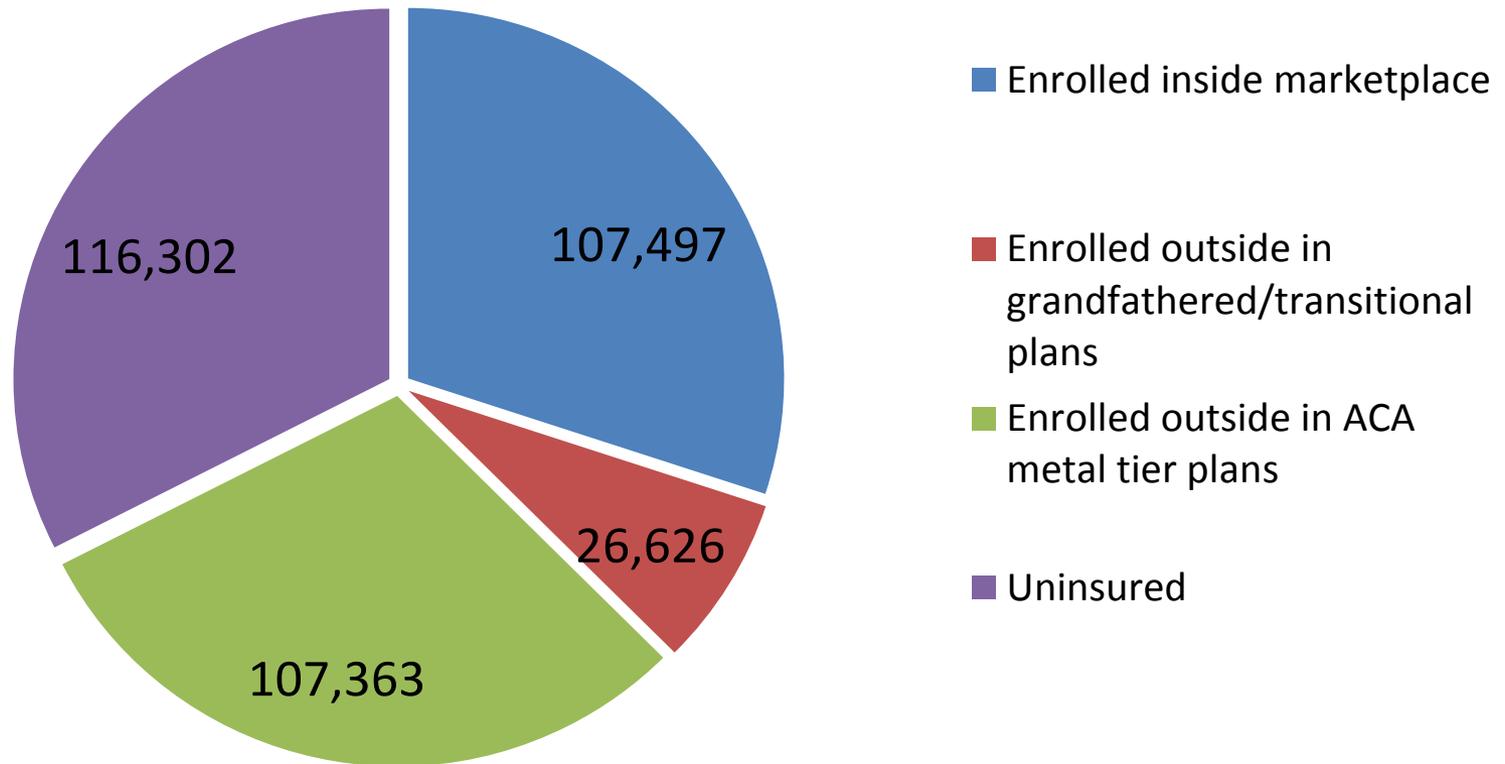
Cost-sharing Reductions

Example of 2016 Cost Sharing Reduction Plans with Reduced Copays, Coinsurance, Deductible and Maximum Out-of-Pocket

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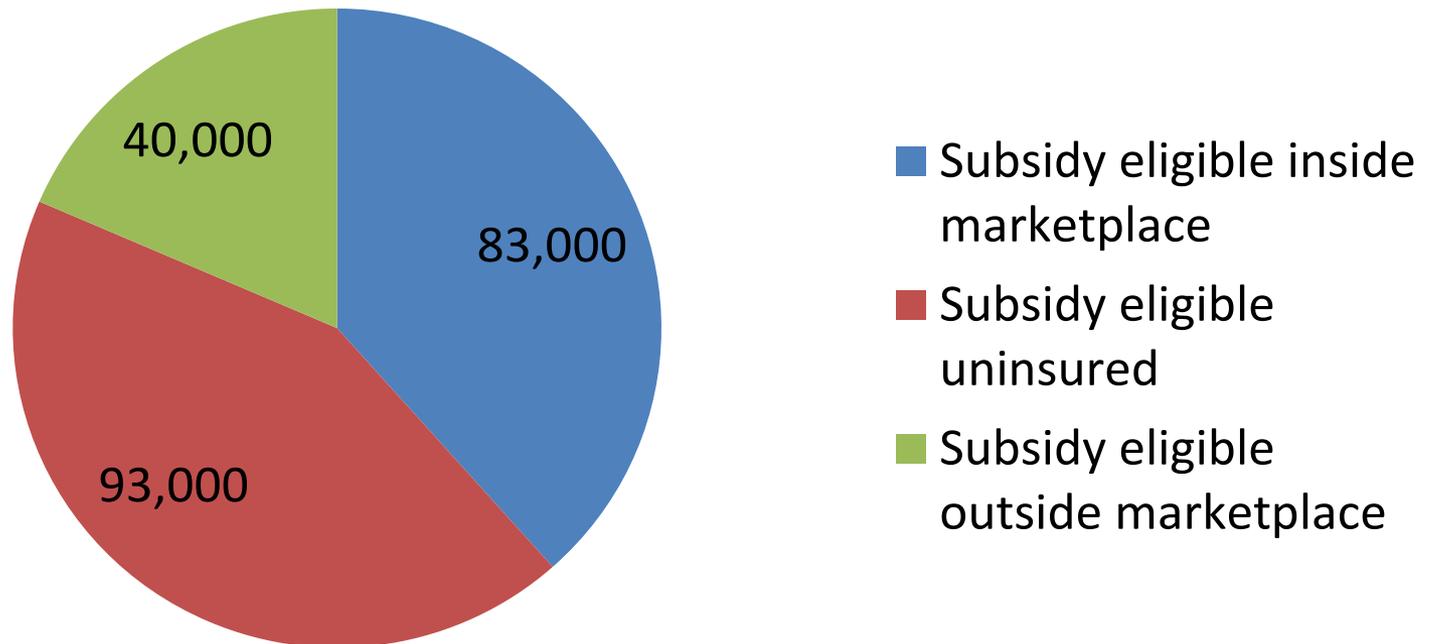
Eligibility for QHPs and Subsidies

QHP Eligible Oregonians



Eligibility for QHPs and Subsidies (cont.)

Subsidy Eligible Oregonians



Oregon Health Plan: Pregnancy Coverage

OHP Pregnancy Coverage - *Forthcoming*

***HB 2934:
Draft Principles and Straw Models***

BHP Scenarios*

Options in Oregon to offer Standard Health Plans:

1. Marketplace: competitive contracting process for commercial health plans to offer BHP options

2. CCOs: seek federal permission to waive the two plan requirement; contract directly w/ CCOs to offer BHP

- Would require federal permission to waive the “two plan” and requirement
- Limit consumer choice

3. Stand alone option: state contract directly with carriers to offer BHP (e.g. PEBB/OEBB)

4. Alternative model: competitive contracting among CCOs and QHP carriers through Marketplace (pending federal/state approval)

*Gray boxes indicate potential BHP scenarios identified as not being “preferable” among the group as of Sept. 16th, 2015

BHP Principles (**draft**)

- Increase access to affordable coverage for uninsured including those ineligible for Medicaid and Oregon's COFA population
- Increase affordability of coverage for Oregonians
- Adopt and spread the Coordinated Care Model (CCM)
- Promote a sustainable and predictable rate of growth (e.g. 3.4 percent in Medicaid, PEBB, and OEBB)
- Sponsor an accountable care model using a measurement framework to incentivize quality and population health improvements
- Reduce churn: minimize and mitigate the frequency of and impact from coverage transitions among insurance affordability programs
- Other principles?

BHP Straw Models		
	Option A: State Administered	Option B: Hybrid Marketplace
Delivery System	CCOs offer BHP	CCOs and Commercial Carriers compete for BHP enrollees using CCM
Benefit Coverage	OHP Plus with Dental	EHB w/o dental; dental as standalone plan available for OOP purchase
Provider Reimbursement	Medicare (~77% of commercial)	Average of Medicaid & Commercial (~81% of commercial)
Member Cost-sharing/Premiums (monthly)	<138% FPL, \$0; 138-150% FPL, \$10; 151-175% FPL, \$20; > 175% FPL, \$40	
Eligibility & Enrollment	Oregon Medicaid eligibility system; 12-month continuous eligibility	FFM eligibility system; open enrollment period
Consumer Choice	Limited to CCOs available per region; requires federal exception	Multiple plan offerings
Administrative Functions (Client services, grievances, premium billing)	OHA Medicaid	Marketplace and carriers
Rate of Growth (annualized sustainable rate of growth)	3.4%	
Implementation Timeframe	Enabling legislation in 2017; Implementation in 2018 contingent on federal approval and IT feasibility	

BHP Program Design & Financing Input(s)(millions)*

BHP Program Elements	Design Options (Scenario 1) †	BHP Program (+/-)
1. Benefit Coverage: OHP Plus (*92% of cost difference b/w OHP and EHB is dental)	\$21.34	
2. Premiums (program revenue)		
\$10 monthly premiums with incomes >175% FPL	(\$2.6-\$3.5)	
\$10 monthly premiums with incomes > 150% FPL	(\$5.5-\$6.7)	
\$10 monthly premiums with incomes 138-150% FPL, \$20 premiums 151-175% FPL, and \$40 above 175% FPL	(\$17.3-19.1)	
3. Provider Reimbursement: commercial	\$76.95-\$79.57	
4. Standard Health Plans expense (8-15%) (92% and 85% MLR)		
8% (92% medical loss ratio MLR)	\$15.49-\$17.35	
15% (85% medical loss ratio MLR)	\$45.49-\$48.79	
5. Administrative Expenses (Premium billing)	\$15.38-\$17.19	
Net – Surplus/(Deficit)		

† (program revenue)/program expense

*Listed in the table are potential design aspects of the BHP program identified as “modifiable” that could change the “bottom line” fiscal result as modeled by Wakely and Urban in the 2014. However, further analysis is needed to accurately and correctly determine the magnitude of these policy options.

Next Steps

- Finalize and submit recommendations to Oregon Legislature

HB 2934 report due to the Legislature by December 2015

Oregon Basic Health Program Study report (2014) prepared by Wakely Consulting Group and the Urban Institute

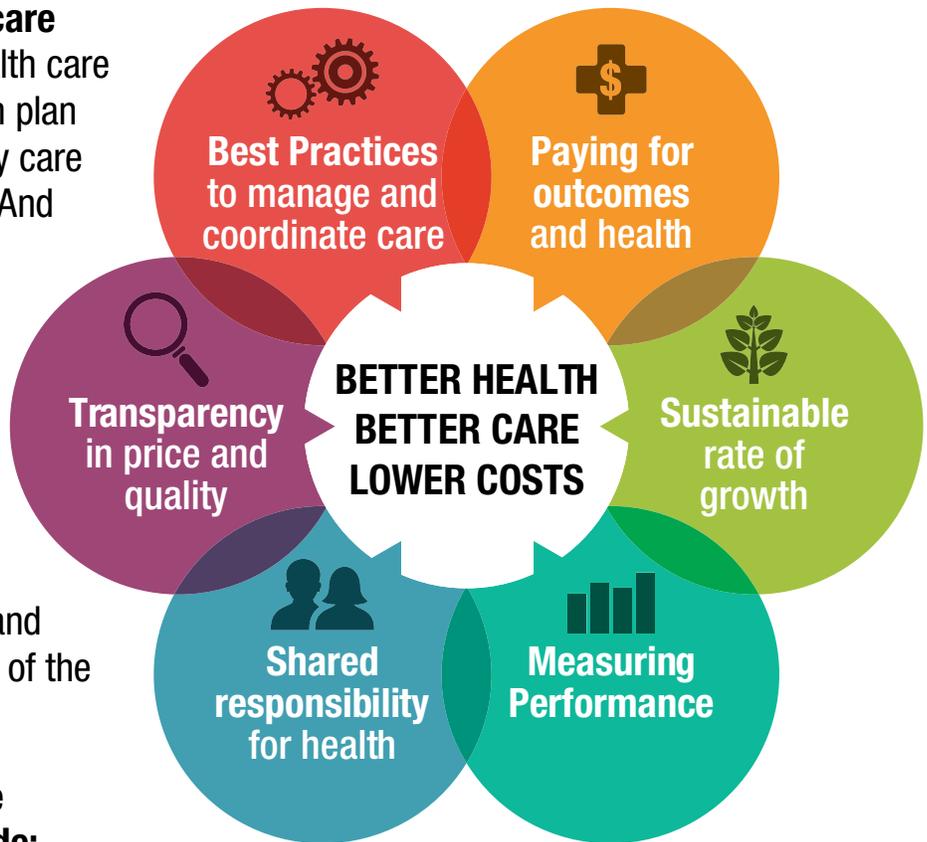
Report available at:

http://www.oregon.gov/oha/OHPR/docs/OregonBasicHealthPlanReport_11.10.2014.pdf

Oregon's coordinated care model

Better health, better care, lower costs: The Oregon Way

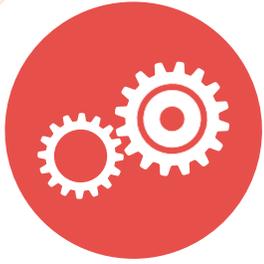
Through the coordinated care model, those paying for health care get a better value and health plan consumers get higher quality care at a price we can all afford. And Oregonians are experiencing improved, more integrated care. With a focus on primary care and prevention, health plans and their providers using the coordinated care model are able to better manage chronic conditions and keep people healthy and out of the emergency department.



Oregon's coordinated care model key elements include:

-  **Best practices to manage and coordinate care**
-  **Shared responsibility for health**
-  **Transparency in price and quality**
-  **Measuring performance**
-  **Paying for outcomes and health**
-  **A sustainable rate of growth**

Separately, these elements all assist in producing better health outcomes at lower prices. When all elements are used together, they are the most effective in achieving better health, better care and lower costs.



Using best practices to manage and coordinate care

The model is built on the use of evidence-based best practices to manage and coordinate care. This produces better care, improved outcomes (including a positive patient experience) and lower costs.

Best practices include:

- Value-based benefit design that create incentives for consumers to use evidence-based services.
- These services are the most effective for cost and quality, so they cost less for consumers, their employers or purchasers, and health plans.
- Identification of a primary care clinician as the individual's regular source of care.
- Patient-centered primary care homes that provide team-based care. Care coordination through primary care homes is essential for patients with chronic health conditions.
- Behavioral, physical and dental health care integrated through evidence-based best practices. Evidence-based practices such as shared treatment plans and co-location of services are designed to maximize outcomes and efficiency, and eliminate waste.
- Providers and health systems use electronic health records and information exchange across care settings. These systems improve data accuracy, allowing for better patient care, while reducing costs associated with duplicate or unnecessary services.
- Culturally and linguistically appropriate care.

What it means for

The purchaser of health benefits

- ✓ Lower costs as the result of better quality care and better health outcomes
- ✓ A central point of contact for navigation of services

Your employees

- ✓ Higher quality care and better health outcomes
- ✓ Streamlined information sharing, due to electronic health records and care coordination
- ✓ Improved patient experience
- ✓ Prevention-focused health strategies
- ✓ Improved care coordination, especially for those with chronic health conditions

The health plan

- ✓ Providers are using evidence-based best practices
- ✓ More robust picture of members
- ✓ Information from more care delivery points is available (dental, physical, mental)
- ✓ Case management efficiencies developed



Shared responsibility for health

When providers, payers and consumers work together, improving health becomes a team effort. Informed, engaged, and empowered providers and consumers can share responsibility and decision-making for care, while coming to joint agreements on how the individual wants to improve or maintain positive health behaviors.

Shared responsibility for health results from:

- Shared decision-making. Providers use shared decision-making as a standard of care with patients and their family members, as appropriate, as well as strategies that activate patients to take charge of their health and any chronic condition needing management.
- Health plan members taking a health risk assessment. This is one of the first key steps in becoming involved in one's own health outcomes.
- Benefits that provide incentives for preventive care and healthy behavior, and support the use of evidence based services. This can include low- and no-cost services for evidence-based screenings, well-child visits and other preventive services. Incentives can be used for personal health behaviors and improved health status using evidence-based strategies relating to diet, exercise, smoking and medication use. Services that are not evidence-based would be more expensive, while evidence-based services would cost less.
- Consumer and community engagement and collaboration. Involving consumers and community members in advising health plans and practices through consumer advisory councils, and regular opportunities for feedback from consumers improves opportunities for shared responsibility for health. Additionally, collaboration with other entities such as public health, non-profits, and local government improves opportunities for shared responsibility for the health of the community.

What it means for

The purchaser of health benefits

- ✓ Cost savings achieved through healthier members and use of higher quality, evidence-based services and preventive services.
- ✓ Healthier employees who are more engaged in their health.

Your employees

- ✓ Better health through incentives, awareness and ownership of one's own health.
- ✓ Individual savings and improved health by using preventive care and evidence-based services.

The health plan

- ✓ Healthier, more involved health members.
- ✓ Cost savings achieved through healthier members and providers' use of higher quality, evidence-based services.
- ✓ Better knowledge of members' health through assessments; allow the plan to focus on interventions when and where needed.



Transparency in price and quality

Cost and quality data that is readily available, reliable and clear helps patients understand their health plan and provider choices and it helps purchasers make decisions about choosing health plans. With access to data, patients can share responsibility in their health care decisions. Increased transparency on price and quality can also lead to increased accountability.

Transparency in price and quality means:

- Transparency of prices to allow for comparisons of providers.
- Clear information about the price of specific services. This includes information about the benefit design, such as deductibles, coinsurance, and balance of account-based plans.
- Transparency of provider performance on quality. Information on quality, patient experience, and volume is readily and clearly available to plan participants when the nationally recognized or endorsed measures of hospital and physician performance are used.

What it means for

The purchaser of health benefits

- ✓ Allows you and your employees to make decisions based on price and quality.
- ✓ Provides improved understanding of the costs of health care decisions.

Your employees

- ✓ Better health through incentives, awareness and ownership of one's own health.
- ✓ Individual savings and improved health by using preventive care and evidence-based services.

The health plan

- ✓ Allows for a more transparent view of provider performance. This information allows health plans to provide incentives for quality over quantity.
- ✓ Strategic insight into contracting.



Measure performance

Performance measurement that's consistent across health systems improves opportunities, performance, and accountability, while easing providers' reporting burden. It may also help improve the quality of care in the health system as a whole.

Successful performance measurement comes through:

- An aligned, consistent measure set. Measures are consistent across major public and private payers, including commonly defined measures in each of the following areas: access, quality, patient satisfaction, patient activation, service utilization, and cost.
- Regular analysis of information.
- Provider-level and administrator-level measurement. Performance is measured at the clinician, practice team or practice site, and organizational levels. Also, measure performance across all provider types and providers with meaningful volume for the health plan.

What it means for

The purchaser of health benefits

- ✓ Allows you and your employees to make decisions based on price and quality.

Your employees

- ✓ Informed decision-making when choosing provider and health plan.

The health plan

- ✓ Allows for a more transparent view of provider performance and with this information, allows health plans to provide incentives for quality over quantity.



Pay for outcomes and health

Paying for better quality care and better health outcomes, rather than just more services, is essential to the model. Innovative payment methods such as population and episode-based payments, and offering incentives for quality outcomes instead of volume-based fees support better care and lower costs.

Innovative ways of paying include:

- Pay providers according to performance. Providers who perform better can be paid more.
- Design payment and coverage approaches that cut waste while not diminishing quality. This includes reducing unjustified variation in payments, not paying for avoidable complications and hospital-acquired infections, or lower payments for unnecessary services.
- Support primary care. A robust primary care system is at the heart of the model; primary care payments should support both an effective primary care infrastructure and the provision of high-quality primary and preventive services.
- Increasing the proportion of total payments based on performance over time, or implementing a population-based model where the plan and providers share financial risk.

What it means for

The purchaser of health benefits

- ✓ Healthier employees. All members receive high-quality preventive health care and for those with chronic health conditions, care will be better managed.

Your employees

- ✓ High-quality preventive care.
- ✓ Team-based care helps those with chronic health conditions better manage their condition and keeps them in their best health.

The health plan

- ✓ Cost savings achieved through healthier members, use of higher quality, evidence-based services by providers, and cutting waste.
- ✓ Ability to support different payment structures for higher performing providers.



Sustainable rate of growth

Bending the cost curve is a vital component of the coordinated care model – and one that strengthens all other principles. Preventing a cost shift to employers, individuals, and families, and reducing inappropriate use and costs through a fixed-rate-of-growth approach is the foundation to health care transformation.

Achieving a sustainable rate of growth results from:

- Population-based contracts that include risk-adjusted annual increases in the total cost of care for services reimbursed.
- Provider contracts that include provisions that agree on rates and quality incentive payments for each contract year.

What it means for

The purchaser of health benefits

- ✓ A better understanding of health plan costs, how they'll grow over time, and the ability to budget over long periods of time.

Your employees

- ✓ Costs savings, and more affordable premiums, co-pays and co-insurance.

The health plan

- ✓ A better understanding of costs and how they'll grow over time.