Oregon Health Fund Board

Aim High: Building a Healthy Oregon

DRAFT FOR
PUBLIC REVIEW & COMMENT

September 3, 2008

The Oregon Health Fund Board

September 3, 2008

Governor Kulongoski
Members of the Oregon State Legislature
Fellow Oregonians

We are seven Oregon citizens, supported and advised by hundreds of other Oregonians, a dedicated staff, and the work of many consultants and advisors.

Today, we have published a draft report which proposes that Oregon should aspire to provide "world-class health" to all Oregonians. We invite the public to comment on our draft report, which is a working document and a blueprint for important work to be done by all Oregonians over the next several years.

When we say "world-class health", we mean that Oregonians should have a health system which achieves three objectives (the "triple aim") at once:

- A healthy population, measured by life expectancy, infant mortality, quality of life, universal access to care, and similar metrics accepted throughout the industrial world;
- High quality outcomes for each individual who encounters the health care system, with patient-centered care based on the best available science, but also on the human needs of each individual; and
- Reasonable per capita costs shared in an equitable way by the entire population.

World-class health for all Oregonians is not just an inspirational or idealistic aspiration. It is the most pragmatic course available to us. With this goal, Oregonians can work together to create a healthy population and affordable, quality health care for all.

Oregonians don't have that today. We have good people working in broken systems. Our population health is falling below world standards. We have gross disparities in health and health care among economic and ethnic groups. Individuals have difficulty getting necessary or appropriate care. We have too many uninsured and underinsured people. The price of health care is rising too high and too fast. Soon the price of family health insurance will equal average family wages. This is simply not sustainable.

We can't fix this broken system simply by throwing more money at it. We can't fix things just by subsidizing insurance costs or changing the financial models of health care.

We must "aim high" and aspire to a new vision of health and health care in Oregon. That vision empowers us to imagine and make changes which hold the promise of a major system transformation. If we start by assuming that the task is too hard or too expensive, we will never achieve the quality of life and health that we all desire.

Improving health and health care for Oregonians is not an easy task. But, as President Kennedy said in 1962 when calling on America to send a man to the moon in a decade, we should pursue these goals

> *[N]ot because they are easy, but because they are hard, because that goal will serve to organize and measure the best of our energies and skills, because that challenge is one that we are willing to accept, one we are unwilling to postpone, and one which we intend to win.*[1]

In Oregon, we have smart people who can see what needs to be done. Oregon is a society of innovators and entrepreneurs. We have a culture of creative change and there is wisdom in all of us which is necessary to achieve a common goal. The role of the State is to unleash those creative forces, to inspire change, and to create in Oregon a health care system which ranks among the best in the world. Indeed, a world-class health care system should be part of Oregon's strategy for a sustainable 21st Century economy.

As we pursue these "triple aim" objectives, we need to be clear about what we mean by quality. The Institute of Medicine defines quality as:

> *The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.*[2]

This is a useful but incomplete definition. The costs of health care (and the social costs of unmet health needs) must be linked with quality to achieve value. Value is given and value is received when quality is directly associated with cost.

Our report identifies eight building blocks for action and makes numerous specific recommendations to help us achieve this kind of world-class health in Oregon. We propose that the Legislature create a new Oregon Health Authority to consolidate existing state health initiatives and to provide leadership for a 21st Century health care system in Oregon. We propose an expansion of Medicaid and children's health programs in 2009, but these are starting points, not the finish line.

This work cannot succeed if it is solely a government initiative. Health and health care is the responsibility us all. We depend on each other to build and achieve a healthy society, which includes effective, affordable health care when we are sick or injured.

Coming together to fix a common problem requires that we all be open to change, including change which may impact our individual comfort, income, or stature. To fix health care, we must stop doing things that don't work and start doing things that do work. That means some of us – perhaps many of us – are going to have to change what we do or how we do it. That is a challenge, and for some it may mean hardship. As a society, we need to plan for and soften the costs of transition. But the alternatives – to do nothing or to tinker on the edges – assure that we all fail.

America isn't building buggy whips, steam locomotives, or Oldsmobiles anymore. We know that our health care system is broken. If we don't fix it, Oregon's economy will go out of business, at least as a world competitor. If we do fix it, we will create a population that is healthier not only in our bodies and minds, but in our economic opportunity. We will build a foundation for a vital Oregon prepared for 21st Century competition.

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[1] President John F. Kennedy. Address at Rice University on the Nation's Space Effort, delivered at Rice University, Houston, Texas. September 12, 1962.

[2] http://www.iom.edu/CMS/8089.aspx

The work of transforming Oregon's health care system is serious work. It cannot be done by the Legislature alone, or by a single board or commission. But it can be done. The task is not primarily to change the financing system, but to change the way we think about and organize health care and create healthier communities. *To be clear, your Board sees no sustainable way to finance universal health care except with hand-in-hand changes that transform the health care system as we know it.*

Your Board categorically rejects any idea that Oregonians do not have the will or the stomach – or the money – for change. We have heard otherwise and we have seen with our own eyes that seeds are being planted all around us for essential and transformational changes. We also believe that a sound, well functioning health system will save us money over time, not only by reducing the per capita costs of health care, but by creating a healthier society.

The challenge to all Oregonians is to step up now, in the fall of 2008 and in the 2009 Legislative session. We need to support sensible legislation proposed by this Board which will enable the State to act as a catalyst for change. But, we must also recognize that we all have work to do.

We can do these things. We are Oregonians.

THE OREGON HEALTH FUND BOARD

The only limit to our realization of tomorrow will be our doubts of today.
Franklin Delano Roosevelt

TABLE OF CONTENTS

Executive Summary 6

Introduction 11

The Eight Essential Building Blocks: A Diagram

- **Building Block 1: "Bring Everyone Under the Tent"** 17
- **Building Block 2: Set High Standards – Measure & Report** 24
- **Building Block 3: Stimulate System Innovation & Improvement** 33
- **Building Block 4: Unify Purchasing Power** 54
- **Building Block 5: Train a New Health Care Workforce** 63
- **Building Block 6: Ensure Health Equity for All** 67
- **Building Block 7: Advocate for Federal Changes** 71
- **Building Block 8: Oregon Health Authority** 74

Conclusion (To be developed)

Acknowledgements (To be developed)

Appendices

- **Appendix A: Senate Bill 329, The Healthy Oregon Act (To be included)**
- **Appendix B: Board Members, Committee and Workgroup Members, and Staff (To be developed)**
- **Appendix C: Committee Report Executive Summaries (To be developed)**

EXECUTIVE SUMMARY

The Oregon Health Fund Board
In June 2007, the Oregon Legislature passed the Healthy Oregon Act,[3] which established the Oregon Health Fund Board, a citizen board of seven individuals supported by hundreds of volunteers serving on six committees and two workgroups. The Board's comprehensive action plan, titled **"Aim High: Building a Healthy Oregon,"** lays out a blueprint for reforming Oregon's health care system. The Board is indebted to the scores of community members and healthcare professionals that commented on the work as it progressed. *This September 2008 Working Draft is offered for additional public comment and is subject to change. It is a work in progress*

A Sense of Urgency
The Board can only underscore what most Oregonians and Americans already know. Our health care system is failing. We need to act immediately to make a change. Here are three concerns, any one of which indicates that we must act with a sense of urgency:

- Health care costs too much, and the costs are escalating far beyond the rate of inflation and people's ability to pay. More and more residents are uninsured or underinsured. Within a few years, unless we change, the premium for a family health insurance policy will equal the average family wage. As more people lose insurance, the public sector will inevitably bear more of the costs of health care.
- The quality of individual health and health care is uneven, with many people failing to get the care they need or even getting the wrong care. There are gross disparities in care and outcomes among economic and ethnic groups. Our population is less healthy than many other countries – and falling behind as other countries improve.
- Even if we had affordable, quality health care, we do not have a business model or workforce to meet the needs of a growing and aging population. We must imagine a new, community-based system designed to keep us healthy and provide essential primary care, at low cost and readily accessible, to every child and adult.

Let us be clear: the present health care system is broken and in urgent need of change. It is too big for any individual interest group to fix. Changing it requires collaboration and leadership, with a shared goal. As taxpayers, we all pay the costs of a broken system. We must all come together to reshape this system.

The Board's Goals and Underlying Thinking
After a year of study, our conclusion is that Oregon should aspire to nothing short of *world-class health* for all Oregonians. When we say "world-class health", we mean that Oregonians should have a health system which achieves three objectives at once:

- A healthy population
- Extraordinary patient care for all
- Reasonable per capita costs shared in an equitable way by the entire population.

This is not just an idealistic aim. *It is the pragmatic choice*. It is the Board's unanimous recommendation.

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[3] Senate Bill 329, Chapter 697 OR Laws 2007

Your Board proposes an action plan that will move us towards this goal.

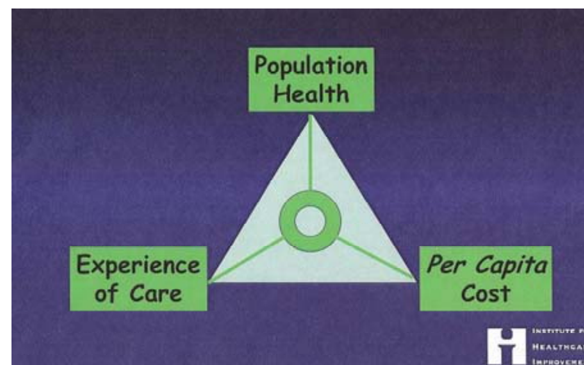
It is clear to your Board that Oregonians cannot simply put more good money into a broken system and expect that it will work. It is also clear to us that Oregon has the creative spirit, the scientific talent, and the leadership to become a world leader in health and health care. Setting this as a goal means that world-class health becomes a driver for our entire economy.

As hard as it is to believe, the problem is not just that we have 600,000 Oregonians without health insurance. We also have a population that is suffering from ill-health, a health care system that is paid to treat illness, not to increase health, and citizens, employers and unions that are suffering under the burden of a costly system. There is no "band aid" for a system that is collapsing.

Your Board, on behalf of all Oregonians, believes that in order to address this complex set of symptoms, we must *transform* our thinking about health care. We have learned, by studying the problems of our system and the innovations that have been tried here in the US and abroad, that a healthy population - and affordable health care is within our reach – *if we reset the system goals, incentives and structure.*

We must "aim high" and aspire to a new vision of world-class health and health care in Oregon. This vision empowers us to imagine and make changes which hold the promise of major system transformation. Please note that we did not say, "Oregon just needs to provide health insurance to more people." We set our goals much higher. We have to provide *health and extraordinary patient care for all* at a *reasonable cost*. If our goal is "health" – not just "health insurance" - reinventing a sustainable system becomes both possible and essential.

These three goals have been called the "Triple Aim", a nice shorthand put forward by the Institute for Healthcare Improvement (IHI), whose founder, Don Berwick MD, has challenged health care leaders throughout the world to rethink our social contract so as to create healthy populations and affordable health care for all. Here is a simple picture of the Triple Aim:



We can achieve these "Triple Aim" objectives in Oregon in a reasonable time – less than a decade – if we collaborate together. It will take creative thinking and shared responsibility from many people to reach our goal. To get there, we must act immediately and boldly to put in place building blocks for change. Our report is about the change necessary to Build A Healthy Oregon.

Key Strategic Recommendations
In this report, your Board proposes a number of specific action strategies to achieve the triple aim objectives and to provide world-class health for all Oregonians.

The overarching strategy is for the State – in partnership with communities – to act as a **smart purchaser**, an **integrator** of health care and community services, and an **instigator** of community-based innovation. By acting as a smart purchaser, the State will become a wise steward of the public's investments in health and health care, creating the pressure and excitement necessary to stimulate the efficiency and innovation that is required in a world-class health care system. As an integrator, the State will take a lead role in seeing that each of the triple aims is achieved in optimal balance to the other two aims.[4] As an instigator, the State will provide resources and collaborative structures to incubate new thinking.

We recommend that the 2009 Legislature create an Oregon Health Authority, with a strong citizen board and experienced non-political leadership, to coordinate the State's existing patchwork system of purchasing and regulating health care, community services, and workforce training. This new Authority will become the organizer and integrator of Oregon health care policy and purchasing and will coordinate the State's investments in health service innovation. One of the Authority's most important tasks will be to build the system for 100% access to health care on the foundation of a transformed health care system.

The Authority will be charged with using seven additional strategic building blocks for change. After a year of study, it is clear to us that business as usual will not suffice. As the Institute for Health Improvement has said, the critical, missing component in our health care system is a set of "integrators," entities that are responsible for all three of the triple aim objectives – not just one. *The Oregon Health Authority will serve as a macro-integrator* for the health system in Oregon. The Authority will focus on quality, costs and the health of the population. The 7 building blocks for change are:

1) Bring "Everyone Under the Tent". The Board believes that there are enough resources in the system right now – without changing the delivery system – to provide health insurance to all the children of Oregon. This can be done by leveraging federal funds with provider-based taxes. The Board also believes that we can and should bring additional adults into the Oregon Health Plan using some form of provider tax and possibly other tax programs to leverage federal matching funds. These taxes should not be passed on to the public in the form of higher health care costs or insurance premiums; they can be internalized by the existing delivery system. The Legislature and stakeholders should agree to fund these programs within existing federal waivers. This action will bring millions of dollars of federal funds to Oregon and reduce the number of uninsured by nearly 200,000 people.
2) Set High Standards—Measure & Report. Ensuring *transparency of costs and health outcomes* throughout the system will create competitive pressure between providers to continuously improve.
3) Stimulate System Innovation & Improvement. Insisting on *new models of care* including prioritizing prevention, management of chronic disease, shared decision making at end-of-

[4] "The root of the problem is that the business models of almost all US healthcare organizations depend on keeping these three aims separate. Society, on the other hand, needs these three aims optimized simultaneously." Tom Nolan, PhD, Institute for Healthcare Improvement.

life, use of evidence-based medicine and a strong emphasis on primary care will improve health outcomes and reduce costs. In addition, creating *learning communities and local collaborations* between stakeholders will encourage innovative initiatives in the health care system and for the population at large.

4) Unify Purchasing Power. The State, by coordinating its purchasing strategies, will stimulate implementation of new models of care, reduction of unnecessary administrative costs and reasonable price setting. Combining tough purchasing power with innovative solutions that deliver high value services will increase the pace of change.

5) Train a New Health Care Workforce. A new system requires a new workplace model for health care delivery. Creating a strategy that encourages existing and newly trained professionals to work at the top of their licenses, and who rethink the work itself, will build a *21st Century health care workforce for Oregon*.

6) Ensure Health Equity for All. Working to address the social determinants of health is the only way to fully and finally address population health. Including the *principle of health equity in every aspect of health care* will ensure that we are getting to the root causes of ill-health.

7) Advocate for Federal Changes. Significant change for Oregon must be accompanied with Federal waivers, additional funding and many other policy changes. Oregon must advocate for *Federal policies that support the health care goals of Oregon*.

The Board expects the new Oregon Health Authority to be a *catalyst* for change. The State and other governments such as cities, counties and schools play a major role in Oregon's health and health care systems already. For example, they:

- Are major purchasers of health care;
- Train and license health care workers;
- Provide many other public services essential for a healthy population;
- Regulate and potentially design insurance products;
- Provide hands-on health care directly and indirectly through state, community and tax-supported clinics and services; and
- Hold community values.

If these activities are coordinated by the new Authority, and if the Authority works in close collaboration with Oregon business and health care providers, we have all of the tools to create world-class health for all Oregonians.

Progression Toward These Goals

We cannot transform a complicated economic and social system in one step. We can, however, make intentional and steady progress from a broken system to a world-class system.

The Board's top level timeline for making progress towards these objectives is:

2009 100% access for all children and adults currently eligible for federal matching funds under existing waivers by funding the Oregon Health Plan and Children's Health Insurance.

Create the infrastructure for a world-class health and health care system including, an Oregon Health Authority, state-wide learning communities, a quality institute and local community collaboratives to help transform the healthcare system so that it provides health, continuously improves care, and reduces costs.

2011 The Authority and other entities are fully operational and implementing the specific building blocks for change recommended in our report, including final development of an essential benefit package

2013 The Authority has in place an insurance exchange, essential benefit package and other strategies designed to achieve 100% access to healthcare for all Oregonians.

Your Board believes that providing 100% access to health and health care for all citizens of Oregon is possible within a decade *if* we build the infrastructure that will promote new ways to deliver health care at higher quality and lower cost. If this new infrastructure shows progress towards *increasing health outcomes and reducing costs* – as we expect - then inviting all Oregonians into the system in a few short years at a very reasonable price is attainable.

Our report outlines a potential strategy to provide access by building on the present insurance model, including employer insurance, and in addition developing a publicly financed insurance option, a "public plan," that would reside within the individual exchange. It is our recommendation that all plans within the individual exchange provide an essential benefit package founded on the principles of prevention first, extraordinary chronic care management, medical homes, dignified end of life care and personal responsibility. [5]

We must in any case continue to invest in community clinics and strong public health initiatives. These public investments create a healthier population and help insure that we provide essential services at the right time and in the right place to as many Oregonians as possible.

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[5] Your Board recognizes that any future alternative financing system must ensure that costs are not shifted from employers to employees, and, in addition, that those most in need of financial assistance are those most likely to receive it.

INTRODUCTION

In June 2007, the Oregon Legislative Assembly passed the Healthy Oregon Act (Senate Bill 329, Chapter 697 Oregon Laws 2007). The Act called for the appointment of the seven-member Oregon Health Fund Board ("Board") to develop a comprehensive plan to ensure access to health care for all Oregonians, contain health care costs, and address issues of quality in health care. The Board's comprehensive action plan, titled "Aim High: Building a Healthy Oregon," reflects the work of scores of volunteer committee members, testimony and input from hundreds of Oregonians, detailed review of health services research and policy initiatives under consideration or adopted by other states, and advice from local and regional policy experts who assisted the Board and its committees.

The Board's Goals for System Reform

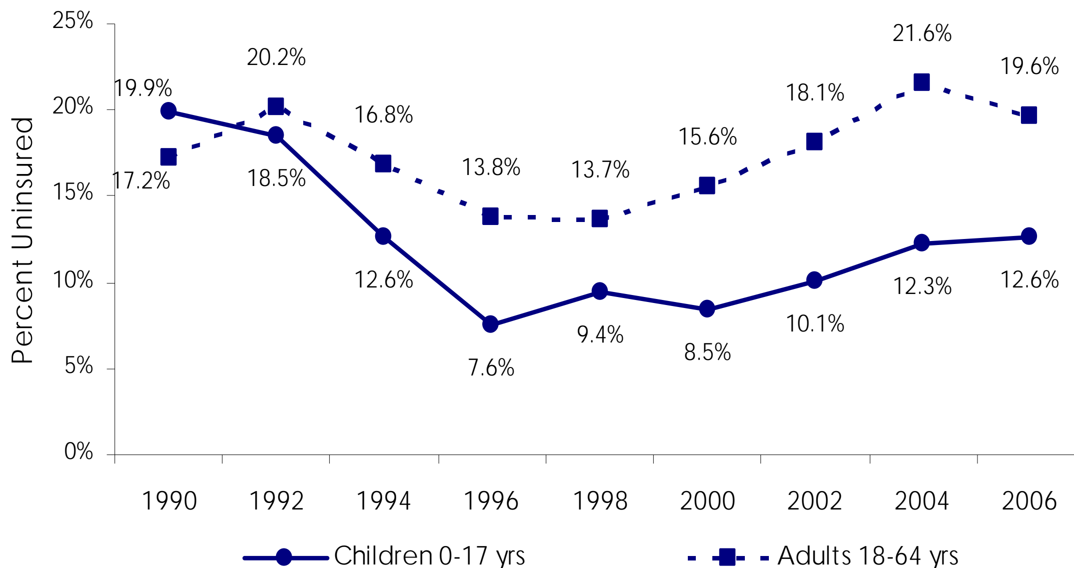
The Board synthesized the twelve goals enumerated in SB 329 into the following four goals:

- Expand coverage to Oregon's uninsured populations;
- Contain the annual increases in health costs in Oregon;
- Continuously improve quality, safety, efficiency and patient satisfaction in Oregon's health care systems; and
- Improve the health of ALL Oregonians.

Symptoms of the Problem

- **Over a half-million Oregonians don't have access to health care.**

Percent Uninsured in Oregon, 1990-2006

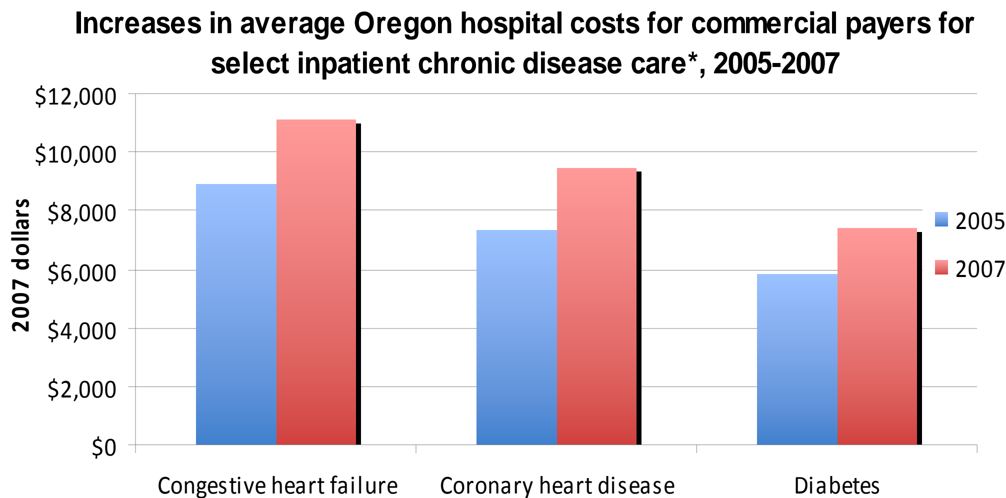


Source: Oregon Population Survey, 1990-2006.

One in six Oregonians are without health insurance coverage—this represents about 576,000 individuals of all ages, and about 116,000 are children under the age of 19.[6] More than 71,000 may be eligible for the Oregon Health Plan (Medicaid) or the State Child Insurance Program (SCHIP), but not enrolled. In addition to the currently uninsured, another 299,000 insured Oregonians have experienced a health insurance coverage gap at some time during the previous 12 months.

- **Health care is increasingly unaffordable for Oregonians and Oregon businesses**

Health care costs are driven by a variety of factors including innovation through medical technology and treatments, waste and inefficiency, health insurance status and medical errors and liability. In Oregon from 2005-2007, the average cost of inpatient hospital care increased by at least 25% for three chronic conditions.



Source: Office for Oregon Health Policy & Research analysis of data from http://www.oregon.gov/OHPPR/RSCH/comparehospitalcosts.shtml *Includes all 3M APR-DRG risk categories. CHF=APR-DRG 194, CHD=APR-DRG 198, Diabetes=APR-DRG 420

All Oregonians pay for system inefficiencies and services as well as services provided to the uninsured through increasing premium costs, which far outpace increases in per capita income: between 2000 and 2006, per capita income in Oregon increased 18.5%[7] while the average cost of a family health insurance premium increased by 74.5%.[8]

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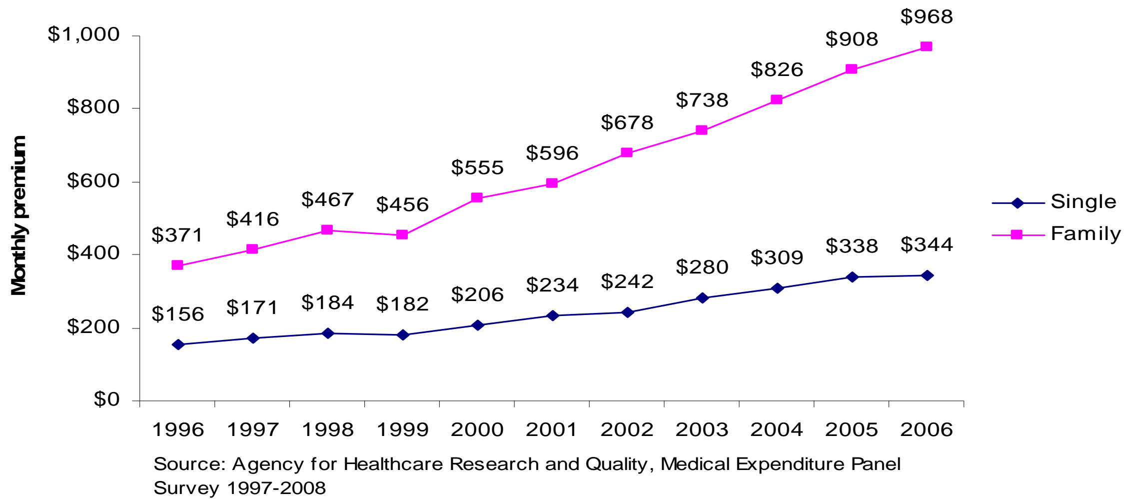
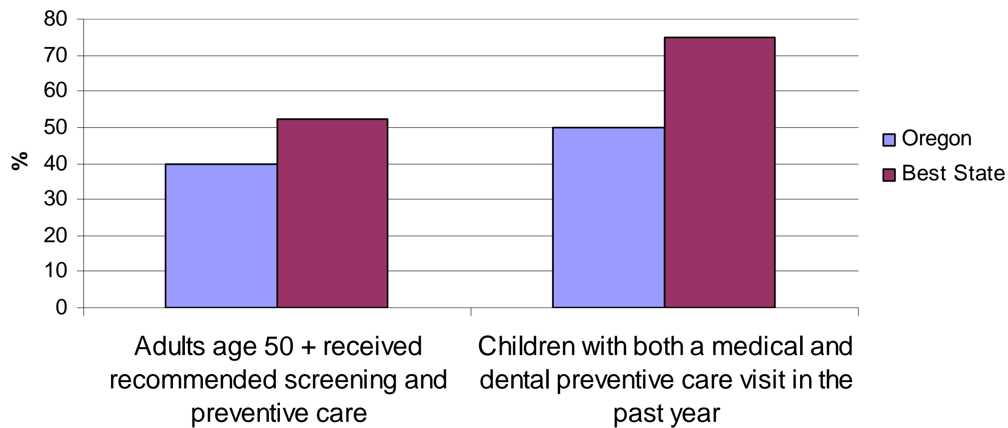
[6] Oregon Population Survey 2006, Analysis performed by the Office for Oregon Health Policy & Research
[7] Regional Economic Information System, Bureau of Economic Analysis, U.S. Department of Commerce, [http://www.bea.gov/regional/spi/SA04fn.cfm]
[8] Medical Expenditure Panel Survey, MEPSnetIC (Oregon), 2000-2006.

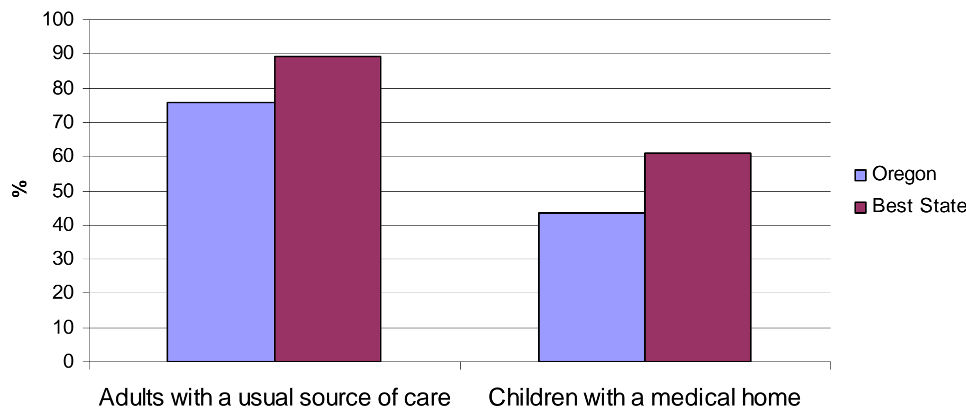


➢ **The health care system is increasing in cost but provides inconsistent quality**

According to the Commonwealth Fund State Scorecard, Oregon ranks 34th nationally in the quality of care the health care system delivers and 42nd for quality of care provided to children.[9]



[9] Commonwealth Fund State Scorecard.



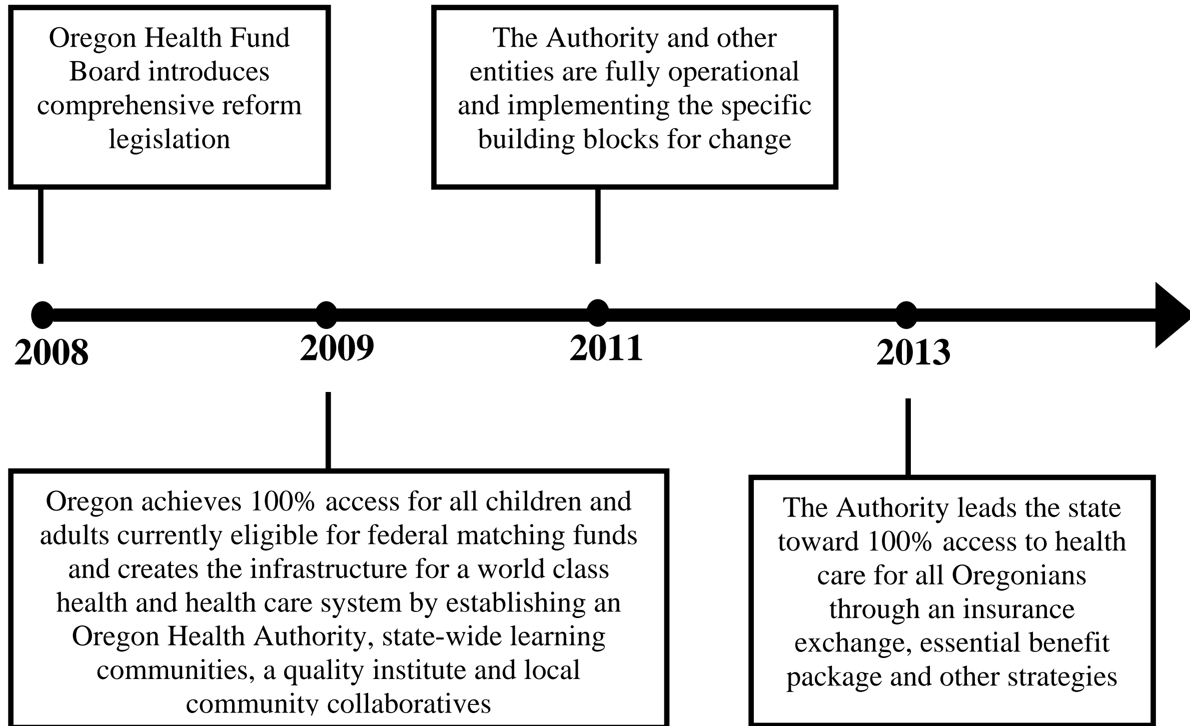
The recommendations of the Board as outlined in this report will extend coverage to an additional 216,000 Oregonians (116,000 children and 100,000 low-income adults) in the 2009-2011 biennium and to 96% of all Oregonians by the 2013-2015 biennium, while working toward 100% access. Just as important, if not more so, are the recommendations for fundamental delivery system changes; addressing health equity, payment reform; measurement, reporting and standard setting; focusing and unifying purchasing power and advocating for the removal of federal barriers to change.

Strong Committee Work Paved the Way for the Board's Action Plan

In addition to creating the Board, the Healthy Oregon Act also established committees to develop recommendations on specific aspects of the reform plan. These committees were comprised of Oregonians representing a wide range of expertise and perspectives and developed reform strategies addressing:

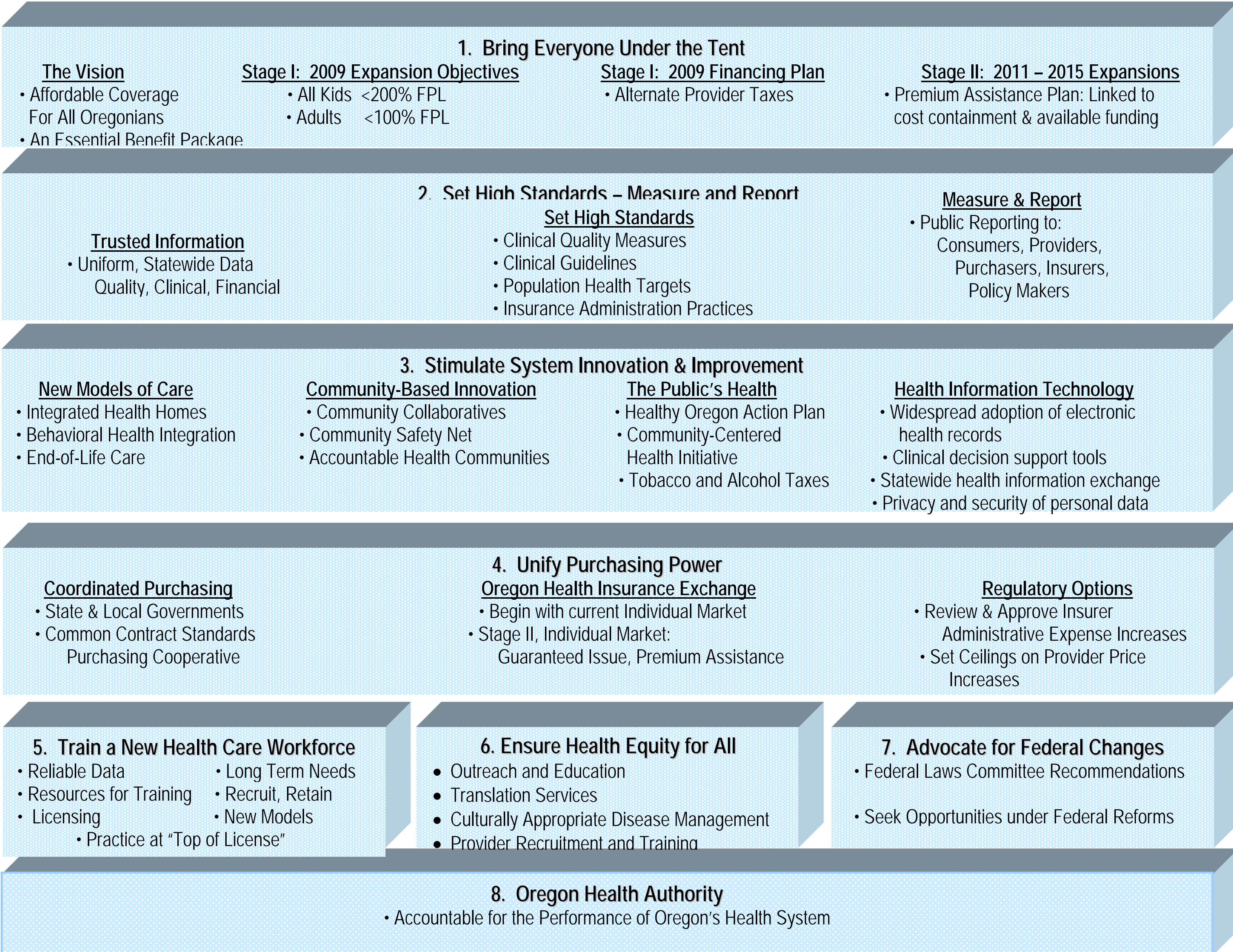
- Health benefit design;
- Delivery system reform;
- Insurance and premium assistance eligibility and program enrollment;
- Implications of federal law to state health reform and suggested changes;
- Strategies for financing the proposed reforms; and
- Strategies for promoting equitable health care for all individuals.

Timeline for Change



Using Board-developed charters, the committees developed recommendations that were submitted to the Board in the spring, of 2008. After reviewing these recommendations, the Board has developed this draft Action Plan for public review and comment. Public responses will be received in September. After considering the public's input and any final revisions, the Action Plan will be completed in October, and sent to the Governor and legislative leadership in November.

BUILDING A HEALTHY OREGON: THE 8 ESSENTIAL BUILDING BLOCKS



BUILDING BLOCK 1: "BRING EVERYONE UNDER THE TENT"

Objective: Every Oregonian has access to affordable, quality health care.

Strategy: Expand access to affordable coverage through new and existing programs.
As described in the Executive Summary, Oregon must simultaneously ensure access to care for all Oregonians and transform the delivery system so that the expanded access is to higher quality, more affordable care. In other words, Oregon strives to achieve the "Triple Aim" goals of improving population health and patients' experience of care while also lowering per capita costs.

These goals will be achieved over the next several years by building on a five-part system of health care financing. Coverage expansion efforts will employ the systems through which many Oregonians currently receive coverage:

- The Oregon Health Plan (OHP) for those in and near poverty;
- Premium assistance through a new Oregon Health Insurance Exchange (OHIE) for Oregonians who do not have access to health insurance from their employers and for those receiving help paying their premiums;
- Employer-based group coverage for employees and their dependents who work for employers that offer group coverage;
- Medicare for Oregonians qualifying due to age or disability;[10] and
- The individual (non-group) health insurance market, through the OHIE.

Federal health reform may impact this strategy. Your Board recognizes that any future alternative financing system must ensure that costs are not shifted from employers to employees, and, in addition, that those most in need of financial assistance are those most likely to receive it.

Based upon econometric modeling done for the Board's Finance Committee, the programs noted above would provide coverage to 96% to 97% of all Oregonians. The modeling also projects that doing so will cost somewhere between $1 billion and $1.6 billion annually in state financing *[See Table 1]*. The Board recognizes that such an expansion of coverage must be inextricably linked to true system reform that will increase efficiencies, improve quality, and drive down costs.

The Board believes that there needs to be a clear "line of sight" between the sources of revenue identified to finance reform and the uses of those funds. Revenue raised by proposed funding mechanisms should flow through the health care system and affect employers, providers, insurers, and consumers. For example, with a payroll tax and a provider tax, funding could be made available to expand insurance coverage. This expanded coverage should lead to reduced uncompensated care. For health care providers, this new revenue would positively offset payments they have made through the provider tax. For insurers, this should result in reduced costs and therefore lower commercial insurance premiums charged to employers and consumers. These reduced premiums would offset payroll taxes.

10 As Medicare eligibility and benefits are determined by the federal government, the Board's plan assumes Medicare is an important coverage component but does not attempt to build a reform plan predicated on reforms to the program.

Table 1
Estimated Annual State Costs & Revenue Requirements for Full Expansion[11]

	Annual Amount (in millions)
Oregon Health Plan	$389 - $422
Insurance Exchange	$628 - $1,184
Total State Cost	**$1,017 to $1,606**
Revenue Payroll Tax	$624 - $661
Revenue, Other Sources	$393 - $945

Other possible funding sources for the health system reforms include a moderate increase in the tobacco tax and an increase in the tax on alcoholic beverages. These funding sources could be logically used for smoking cessation programs and other public health initiatives (tobacco tax), and to help improve access to mental and behavioral health (alcoholic beverages tax). For more on the Finance Committee's work, please see Appendix D.

Strategy: Implement an Essential Benefit Package.
The long-term goal is for every Oregonian to have the Essential Benefit Package of covered health services. Current benefit designs that provide equal coverage for both effective services and those of uncertain or unproven value contribute to the rising cost of health care. Therefore, the Board believes that restructuring the way health insurance works so that services that are proven to be effective are covered more fully and cost sharing is set in a rational fashion will encourage more appropriate utilization. This alternative strategy will shift emphasis to services resulting in greater population health. This is a lesson Oregon can learn from other health care systems around the world that use fewer resources and have better outcomes.

The Board recommends that the Legislature authorize, to the extent allowable by federal law, the implementation of an Essential Benefit Package (EBP), based on the principles outlined by the OHFB Benefits Committee, and require that all health insurance plans offered in the state must meet or exceed. No health plan in the state will be allowed to offer coverage less than the EBP, although levels of cost sharing may differ. The EBP benefit level will not affect those individuals currently receiving OHP Plus benefits. The OHP Plus benefits should be offered to all pregnant women and children under 200% FPL and adults up to 100% who would qualify under the current OHP rules. The EBP, with affordable cost sharing included, will apply to future expansion populations with moderate incomes.

The EBP will include a defined set of health care services that is affordable and financially sustainable, building off of the priorities outlined in the Prioritized List of Health Services, which was developed and is maintained by the Health Services Commission (HSC). Furthermore, the HSC will be provided with the additional resources necessary to ensure that the Prioritized List reflects the most current evidence-based research available.

The EBP will include the following considerations:

[11] Analyses conducted by the Institute for Health Policy Solutions and Dr. Jonathan Gruber of Massachusetts Institute of Technology for the Oregon Health Fund Board Finance Committee. The range of costs is based on the model components. For details of the modeling, please see the Finance Committee report Executive Summary in Appendix C.

- Require little or no individual contribution for those living below the federal poverty level, with the contribution increasing on a sliding scale basis as a family's financial means rises.
- Do not discourage the private market from offering plans that are more comprehensive than the EBP, in order to provide greater consumer choice for those who can afford higher premiums.
- Promote the provision of services in an integrated health home in an effort to reduce unnecessary hospitalizations and emergency department visits.
- Require little or no cost sharing for evidence-based preventive care and other value-based services, such as those shown to keep individuals with chronic illnesses from experiencing preventable acute exacerbations of their disease.
- Reward patients for actively participating in their own care.
- Assign higher cost sharing on elective or discretionary services.

The Board believes that purchasers, insurers, and consumers will benefit from these principles through a healthier population at reduced cost.

Strategy: Expand access now, beginning with children and low-income Oregonians. Increasing access to health insurance is good for the health of Oregonians and for Oregon's economy. In 2005, the Institute of Medicine estimated that nationwide, the cost to the economy of having 40 million uninsured people is $65 to $130 billion a year.[12] If that amount is applied to Oregon's approximately 600,000 uninsured and adjusted to 2008 dollars, between $1.25 and $2.5 billion is lost annually as a result of leaving these Oregonians without health care coverage.[13]

Investing in public coverage is an important first step toward achieving the state's goal of 100% access. Enrolling children and low income adults in health insurance will reduce the state's uninsured population by at least one third, and will restore coverage lost due to previous state budget cuts.

Children: Governor Kulongoski has long been an advocate for covering all uninsured children, and the Board embraces his vision for giving all uninsured Oregon children under age 19 an opportunity to enroll in comprehensive, affordable health insurance coverage.

In 2009-11, the state will expand coverage to all Oregon children:

- Many children will receive coverage through the existing programs, the Oregon Health Plan (OHP) and the Family Health Insurance Assistance Program (FHIAP).
  - Children with family income up to 185% FPL (approximately 60,000 children) are currently eligible for OHP and FHIAP. The Governor's plan includes increased outreach efforts to enroll and retain these children in coverage.
  - Eligibility for OHP and FHIAP will be expanded to allow children with family income from 185% to 200% FPL (approximately 12,000 additional children) to enroll at no cost to their families.

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[12] Institute of Medicine, "Hidden Costs, Value Lost," (Washington: National Academy Press, 2003), p. 112.

[13] 2000 dollars adjusted to 2008 dollars using the United States Department of Labor, Bureau of Labor Statistics Inflation Calculator found at: http://www.bls.gov/data/inflation_calculator.htm

- Children with family income between 200% and 300% FPL with access to coverage through an employer will have access to FHIAP as well, and will have help paying premiums on a sliding-scale basis.

- A new program will allow families who do not have access to coverage at work to get their children covered.
  - Families with incomes from 200% to 300% FPL will have access to premium assistance on a sliding-scale basis.
  - Families with income above 300% FPL who do not have access to employer-sponsored insurance for their children will have access to this affordable product for their children. These families will be responsible for the full premium cost.

To help finance this program expansion, Oregon will seek federal waiver approval in order to receive federal financial participation for children between 185-300% FPL. The state will not seek federal match for those families with income over 300% FPL. Through these actions, Oregon will ensure that high-quality, affordable coverage is available to all children in the state.

Low-income adults: In addition, the state will open Oregon's Medicaid program, the Oregon Health Plan (OHP), to all adult Oregonians with incomes at or below 100% of the Federal Poverty Level (FPL). As a second stage, ensure access to premium assistance for all low-income adults below 185% of poverty, which is allowed under the state's current federal waivers.

As of June 2008, the OHP Standard program covered 24,000 adults with incomes below 100% FPL. To improve coverage for low-income adults, the state will re-open the program to all adults up to 100% FPL. This will allow entry to approximately 100,000 new enrollees. Additionally, the OHP Standard benefit package is considered to be inadequate for those living below poverty, and the more robust OHP Plus level of benefits should be restored for this population.

Strategy: Reduce barriers to enrollment and re-enrollment for children.
More than half of the 116,000 uninsured children in Oregon are eligible for, but not enrolled in OHP or FHIAP. To expand enrollment, Oregon will simplify the application process, improve outreach with application assistance, increase the number of school-based health centers, create a 24-hour nurse advice line, establish a disease-management program, and extend eligibility for coverage from six to twelve months.

Strategy: Finance coverage expansions in 2009 with provider taxes.
The cost of expanding health insurance coverage to all Oregonians is not insignificant. See Table 1 for estimates of the cost of expanding coverage for Oregonians in 2009-11 and 2011-13. The current funding for OHP Standard, which is a mix of hospital and health plan provider taxes, is due to end in 2009. The coverage expansions outlined above will be financed through restructured taxes on these health care providers. Well-structured and efficiently-administered provider taxes will be used to leverage additional federal financial participation to expand coverage to over 175,000 uninsured Oregonians, and bringing over a billion dollars in new federal funds into the state. These dollars can fuel new jobs and help communities across the state while offering needed coverage to those currently uninsured.

Table 1: Estimated State and Federal Funds Needed to Support Coverage Expansions (2009 – 2013)
(millions)

	State Funds[1] '09 – '11	Federal Funds	State Funds[1] '11 – '13	Federal Funds
Coverage for Kids	$ 62	$ 120	$ 79	$ 150
OHP Standard	$ 354	$ 604	$ 671	$ 1,008
Coverage Subtotal	*$ 416*	*$ 724*	*$ 750*	*$ 1,158*
Improved Benefits	$ 50	$ 75	$ 77	$ 116
Increased Provider Rates	up to $ 100	$ 250	up to $ 100	$ 250
System Transformation (including public health)	up to $ 50	$ 0	up to $ 50	$ 0
Total	**$ 616**	**$ 1,049**	**$ 977**	**$ 1,524**

[1] New provider taxes and tobacco taxes
Source: Oregon Department of Human Services, Division of Medical Assistance Programs, July 2008.

The cost estimates for the 2009 OHP expansions include two items that the Board strongly endorses: 1) Improving the current OHP Standard benefit to levels similar to the OHP Plus benefit package; and 2) Improving the reimbursement rates to providers who serve OHP members. The latter action is absolutely necessary to ensure the broad and active participation of providers in the Oregon Health Plan.

To ensure that the taxes are equitable and sustainable, the Board believes the specific mix of taxes and tax rates must be determined collaboratively by the Governor, Legislature, and interested stakeholders.

While this draft plan endorses the use of provider taxes, the Board has expressed to the Governor its concern with the potential "pass-through" of these taxes on to those who pay health insurance premiums. A hospital provider tax, when combined with significant federal matching funds, will decrease hospital uncompensated care costs that are already being paid for by the purchasers of health insurance. An insurance premium tax, however, is less transparent and could be shifted directly on to purchasers in the form of higher monthly premiums. The Board cannot support any tax strategy that increases the cost of health insurance to purchasers already over-burdened by escalating health insurance costs.

To guard against this risk, rigorous oversight of the financial performance of provider organizations paying a tax will be necessary, and even new regulatory controls.

Public comment on this issue during September will inform the Board's deliberations and recommendations included in the final report.

Strategy: Tie additional coverage expansions (2011-2015) to cost containment successes and available funding.

The first stage of state-sponsored coverage expansions targets all children and adults with income below 100% FPL. The Board recognizes that individuals above 100% often have difficulty affording health insurance. To ensure that coverage is affordable for all purchasers, whether or not they access state assistance, cost containment strategies must be implemented system-wide. Future expansions will be linked to cost containment success. While expanding

OHP enrollment to children and low income adults, Oregon will simultaneously plan for a future market that includes:

- A requirement that all Oregonians obtain health insurance coverage;
- Reform of the individual (non-group) insurance market rules;
- State contributions for low and moderate income families;
- A “pay or play” payroll tax; and
- An insurance exchange for those receiving state contributions which may include the option of a publicly-owned health plan.

ACTION STEPS:

1. Expand coverage for children and low-income adults.
Starting in 2009, the Oregon Health Plan (OHP) and the Family Health Insurance Assistance Program (FHIAP) expand free coverage to all children up to 200% FPL. Children with family income between 200% and 300% FPL receive subsidized coverage through FHIAP .OHP expands coverage to adults up to 100% FPL.

The 2009 Legislature authorizes the Authority to direct appropriate state agencies to create an affordable, high-quality insurance product for these families to purchase. For those families between 200% and 300% FPL this will be with premium assistance based on income. For children with family income above 300% FPL it will be a full buy-in, without state contribution to premiums.

The Department of Human Services (DHS) currently has federal approval to enroll children up to 185% of FPL and adults to 100% FPL. To expand OHP beyond these levels, the state must seek federal approval to amend its Medicaid waiver authority. To allow the enrollment of children up to 300% of FPL in OHP and FHIAP, the 2009 Legislature will need to authorize DHS to apply for federal waiver authority.

Both the OHP Plus and Standard populations will receive the same benefit package, thereby raising benefit levels for OHP Standard enrollees to match those currently provided to OHP Plus members and eliminating the current two-tiered benefit structure within OHP. Additionally, the Legislature directs the Authority to oversee the development of cost-sharing protections and requirements for program enrollees.

2. Reduce enrollment barriers.
Starting in 2009, the Authority works with OHP, FHIAP and other partners to ensure enrollment by all eligible children. This effort includes eliminating barriers to enrollment by simplifying the OHP application process, providing outreach with application assistance, increasing the number of school-based health centers, ensuring access to 24-hour nurse advice; maximize care management programs, and extending eligibility for coverage from six months to a year.

3. Conduct targeted and aggressive outreach to multicultural communities.
The Legislature appropriates state funds, with additional Medicaid matching funds, to support: community-based organizations in delivering culturally-specific and targeted outreach and direct application assistance to members of racial, ethnic, and language minority communities; individuals living in geographic isolation; and populations that encounter additional barriers such as individuals with cognitive, mental health or sensory disorders, physical disabilities, chemical dependency, and individuals experiencing homelessness. Resources and interventions are

targeted to meet the goal of 100% enrollment of individuals who are eligible to participate in Oregon public health insurance programs.

4. Authorize and implement financing for coverage expansions.
The Governor, Legislature, and relevant state agencies and stakeholders work together to develop provider taxes that will support the proposed coverage expansions described above. The 2009 Legislature authorizes the financing necessary to implement the child and adult population expansions, and gives DHS or another entity the authority to utilize these funds for this program.

5. Secure Legislative direction to develop changes to the Oregon insurance market.
The Legislature authorizes funding and staffing for the Authority to plan changes to the Oregon insurance market. Those changes include but are not limited to: an individual insurance requirement; an essential benefit package requirement; individual market reforms; state premium assistance for low and moderate income Oregonians; a "pay or play" payroll tax; an insurance exchange to administer premium assistance and move system reforms; and the creation of a publicly-owned health plan that would be an option within the insurance exchange.

6. Prepare for additional coverage expansions.
In 2009 and 2010, the Authority creates a detailed plan and implementation strategy for additional coverage expansions in 2011-15.

➢ Trusted Information

Objective: Collect and disseminate uniform and complete information on which to make policy decisions and set standards for system improvement.

Strategy: Establish an all-payer, all-claims data collection program.
In order to implement large-scale, innovative reform of Oregon's health care delivery system, the state will establish a new information system to protect the state's investment and ensure, as much as possible, a high-performing, high-quality and cost efficient health care delivery system for all Oregonians.

The current health care delivery system in Oregon does not consistently deliver high-quality care or always deliver recommended evidence-based care to Oregonians. For instance, only 40% of adults over age 50 receive recommended preventive care, and only 84% of hospitalized patients receive recommended care for myocardial infarction, congestive heart failure, and pneumonia.[14] In addition, quality of care, utilization of specific procedures, and treatment options vary significantly depending on where in the state a patient receives care.[15] A comprehensive claims database will enable utilization benchmarking and measurement of change. A quality claims database will allow for the creation of a robust set of evidence-based measures as well as new benchmarking systems, such as episodes-of-care grouping benchmarks and hospital efficiency benchmarks.

A statewide, all-payer, all-claims reporting program is a necessary first step in creating a comprehensive collection of uniform information about the entire patient experience. Through this collection, analysis, and public reporting, providers can benchmark their performance, identify opportunities for quality improvement, and design effective quality improvement initiatives. With this information, purchasers can identify and reward high-performing providers who delivery high-quality, high-value care to their patients, and consumers can access information to help guide critical health care decisions. Policy makers can make improved strategic decisions for the priorities of Oregon, both by providing funding and also through the development of public-private partnerships at the local level for development of community specific initiatives.

The utility of claims information is that it can be used to assess utilization of services (answering questions such as: is there significant variation of utilization of specific services in specific areas and if so why?), examine conditions or procedures (How many people in Medford have asthma and how many are being hospitalized with asthma compared to other areas of the state?), compare payments for specific services (What is the cost and quality variation of diabetes care in the Portland metropolitan area versus the Bend-Redmond area?). Through the creation of an Oregon all-payer, all-claims reporting program, Oregonians will have access to comprehensive, uniform information, which will help shape successful strategies for providing consistent, high-

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14 Cantor JC, Schoen C, Belloff D, How SKH, and McCarthy D. Aiming Higher: Results from a State Scorecard on Health System Performance. The Commonwealth Fund Commission on a High Performance Health System, June 2007.

15Performance Report for Chronically Ill Beneficiaries in Traditional Medicare: Hospitals – Oregon. Provided by Elliot Fischer and the Dartmouth Atlas Project.

quality health care to all Oregonians, and will allow the program to monitor progress toward that goal.

Strategy: Expand data collection efforts to include data on race, ethnicity, and primary language.

Efforts to identify and redress health disparities in Oregon are limited by lack of information. Many health care providers do not collect race and ethnicity data and those that do often use differing methodologies, making it impossible to do a state-wide assessment of the accessibility and quality of health care for Oregonians by race, ethnicity, or primary language. Without this critical information, it is difficult to develop strategies that align resources with need or to evaluate the successfulness of interventions.

To identify and address disparities in health care access, utilization, disease status and quality of care, Oregon will require that race, ethnicity, and primary language data is collected at the same time other billing data is collected. Data definitions and data collection will be standardized so that sources can easily be combined and compared.

Strategy: Ensure comprehensive reporting by insurers and health facility.

Two agencies are primarily responsible for monitoring the financial performance of insurers and hospitals and ambulatory surgical centers (ASCs): the Oregon Insurance Division and The Office for Oregon Health Policy & Research (OHPR), respectively. Currently each agency has broad statutory authority to require financial and related information from subject entities. It may be necessary to provide additional resources in the form of additional personnel or consulting expertise to assure that the reports generated by the Insurance Division and OHPR are produced in a timely manner using industry performance standards.

Two additional reports from health insurers would improve the public's understanding of market conditions:

- Health insurers and other third-party administrators (TPAs) would report to the Insurance Division on a regular basis the contract rates paid to health care providers. The data will be aggregated across providers to protect individual plan proprietary data from public disclosure while still allowing for public reporting to better understand local market conditions. Reports will document the range of annual increases in prices insurers pay to facilities and professional providers (by specialty) in a given market area.

Such reports will improve the "line of sight" or understanding between provider price increases in a local market and the resulting change in health insurance premiums that occur several months later. The State of Minnesota recently enacted legislation requiring such reporting.[16]

- The "health" of Oregon's commercially-insured health insurance market is of significant concern to Oregonians. Currently there is no information available to understand what is happening in local markets: Is the number of insured residents growing or falling?

To rectify this problem, all health insurers and TPAs will report to the Insurance Division their respective memberships by defined lines of business (individual, small group, large group) by zip code. The insurer-specific data would be protected from public disclosure, but will be aggregated across all insurers and TPAs by lines of business and local markets. The reports will inform interested stakeholders of local market conditions ("the canary in the mine"), and can be

16 Senate File No. 3780, 2007-2008 Legislative Session.

evaluated in terms of changes in provider prices, insurer premiums, and local economic conditions.

During the course of the work of the Board and its committees, concern has been expressed about the significant capital investments by hospitals and ASCs either underway or planned for the future. The Board believes it is in the public interest to require more community involvement in major capital projects.

- The Authority should develop standards for reporting by hospitals and ASCs that plan to invest more than $x million in a capital project (threshold amount to be determined). The standards would require the facility to hold public meetings in the facility's service area to describe the project, its impact on access, clinical quality, and the cost to non-government payers in the future. While the input received by the facility's governing body is non-binding, it will help the facilities' leadership better understand the perspectives of the individuals and businesses in the community that pay for such projects through their health insurance premiums.

ACTION STEPS:

1. Establish an all payer, all claims data collection program.
In 2009, the Legislature appropriates the necessary financial resources and directs the Office for Oregon Health Policy and Research (OHPR) to establish an all-payer, all-claims data collection program. This data collection program is given the necessary authority to collect uniform administrative claims data from carriers, implement carrier and facility performance reporting, and develop and publicly disseminate evidence-based treatment and effectiveness information.

In partnership with carriers and providers, in 2009 the Authority develops data protocols and requirements to begin the rules process. The Authority begins disseminating information to affected carriers and providers in the same year. From 2009-2010, the Authority implements reporting requirements and, in 2010, begins data collection and analysis.

2. Require the collection of data on race, ethnicity, and primary language.
By state regulation, all health care providers and health plans will include data on patient race, ethnicity, and primary language as part of the administrative dataset created for the all-payer, all-claims dataset.

3. Authorize collection of additional reporting by insurers and TPAs.
The Legislature authorizes the Insurance Division to: a) require health insurers and TPAs to report the contract rates paid to providers and report on the percentage increases in such rates in local markets by facility and other provider groupings; and b) require health insurers and TPAs to report their membership by defined s of business and zip code and report on changes in the number of insured residents by local markets.

4. Authorize reporting of proposed capital expenditures.
The Legislature authorizes the Authority to develop standards to be followed by hospitals and ASCs in reporting to local communities planned capital investments over a specified threshold amount.

➢ Set High Standards

<u>Objective:</u> Improve consumers' and others' ability to compare coverage based on cost and quality; reduce unexplained variation in care.

<u>Strategy:</u> Develop a common set of measures, standards, and targets for Oregon to improve quality in the health care system.

The availability of comparative effectiveness reviews and the clinical guidelines that result from them have been shown to improve patient care. The IOM report, "Crossing the Quality Chasm," stresses that patients are entitled to care based on the "best scientific knowledge." However, evidence is often far-reaching and complicated and individual clinicians cannot reasonably be expected to consider it all.

By developing a variety of measures, standards, guides, and targets, the various parties engaged in the health care system will have the tools to gauge their performance and progress. Evidence-based measures such as clinical quality measures, clinical guidelines and standards, health and outcomes targets, per capita/CPI cost increase targets, and standards for insurance administrative practices are important tools for identifying unnecessary care and modifying provider practice patterns.

<u>Strategy:</u> Increase the use of evidence-based practice in the Oregon healthcare system by supporting and implementing a public-private collaborative effort to:

1. **Implement common clinical coverage guidelines and standards**
2. **Promote and expand comparative effectiveness research**

There is wide variation in medical care for certain conditions between communities in Oregon. For example, some communities have much higher rates of surgery for back problems than other areas. These areas of unexplained clinical variation are high priority areas for the creation of evidence-based guidelines. Other high priority areas for guideline creation are those areas of medicine with high overall expenditures in the state. For example, care for patients with diabetes and congestive heart failure is expensive due to the number of patients involved, the complexity of disease, and the cost of complications stemming from these diseases. Many of these conditions already have high quality evidence-based guidelines available at a national level. By creating or adopting guidelines, and encouraging their use in the treatment of these highly variable and expensive conditions, the state will improve health outcomes while reducing the overall cost of care.

Oregon has been a leader in evidence-based clinical reviews in pharmaceuticals and other medical technology since the early days of the Oregon Health Plan. Oregon's Health Resources Commission's work has become the template for a multi-state consortium that shares expense and conducts exhaustive reviews of the medical literature to determine the best evidence about effectiveness of prescription drugs before they purchase for their Medicaid programs. It has also done similar reviews of new medical technology, looking at the comparative effectiveness of new devices or procedures. The Health Services Commission has been a pioneer in its ongoing development of the Oregon Health Plan's Prioritized List of Health Services, using the best evidence to determine which health care services should be covered. However, both efforts have largely been confined to Medicaid. Oregon's health care providers are often bombarded by

multiple recommendations from a variety of sources, not always unbiased or supported by clear evidence, and often differing across health insurance plans.

The work of Minnesota's Institute for Clinical System Improvement (ICSI) demonstrates how public-private collaboration can lead to increased use of evidence-based medicine and thus improved quality of care. ICSI is an independent, non-profit organization that facilitates collaboration on health care quality improvement by medical groups, hospitals and health plans that provide health care services to people in Minnesota. The group produces evidence-based best practice guidelines, protocols, and order sets which are recognized as the standard of care in Minnesota. In addition, the group facilitates "action group" collaboratives that bring together medical groups and hospitals to share strategies and best practices to accelerate their quality improvement work. While Oregon has public forums dedicated to producing evidence-based guidelines for the state, an expanded role for these groups could lead to more widespread use of standardized evidence-based guidelines. Oregon can model its collaborative efforts on ICSI's successes and draw on Minnesota for lessons and best practices.

Strategy: Establish an Oregon Quality Institute.

In order to maximize its impact on quality of care across Oregon, the Health Authority could greatly benefit from a coordinated effort to establish and implement a statewide quality improvement strategy. There are numerous public and private efforts underway across the state to improve health care quality, but these efforts are uncoordinated and often even duplicative. The Authority could lead Oregon toward a higher performing health care delivery system by initiating, championing, and aligning efforts to improve the quality and transparency of health care delivered to Oregonians. While a significant piece of this work would focus on the collection and public reporting of health care quality information, other roles for the Authority would focus on helping providers, purchasers, consumers, state government, and other stakeholders effectively use this data to improve quality across the health care system.

The Authority should be responsible for setting the quality agenda for Oregon and setting ambitious goals for increased transparency and quality improvement; however, there are a number of alternative ways in which the Authority could carry out the technical work that would be required to move toward these goals. In one possible arrangement, the Authority could establish a semi-independent Oregon Quality Institute, with its own board and technical committees comprised of a wide range of public and private stakeholders. The Quality Institute's budget and overall agenda would be set by the Authority, but the board and its committees would have the ability to develop specific initiatives to carry out the overall goals of quality improvement. Specifically, roles of the Quality Institute would include: convening public and private stakeholders to align all groups around common quality metrics for a range of health care services; ensuring the collection and timely dissemination of meaningful and accurate data about providers, health plans, and patient experience to a wide range of audiences in appropriate formats; ensuring providers have the ability to produce and access comparable and actionable information about quality, utilization of health care resources, and patient outcomes that allows for comparison of performance and creation of data-driven provider and delivery system quality improvement initiatives. In all of its work, the Quality Institute will partner and collaborate with other stakeholders to maximize output and minimize duplication of efforts.

In an alternative arrangement, the Health Authority could decide to contract with existing entities and organizations to carry out this work, without creating a new Oregon Quality Institute. In

either case, significant dedicated public funds would be required to sustain Oregon's progress toward quality improvement goals.

ACTION STEPS:

1. Empower the Authority to set standards.
The Legislature empowers the Authority to develop clinical quality measures, health and outcomes targets, clinical guidelines and standards, per capita/CPI cost increase targets, and standards for insurance administrative practices. The Authority or the Department of Consumer and Business Services requires participation by carriers as part of the DCBS oversight of insurers. The Legislature authorizes DCBS to require that self-insured plans and reinsurers participate as a requirement of the business license or other licensure process.

2. Create a Clinical Improvement Assessment Project
The Legislature creates a Clinical Improvement Assessment Project that builds on existing state structures to bring Oregon's health care providers together to improve the quality and value of health care they provide. It can also bring together public and private sector providers, similar to efforts in Minnesota, to agree to common set of clinical guidelines to promote evidence-based practice. It will operate under the oversight of the Authority.
Systematic reviews are the building blocks underlying evidence-based practice; they focus attention on the strengths and limits of evidence from research studies about the effectiveness and safety of a clinical intervention. Under a Clinical Improvement Assessment Project, public purchasers of health care conduct and support research on the comparative outcomes, clinical effectiveness, and appropriateness of pharmaceuticals, devices, and health care services to meet the needs of Medicaid, the State Children's Health Insurance Program (SCHIP), the Public Employees Benefit Board (PEBB), the Oregon Educator's Benefit Board (OEBB), Corrections Health, and University Health as well as the recipients of any publicly purchased health care.

A Clinical Improvement Assessment Project will offer better access to comparative effectiveness reviews for state purchasers of health care as well as private health plans, providers, private purchasers, and the health care system as a whole. It assists providers to have a clear and common set of clinical guidelines across all health insurance plans to better provide consistent evidence-based care as much as it is available.

Under the Clinical Improvement Assessment Project:

- The Health Services Commission (HSC) will develop standard sets of evidence-based guidelines by reviewing and endorsing existing high-quality guidelines whenever possible and convening expert panels to create them when they don't exist. All providers in the state will have access to these guidelines, and the HSC will focus first on those chronic conditions with the highest cost, variation in treatment utilization, and/or variation in quality of care. As developed, policies can require that providers serving patients in publicly funded programs follow these guidelines. The HSC will work with private purchasers and health plans in the development of the guidelines, and common policies can be created to encourage their utilization across both the public and private sectors. The HSC will also be responsible for keeping the Essential Benefit Package up-to-date according to the approved guidelines, comparative effectiveness research conducted by the Health Resources Commission or other trusted sources, and public input.

- The Health Resources Commission will partner with existing state, national, and international entities that are already investing in comparative effectiveness research. The Project will support the use of high quality comparative effectiveness research to make public and transparent policy decisions. By using such research, common policies can be developed across publicly-funded health programs regarding the coverage of new and existing treatments, procedures, and services. By partnering with private health plans, uniform criteria and evidence can be made available to all of Oregon's health care providers for patient care in both the public and private sectors.
- The work of the Health Services Commission and the Health Resources Commission would be closely aligned to each other and in coordination with the overall health objectives determined by the Authority.

3. Adopt recommended guidelines.
Expert panels, using the best available evidence, identify or develop evidence-based guidelines for conditions with high variability or expense. The state then encourages the adoption of these guidelines. Strategies for adoption could include mandating guideline use by state sponsored insurance programs, voluntary adoption by private insurers, or publishing the guidelines as best practices throughout the state.

4. The Authority establishes ambitious goals for increased transparency and quality improvement for Oregon.

5. The Legislature makes a substantial, long-term investment in Quality Improvement.
The Legislature appropriates necessary and sustainable financing to support quality improvement initiatives across Oregon. The Authority uses this investment to establish and fund an Oregon Quality Institute or to contract with existing entities and organizations to carry out coordinated quality improvement initiatives. The Authority oversees the establishment and maintenance of a health care quality data collection and reporting system and as possible initiatives to engage consumers, providers, purchasers, state government, and other stakeholders in utilizing this data to improve health care quality.

Objective: Decrease administrative spending by simplifying and standardizing administrative processes.

Strategy: Develop standard formats and processes for eligibility, claims, payment and remittance transactions.
Administrative expenses account for a significant percentage of total health care spending. There are significant opportunities to increase administrative efficiency across the health care system. Reform efforts in Minnesota have projected significant savings through a standardization of administrative transactions between providers and payers. In 2007, Minnesota passed an update to the state's Healthcare Administrative Simplification Act, which requires all health care payers and providers to electronically exchange information for eligibility verification, claims, and payment and remittance advice transactions using standard content and format established by the Department of Health. Projected savings for 2008-2012 are $215 million.[17] Based on Minnesota's methodology, Oregon can reasonably expect to save over $400 million over ten years if similar standards were adopted.

17 J. Golden. February 7, 2008. Health Information Technologies and Health Care Transformation. Presentation at the State Coverage Initiatives Winter Meeting. Nashville, TN.

A number of stakeholder groups, including the Oregon Association of Hospitals and Health Systems, the Oregon Medical Association, and various insurance carriers, have joined together to develop a set of voluntary standards for administrative transactions. While the state should not spend limited resources on duplicative efforts, it is important for the state, as a large purchaser and payer, to be an active player in efforts to standardize administrative processes. In addition, in order to maximize administrative efficiency, all providers and payers must adopt the same standards. Thus, while voluntary standards might be an important first step in reducing administrative costs, it may be necessary for the state to establish requirements for all providers and payers in the state in order to reach full adoption of common standards.

ACTION STEPS:

1. **Develop standard formats and processes for eligibility verification, claims, and payment and remittance advice transactions.**
   The Department of Consumer and Business Services (DCBS) collaborates with public and private stakeholders to develop standard formats and processes for the electronic exchange of eligibility verification, claims, and payment and remittance advice transactions. By December 31, 2009 DCBS endorses a single standard for format and content of administrative transactions for all payers and providers in the state.

2. **Ensure all providers and payers adopt state standards for electronic administrative transactions.**
   DCBS sets benchmarks for levels of provider and payer adoption of administrative transaction standards, leading to complete adoption by July 31, 2011. DCBS monitors levels of voluntary adoption and assesses need for legislation or administrative rule to require all providers and payers to adopt standards.

➢ Measure & Report

<u>Objective:</u> Make comparable information about provider performance and costs widely available.

<u>Strategy:</u> Institute public reporting that gives the Legislature, consumers, providers, purchasers and carriers information across payers and providers.
One of the major problems with the current health care system is that comparable information about provider performance and costs is not widely available. Providers need better information to benchmark their performance, identify opportunities for quality improvement and design effective quality improvement initiatives that allow for better health outcomes at a lower cost. Purchasers need ways to identify and reward high-performing providers who delivery high-quality, high-value care to their patients. Consumers need better cost and quality information to help guide critical health care decisions and communities need information about health spending and resource utilization so that health planning decisions can be made to maximize population health. Any effort to contain costs within the health care system will rely on the availability of clear information that allows for the identification of delivery practices that improve individual and population health while reducing costs.

ACTION STEPS:

1. Authorize the Authority to develop and implement public reporting of health care quality data.
The Legislature authorizes the Authority to establish a system for collecting and publicly reporting data on health care quality. This includes authorization to require providers and/or health plans to submit quality data, although the data system will be based on voluntary reporting wherever possible. Reporting systems developed by the Authority will provide comparable information about quality of care, utilization of health care resources and patient outcomes. To the extent practicable and appropriate, data will be easily accessible to providers, health care purchasers, health plans, and other members of the public in appropriate formats that support the use of data for health care decision-making and quality improvement.

2. Ensure that advances in quality are reaped by individuals of all backgrounds.
In its role as convener and collaborator, the Quality Institute should also be responsible for:

- Training provider organizations and health plans on protocols for collecting race, ethnicity, and primary language data based on the highest national standards. This will ensure consistency and comparability among data sources, increase cultural competency, and reduce provider discomfort with collecting this kind of information from patients.
- Developing a Health Disparities Elimination strategy that utilizes data to identify disparities and assist communities with evaluating interventions to reduce disparities.
- Aligning data resources to support quality health care across all demographic populations in Oregon.
- Disseminating meaningful and accurate information on health quality and utilization of health care resources in a manner that is accessible and understandable to individuals from a variety of cultural, ethnic, and educational backgrounds.

➢ New Models of Care

<u>Objective</u>: Create community health care systems that are coordinated, integrated and equitable.

<u>Strategy:</u> Pursue development of integrated health homes.
The state, as an ***integrator of health care and community service*** can provide leadership in system innovation and improvement. It must seek opportunities to revitalize primary care across the state and re-design the health care delivery system to maximize individual and population health. Primary care infrastructure and reimbursement policies should be designed to encourage patient-centered, coordinated, cost-efficient, longitudinal care and stress the importance of wellness, prevention and effective disease management rather than episodic, illness-oriented care. The integrated health home model (IHH) can serve as a blueprint for this type of re-design and should guide primary care practice transformation across the state. While this model allows for many different care settings to serve as integrated health homes, they all share common features. Integrated health homes establish personal and continuous relationships with patients, provide team-based care, assume responsibility for providing culturally competent care for all of a patient's health care needs, coordinate and integrate care with the care received from other providers and organizations, focus on quality and safety, and provide patients with enhanced access to care services.[18]

The integrated health home builds strong provider-patient relationships which can improve overall health, empower individuals to better manage their own health, improve quality of care, increase efficiency through care coordination and better disease management and lead to savings across the system. While integrated health homes are just starting to be implemented in the U.S. on a large scale, a number of local demonstration projects have shown that the model can produce tangible results. For instance, the Southcentral Foundation in Alaska led an implementation of an integrated health home model at the Alaska Native Medical Center which improved a variety of care measures over a 5-year period, including decreased overall and disease-specific hospitalizations, improved childhood immunization rates, decreased emergency room and provider visits, and decreased visits to specialists.[19]Implementation of a care-management based integrate health home model at Intermountain Health Care in Salt Lake City resulted in significant health improvements, including improved glycemic control, decreased hospitalization rates and decreased death rates in elderly patients with diabetes, compared to patients at control clinics.[20]

Experience from other states reflects significant savings from enrolling people in integrated health home. By requiring all Medicaid and SCHIP recipients to enroll with an integrated health home and providing integrated health homes with care coordination payments, the Illinois

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[18] A more comprehensive description of the integrated health home model and current state and national integrated health home pilots can be found in a research paper prepared by the Office for Oregon Health Policy and Research, available at http://www.oregon.gov/OHPPR/docs/The_Medical_Home_Model_Final.pdf.
[19] Eby D. Healthcare Transformation. Presentation at the Oregon Community Health meeting. Southcentral Foundation Alaska Native Medical Center. December 2006
[20] McConnell J, Dorr D, Radican K, et al. Creating a Medical Home Through Care Management Plus. Presentation at Academy Health Annual Meeting. April 10, 2007.

Medicaid program has been able to save $34 million annually.[21] By following a similar policy and supporting integrated health homes with networks of case managers, provider learning networks, and dissemination of best practices and clinical guidelines, the North Carolina Medicaid program has reduced its per-member-per month costs by $37 after four years.[22] Similar policies for Oregon could lead to savings of $120 million over ten years, if OHP required all participants to enroll in an integrated health home. If OHP followed North Carolina's lead and created additional support networks for integrated health homes, the state could save as much as $50 million in the first year, with ten year savings as much as $2.5 billion.

Strategy: Develop learning collaboratives to improve and further the dissemination of new models of care.

Sharing by those doing the delivery of care with each other is a key tool to improve the delivery of care. Improvement efforts are at the core of collaborating with those doing similar types of work to understand how to look at systems of clinical settings and improve the quality and efficiency of each step. Partnering, as both an ***integrator of health care and community and an instigator of community-based learning***, the state can partner with both providers and plans to disseminate new models of care. Learning collaboratives allow healthcare providers and their clinical staffs across integrated health homes to share information about quality improvement and best practices. Efforts in this area should build on current learning collaboratives already underway in Oregon amidst some early pilots of integrated health homes.

Each practice and provider organization will develop slightly different integrated health home models in order to best serve their patient population and it is vital that providers have a forum dedicated to sharing best practices and lessons learned. Technical assistance and collaboration by both public and private health plans can further the sharing amidst the providers and staffs, working closely to identify and assist to remove barriers to systematic improvement. Focused efforts for the unique challenges of rural and urban providers and for practices serving more vulnerable populations need to be considered in the development of curriculum for these collaboratives, along with a strong patient-centered approach. The integrated health home model is still new and providers on the ground implementing the model will have important insight that can help support other providers' efforts and guide policy development.

ACTION STEPS:

1. Create an IHH designation that includes reporting requirements on process, outcome and quality metrics.

The Legislature directs the Authority to develop a standard and streamlined process to identify health care practices as integrated health homes. A common definition will be established based on nationally-accepted certification processes and designed to limit administrative burden on providers. Any provider who meets the structural and performance criteria will be eligible for enhanced IHH payment. All public and private health insurers will be required to utilize this designation process if providing care coordination /management payments to providers.

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[21] Press release from the Office of Illinois Governor Rod Blagojevich. April 28, 2008. http://illinois.gov/PressReleases/ShowPressRelease.cfm?SubjectID=19&RecNum=6784 (downloaded August 1, 2008)

[22] K. Lorito. 2007. CCNC/Access Cost Savings – State Fiscal Year 2005 and 2006 Analysis. Mercer Government Human Services Consulting. http://www.communitycarenc.com/PDFDocs/Mercer%20SFY05_06.pdf (downloaded July 15, 2008).

2. Establish standards for reimbursing designated IHHs.
The Legislature directs the Authority to institute long-term sustainable payment policies that appropriately compensate providers and other partners involved in integrated health home systems of care. Compensation will be provided for developing capacity to provide integrated health home services and for providing these services to Oregonians in a high-quality and high-value manner. New payment strategies will be tested and evaluated to determine the potential to improve patient outcomes and experience, as well as provider experience. These new payment strategies will be part of a comprehensive payment reform strategy. A mixed model of reimbursement will be developed, which includes fee for service payments for certain procedures and risk-adjusted bundled payments for providing integrated health home services. Payment should be tied to designation and reporting requirements of common measures.

3. Develop standard requirements with contracted health plans.
The Legislature directs the Authority to develop a system of per-person care management payments for designated integrated health homes. All publicly-funded programs will use care management payments to support integrated health homes. There will be incentives for enrolled members to utilize IHHs, especially those with chronic diseases.

4. Incorporate IHHs in OHP.
The Oregon Health Plan develops and evaluates strategies to empower consumers to become more involved in their own health and health care by partnering and engaging with integrated health homes. The Department of Human Services Division of Medical Assistance Programs (DMAP) implement and evaluates strategies to provide incentives for OHP participants who enroll with integrated health homes, seek preventative and wellness services, practice healthy behaviors, effectively manage chronic disease with support from health homes. By January 1, 2010, OHP will offer IHHs to its members. In order to achieve this goal, DMAP recognizes the important role safety net providers play in delivering patient-centered integrated health home services to OHP and other vulnerable populations that face barriers to care. Safety net clinics are uniquely positioned to coordinate services with other community efforts and provide culturally appropriate services across a range of health needs.

Further, DMAP should strengthen the relationship between health-focused Community-Based Organizations and the health care delivery system. DMAP will design a contracting mechanism that will empower primary care clinics who primarily serve vulnerable populations to build financial agreements with health-focused community-based organizations that provide culturally-specific health promotion and disease management services. DMAP will also ensure that high-value community-based health promotion, disease prevention, and chronic disease management services are eligible for direct reimbursement.

5. Institute payment restructuring to support the implementation of IHHs.
The Division of Medical Assistance Programs will institute payment restructuring to implement the integrated health home concept in the Oregon Health Plan. These efforts need to be coordinated with the work of the Quality Payment Reform Committee in incenting the use of common quality standards in care delivery

6. Partner across state agencies and with other carriers to implement IHHs.
The Division of Medical Assistance Programs will partner first with PEBB, OEBB, and other public employers, and later with regulated carriers, to incorporate designated IHHs in their plan

networks and to design benefit packages with incentives for members with chronic diseases to seek care from contracted IHHs.

7. Evaluate the impact of IHH model on a biennial basis for six years.
The Legislature acknowledges and supports initial pilots underway across the state and uses the lessons and best practices from these pilots to design, promote, and/or fund a larger scale continuous rollout of the integrated health home model. This rollout will develop new integrated health home models, as well as new models of reimbursement that adequately compensate and support providers and other associated workforce personnel for delivering integrated health home services. There will be opportunities for consumer involvement on advisory committees monitoring the performance of integrated health homes.

8. Establish Learning Collaborative for Integrated Health Homes (IHH).
The Legislature directs the Authority to establish a collaborative for all designated integrated health homes providers in partnership with state agencies to share information about quality improvement and best practices and improve systems of care. IHHs serving OHP clients will be required to participate in the activities of the collaborative. It should build on existing efforts already underway in Oregon. The state may contract with a state or national organization that specializes in quality improvement in order to facilitate the collaborative. The collaborative must be able to accept grants from public agencies, as well as private foundations and partners to fund technical assistance and learning forums.

<u>Strategy:</u> Integrate behavioral health services.
Chronic behavioral health conditions account for a significant amount of morbidity and mortality and a large portion of health care spending in Oregon. In 2006, the economic costs of substance abuse in this state were nearly $6 billion.[23] Other health, social, and indirect costs associated with inadequately treated or untreated behavioral health conditions are also substantial, in part because many persons with significant behavioral health conditions have co-morbid physical health conditions. Clinical integration is especially beneficial for individuals with conditions as complex as these.

Integration of mental health and addiction services with physical health care and within primary care is an essential goal of a reformed delivery system. Such integration can and should occur in a progressive fashion over a reasonable period of time. As suggested in a recent report from the Institute of Medicine's Quality Chasm series, system transformation should progress from care collaboration to care coordination to care integration.[24] Safety net and community-based clinics (especially those that are linked with community-based mental health and addiction providers) may be better suited to achieve full integration sooner than private practice health care provider organizations. Such integration means effective "clinical" integration of behavioral health and other health care services. However, integration may be more feasible and less complicated when infrastructure and funding streams are integrated or blended and administrative, regulatory, and communication barriers are reduced or eliminated.

The organizations that provide mental health, addiction, and physical health services should be linked whenever possible, especially in serving those patients who would be most likely to present or be served in primary care settings. But even when the services are not provided by an

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[23] R. Whelan, A. Josephson, and J. Holocombe. 2008. The Economic Costs of Alcohol and Drug Abuse in Oregon in 2006. EcoNorthwest.
[24] Institute of Medicine, *Improving the Quality of Health Care for Mental and Substance-Use Conditions*

integrated organization, and irrespective of the level of structural or financial integration of partnering organizations, effective clinical integration models should include: the co-location of behavioral health specialists (including psychiatric prescribing providers) into primary care settings (or primary care providers in behavioral health specialty settings, especially for persons who have serious and persistent mental health or substance use disorders); and appropriate care management to coordinate and assure the provision of services from multiple providers for what commonly occurring co-morbid conditions.

At the systems and health plan level, the integration of funding and services for behavioral health and other health conditions is both appealing and very challenging. Although it is clearly preferable to organize and deliver the services through one health provider organization, it is incumbent upon the system to make sure that the special and complex needs of persons with the most severe conditions get sufficient care and support to prevent them from falling between the cracks and requiring more intense and restrictive care settings than would otherwise be necessary.

Currently the Oregon Health Plan contracts with Fully-Capitated Health Plans (FCHPs) for treatment of physical and addiction conditions, while contracts with Mental Health Organizations (MHOs) provide treatment for mental health conditions. This policy and contracting segmentation potentially causes a lack of care integration among different provider panels that may not be aware of or communicate with other providers in the community serving the same patient.

Ideally there would be one organization contractually obligated to provide the full range of health care services: physical, addiction, and mental health. But the integration and coordination of care can happen when local FCHPs and MHOs collaborate on joint policies and develop processes to link providers serving the same patient. The Addictions and Mental Health Division (AMHD) and the Division for Medical Assistance Programs (DMAP) must develop policies, contracts, and performance standards that require FCHP-MHO collaboration and co-management of shared patient populations.

ACTION STEPS:

1. Develop policies and incentives to integrate behavioral health care.
The relevant divisions within DHS (AMHD, DMAP, and Public Health's relevant offices), along with their constituent providers and consumer/advocate organizations, should collaborate to complete work that has evolved over the past five years to promote clinical integration. DHS and other relevant state agencies should develop policies, performance standards, and incentives that require contracted publicly funded and commercial plans to develop effective care integration strategies.

2. Restructure systems so that patients with multiple conditions can receive care in one clinical location.
Relevant state government entities should address the administrative rules and other regulatory impediments that prevent co-location and eligibility for organizations to provide comprehensive services (and to receive appropriate compensation) for patients with multiple conditions in the same clinical location.

3. Enforce mental health parity.
The Essential Benefit Package provides for parity coverage of mental health and addiction services. Parity is essential if we are to achieve the goal of integrating mental health services.

<u>Strategy:</u> Prevent health disparities before they occur.
Eliminating health disparities in chronic disease will have a profound economic impact on the state's health care systems, will increase earnings over a lifetime, and lower poverty rates, particularly for ethnic minorities.[25] The sustainability of the health care system needs to be addressed by recognizing that the health of the individual begins at home and within the context of families, cultures, and communities. Many chronic diseases have had a disproportional impact on communities of color.[26] Eliminating these disparities requires culturally-specific approaches to promoting health and preventing chronic disease.

Ensuring that providers and patients are able to communicate is also a critical investment in obtaining the full benefit of preventative visits and chronic disease management. Without clear communication, there are increased risks of missed or mis-diagnoses, and poor adherence to treatment recommendations. There are systemic disincentives for ensuring language access -- providers are often providing interpreter services without reimbursement or the ability to purchase in bulk (for smaller provider organizations). The state can provide leadership to eliminate health disparities as it seeks to integrate and instigate system innovation and improvement.

ACTION STEPS:

1. Promote population-based approaches.
The Legislature allocates sustainable funding to support an on-going, substantial investment in public health activities that will prevent disease and promote the health of Oregonians. Targeting culturally-specific approaches to disease prevention and health promotion will be part of this investment.

2. Ensure language access.
DMAP takes advantage of growing technological capacity in Oregon by creating a state-wide pool of qualified, certified interpreters and organizations that may be able to utilize and build on technologies being developed for telemedicine or telehealth. DMAP will seek federal matching funds for interpreter services through Medicaid in order to ensure affordable interpreter services for providers who see Medicaid patients.

<u>Strategy:</u> Restructure payment systems to encourage high-quality health care delivery.
Health care providers (including physicians, other health care professionals, hospitals, and other centers delivering care) should be accountable for quality, efficiency, care coordination, health equities, behavioral health and physical health outcomes. The state's role as both the integrator and instigator of system change can be the key to improving the payment system to pay for the quality of care rather than the quantity of care. Once a public reporting system is established, data should be used to inform payment reform efforts designed to provide incentives to providers delivering high-quality care to their patients. These efforts need to compliment and encourage

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[25] E.D. Crook and M. Peters, *Health Disparities in Chronic Diseases: Where the Money Is,* (The American Journal of Medical Sciences, 335(4):266-270, April 2008).
[26] A. C. Beal, M. M. Doty, S. E. Hernandez, K. K. Shea, and K. Davis, *Closing the Divide: How Medical Homes Promote Equity in Health Care: Results From The Commonwealth Fund 2006 Health Care Quality Survey* (New York: The Commonwealth Fund, June 2007).

innovative approaches to coordinate care management and ensure that Oregonians are getting the right care at the right time and in the right place, as further discussed earlier in this section.

ACTION STEP:

1. Establish a Payment Reform Council.
The Authority establishes a Payment Reform Council to explore new payment models that reward providers for the quality of care they provide, in coordination with providing incentives for innovative models of care that ensure care coordination and efficiency, such as the integrated health home. The work of this committee builds on the efforts to set standards and payment restructuring for the encouragement of integrated health homes and to explore how best to reward and encourage all health care providers to improve the quality and efficiency of care delivered to Oregonians.

Objective: **Provide high-quality, dignified end-of-life care to every Oregonian.**

Strategy: **Create a statewide voluntary, electronic Physician Orders for Life Sustaining Treatment (POLST) Registry to ensure the availability of the POLST form at the time of need.**
Oregon has long been recognized as a leader in the provision of dignified end of life care and will continue to take steps to ensure that patients' wishes about life-sustaining treatments are known and followed. In the case of individuals with advanced chronic illness, the POLST form is an important tool to convey patient wishes. The POLST is signed by a physician or nurse practitioner, thus converting wishes for life-sustaining treatments into medical orders that can be followed by nursing facilities or emergency medical technicians.

The OHSU Center for Ethics, through a voluntary program, has distributed over one million POLST forms. These forms are used in all Medicare-certified hospice programs in the state and in over 90% of all nursing facilities. However, an OHSU survey found that in one in four cases where a POLST had been filled out, it could not be found by emergency personnel in time to act on it. An electronic registry helps ensure that POLST forms are available at the time of need, by allowing EMS personnel to call a central number to determine if a patient has a POLST form and if so, access the orders on the form. A model Portland registry is currently under development.

The POLST form complements an advance directive or other expressions of a person's values. In contrast to an advanced directive, which is encouraged for all adults, the POLST form is intended for persons who might be expected to die within the next year. Expensive advanced directive registries have not been effective and should not be developed as part of an immediate access system. An advanced directive is not enough, as emergency personnel cannot act on an advanced directive and needs to have medical orders. The POLST form provides those needed medical orders. A statewide electronic POLST registry would help ensure immediate access by emergency medical personnel, including emergency departments to a person's vital medical orders that have been thoroughly discussed and reviewed by the person and their medical provider.

Strategy: **Ensure payment systems adequately reimburse providers for services necessary to provide dignified end-of-life care, including decision support and palliative care services.**
Many patients and families are not aware of their end-of-life care options and have not discussed with their health care providers their wishes with respect to invasive treatments, do not resuscitate orders, hospice and palliative care, and other treatments at the end of life. Decision

support processes help patients understand the likely outcomes of various care options, allowing them to reflect on what is personally important, to consider the risks and benefits of each option, and to make decisions with their support team. In addition, a patient facing a life-threatening illness must have access to palliative care services that include specialized approaches focused on improving quality of life through the prevention, assessment and treatment of pain, symptoms and stress associated with serious illness.

Currently, providers are not reimbursed for time spent engaged in decisions-support discussions with patients, and current payment structures do not support palliative care teams to care for patients at the end of life. Revise reimbursement policies to reflect the importance of these vital services and encourage the delivery system to provide comfort and support to patients at the end of life.

ACTION STEPS:

1. Establish a statewide voluntary, electronic POLST registry.
The Legislature approves funding for the establishment and maintenance of a voluntary, electronic POLST registry. This registry builds on current efforts to develop a Portland registry.

2. Create clinical guidelines and for end of life care.
The Legislature approves increased funding the Health Services Commission to develop clinical guidelines for end of life care, including decision support services and palliative care. This work includes methods for integrating payment for these services.

3. Adopt recommended guidelines.
All state-sponsored insurance programs adopt the clinical guidelines and payment policies recommended by the Health Resources Commission. The state publishes guidelines as best practices throughout the state and encourages adoption by private insurers.

➢ COMMUNITY-BASED INNOVATION

Objective: Foster innovation in health care delivery in local communities.

Strategy: Support community-based collaboratives.
Community-based collaboratives in Oregon are developing innovative programs and relationships to better integrate health care across multiple local organizations. If all health care is local, then the transformation of Oregon's health care system will happen locally; within, among and through the scores of organizations, both public and private, involved in health care.

The Board has learned of exciting activities in several Oregon communities that are models for community-driven innovation. Some are geographically focused:

- The 100% Access Initiative (Lane County);
- Health Matters of Central Oregon (Crook, Deschutes and Jefferson counties);
- Jefferson Regional Health Alliance (Jackson and Josephine counties);
- Northeast Oregon Network (Baker, Union and Wallowa counties).

Others are informal networks of health plans, public and private providers, and other organizations, such as: CareOregon's Primary Care Renewal program; Benton County's Public

Health and Local Mental Health Authority integration project; Multnomah County's Coalition of Community Health Clinics.

These programs bring together diverse, community-based interests to work on:

- Community wellness programs that include schools, employers, health care providers, social service and other community entities;
- The development of various forms of Integrated Health Homes to better coordinate the delivery of physical, behavioral and oral health;
- Improving chronic disease management to reduce unnecessary use of hospital emergency departments and inpatient admissions;
- In some cases, the development of local "3-share" programs (employers, employees and community) for low-income, uninsured individuals.

Because community-based innovation projects are the "learning laboratories" for the transformative change called for in this Action Plan, it is in the interest of the state to promote such activities and foster the exchange of best practices among communities at different stages of maturity. As an integrator of health care and community and an instigator of community-driven innovation, the state's leadership to further community collaboration is vital to system change.

ACTION STEPS:

1. Establish challenge grants to support community-based collaboration.
The Legislature authorizes the Authority to support, stimulate and monitor community-based collaboration and appropriates for the 2009 – 2011 biennium at least $1 million to the Authority for challenge grants to existing or emerging community collaboratives. Grants will require local matching funds and specific performance objectives and measures. In awarding grants, priority will be given to proposals that include addressing the needs of multi-cultural communities. The grants may be in the form of direct financial or technical assistance. The Authority will also work with existing community collaboratives to determine their readiness to assume the role of a stakeholder collaborative designated to use Accountable Health Community data to drive change at the local level.[27]

2. Use administrative waivers to express agency support for community-based innovation.
The Department of Human Services' relevant divisions (AMHD, DMAP and PHD) can waive administrative requirements applicable to contracting organizations participating in a community collaborative. The waiver(s) will be predicated on: 1) a demonstration project that promotes new models of chronic care management that will improve care integration; and 2) performance objectives and related measures to objectively evaluate the project's success.

3. Use state contracting leverage to show state agency support for community-based innovation.
The Department of Human Services will work to strengthen the relationship between health-focused community-based organizations and the health care delivery system. DMAP will design a contracting mechanism that will empower primary care clinics that primarily serve vulnerable populations to build financial agreements with health-focused community-based organizations that provide culturally-specific health promotion and disease management services. DMAP will

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27 E.S. Fisher, et al. 2007. Creating Accountable Care Organizations: The Extended Medical Staff. *Health Affairs* 2007; 26(1):w44-w57.

also ensure that high-value community-based health promotion, disease prevention, and chronic disease management services are eligible for direct reimbursement.

Strategy: Acknowledge and strengthen the important role of the safety net in providing health care services to Oregon's vulnerable populations.
The health care safety net is a community's response to meeting the needs of people who experience barriers that prevent them from having access to appropriate, timely, affordable and continuous health services. Health care safety net providers in Oregon deliver services to persons experiencing barriers to accessing the services they need and include a broad range of local non-profit organizations, government agencies, hospitals, and individual providers. Safety net providers are uniquely positioned to be able to understand the needs of the communities they serve and can play a lead role in redesigning health care delivery to ensure patient-centered, culturally appropriate care is available to Oregon's most vulnerable populations.

ACTION STEP

1. Ensure the safety net is represented in all reform efforts to redesign health care delivery.

The Health Authority maintains safety net representation on all of its established committees and councils working to redesign health care delivery to better serve Oregonians' health needs and to improve community health. The Authority requires existing and emerging community collaboratives that apply to the Authority for challenge grants to demonstrate that safety net providers are well-represented in their collaborative groups. The Authority requires applicants for Community Centered Health Initiative grants to establish a role for the safety net in designing and implementing community-based primary and secondary prevention initiatives.

Objective: Create a locus of accountability for quality and cost across the continuum of care by creating a tool to measure performance at the community level.

Strategy: Develop virtual Accountable Health Communities that serve as an analytical framework to compare health outcomes, quality, and cost between different communities.
Accountable Health Communities, a concept that evolved from the Board's Delivery Committee's work and modeled on "accountable care organizations" now underway in Vermont, can foster shared accountability for quality and cost among all providers serving a defined population across the continuum of care.[28] Based on work by the authors of the Dartmouth Atlas that has examined the variation in care patterns across the country in Medicare, the "accountable care organization model" link health care providers and healthcare institutions within a community to define local delivery systems large enough to support comprehensive performance measurement and provide or effectively manage the full spectrum of patient care. Aggregate quality and cost data allow these local delivery systems to evaluate population-based measures, including those which account for the efficiency and coordination between various providers serving a population. In addition, the "accountable care organization model" creates a tool to measure individuals' longitudinal experience with the health care system. Expanding this concept to "Accountable Health Communities" enables the focus to encompass a full range of care systems and also include broader measures of community and public health.

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28 Ibid.

This model allows for comparisons of performance across local delivery systems and the identification of communities with high utilization rates and per capita spending, as well as areas able to more efficiently use resources to improve population health. Aggregating and publishing cost and quality data at the Accountable Health Community level is a vital step to fostering local accountability for health system performance.

Accountable Health Communities can be utilized as a framework from which to analyze and compare outcomes across different communities. But for communities across Oregon, it can guide stakeholder groups within these communities to use data to make health planning and resource utilization decisions that maximize individual and population health and delivery system quality and efficiency. In addition, they can serve as a framework within which new payment methods that reward efficiency and quality can be tested. The state, in its role as an instigator of community-driven innovation, can co-lead the effort in partnership with communities across the state to drive quality improvement interventions.

ACTION STEPS:

1. **The Authority defines Accountable Health Communities across the state and reports quality and cost data accordingly.**
   The Authority or an entity designated by the Authority develops a method for defining Accountable Health Communities across the state. All health outcomes, quality, and cost data reported by the Authority, Oregon Quality Institute, or other government agency are aggregated to account for Accountable Health Communities' performance. The Legislature ensures that the development of Accountable Health Communities is tied to state's increased access to the claims data that will make performance appraisal possible.

2. **The Authority engages community stakeholder groups to use Accountable Health Community data to drive quality improvement interventions.**
   The Authority explores opportunities to encourage and support community stakeholder groups to use Accountable Health Community level data to drive quality improvement interventions and inform health planning and resource utilization decisions. In some communities, established community collaboratives promise to play a lead role in creating effective interventions to respond to quality and cost data. Other communities need to establish collaborative stakeholder groups to translate data into action and drive change at the community level. In either case, these groups can only be successful if they include a range of public and private stakeholders and engage consumers, health plans, purchasers, and a variety of providers, including safety net providers serving the most vulnerable members of each community. The Authority's Payment Reform Committee partners with these community stakeholder groups to use aggregated data to design payment reform initiatives that encourage providers across a community to integrate and coordinate care services.

➢ The Public's Health

Objective: Ensure effective investment in Oregonians to prevent and reduce tobacco use, obesity and other major chronic diseases.

Strategy: Link population health to the health care delivery system and communities. Through making individuals healthier and reducing chronic diseases, there is tremendous potential to improve overall population health, productivity, and reduce health care costs to make cost containment more attainable. As an essential part of health care transformation, creating and maintaining a bridge between population health, the health care delivery system, and communities is essential. The state, as an integrator of health care and community services, can take the lead to improve the health of all Oregonians.

To maximize success, the Authority overseeing health reform must have public health professionals, public and private, integrally involved for population evaluation and decision-making. The Authority should also emphasize broad representation on committees from professionals outside of the "classic" public health and health care delivery sectors (i.e., education, transportation). Through broad participation, the Authority will ensure health impacts to be evaluated and addressed through multiple sectors. Community collaboratives as previously outlined are key partners in coordinating the crosswalk access to clinical care and population health in ensuring members of the community are getting access to the services they need. Integrated health homes need to coordinate across clinical needs, but a strong partnership with their community's public health efforts are integral to improve a community's health.

Tobacco use and obesity are the two most influential modifiable risk factors for the five leading causes of death in Oregon[29]. Funding and implementing effective initiatives to prevent and reduce tobacco use, improve nutrition, and increase physical activity will result in a healthier, more productive population with significantly reduced health care costs. A recent report from the Trust for America's Health projected that if Oregon invested $10 per person on proven community-based disease prevention programs focused on increasing physical activity, improving nutrition, and reducing tobacco use, the state could save over $32 million annually in one to two years and over $200 million annually in 10 to 20 years. This could lead to a ten year savings for the state of $1.7 billion.[30]

Wellness in the workplace is another key aspect of improving population health. The state's Public Employees Benefit Board has initiated work on workplace wellness across state agencies. Several private companies and other cities, towns and municipalities have taken their own steps. Collaborating around best practices and broadening those efforts around the state are an important priority of the Governor's Office as well. Nationally similar efforts have shown marked reduction in absenteeism and improved work productivity, and reduced healthcare costs for employers[31]

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[29] Mokdad AH, Marks JS, Stroup DF, Gerberding JL. 2004. Actual Causes of Death in the Unites States, 2000. JAMA 291(10):1238-1245.

[30] Trust for America's Health. 2008. Prevention for a healthier America: investments in disease prevention yield significant savings, stronger communities. http://healthyamericans.org/reports/prevention08/Prevention08.pdf (downloaded August 11, 2008).

[31] The U.S. Department of Health and Human Services. 2003. Prevention Makes Common Cents. http://aspe.hhs.gov/health/prevention/ (downloaded August 25, 2008).

ACTION STEPS:

1. Authorize the Authority to coordinate development of the Healthy Oregon Action Plan in 2009 as well as implement programs and initiatives targeting prioritized strategies and benchmarks established in the Healthy Oregon Action Plan in 2010.
This singular, comprehensive plan includes statewide, regional and community level benchmarks and strategies to prevent and reduce tobacco use, prevent and reduce obesity, and impact other major chronic diseases. This plan incorporates and builds on work published by the Oregon Public Health Division in the Oregon Statewide Tobacco Control Plan 2005-2010 and the Statewide Physical Activity and Nutrition Plan 2007-2012, and includes both public and private organizations including employers, schools and community organizations.

Example benchmarks of the plan include but are not limited to the following:

- Reduce the percentage of 8th graders who smoke cigarettes to 5%
- Reduce the percentage of 11th graders who smoke to 10%
- Develop and implement effective population specific tobacco control programs directed at specific ethnic and cultural groups affected by tobacco use disparities
- Increasing by 10% the number of workplaces promoting physical activity and healthy eating
- Increase by 10% the number of employers who offer health care coverage for effective health care prevention and treatment of chronic diseases
- Increase the number of major health plans and insurers that cover obesity prevention
- All school and child care settings implement policies requiring all food served to meet or exceed current age-appropriate USDA Dietary Guidelines
- Increase by 10% the number of Oregon children who meet minimum recommendations for physical activity
- Increase by 5% the number of Oregon adults and children who meet the recommendation for daily physical activity

2. Establish and appropriate funds for a Community-Centered Health Initiatives Fund (CCHI) in 2009. Develop criteria and request for proposals for CCHI funding in 2010.
Develop criteria and request for proposals for a Community-Centered Health Initiatives fund which would include but are not limited to one or more of the following:

- Be based on community input;
- Be based on evidence and data, including population health measures reported and have evaluation
- Address behavior change at the individual, community and system levels;
- Coordinate efforts of local county health departments, community-based organizations, schools, employers and health care delivery system entities;
- Work to reduce health care disparities; and
- Be contingent on effectiveness and will be evaluated for effectiveness on an ongoing basis.

The Legislature passes legislation establishing and appropriating funds for a CCHI fund that will finance the development and implementation of culturally and socially appropriate primary and secondary prevention activities in line with the benchmarks and goals established by the Healthy Oregon Action Plan. The Public Health Division in close partnership with communities across the state, using policies and guidelines approved by the Authority, funds and continuously evaluates initiatives at the state, regional and community level to encourage innovation and effective programs.

3. Increase the tobacco and alcoholic beverages tax to fund action steps #1 (Healthy Oregon Action Plan) and #2 (Community-Centered Health Initiatives Fund), and help fund the county public health departments' tobacco use and chronic disease prevention and reduction programs

The Legislature authorizes funding for the Healthy Oregon Action Plan and Community Centered Health Initiative Fund through an increase in the tobacco tax and the alcoholic beverages tax. A $0.50 increase in the tobacco tax would result in 19,000 fewer youth smokers with related lifetime health savings of $332.5 million, and 6,000 deaths avoided. The overall long-term health savings of the $0.50 tax increase would be $419.9 million.[32] An alcoholic beverages tax will help improve access to mental and behavioral health. The funding replaces some or all of the funding lost by county public health programs when timber funds were lost.

The Legislature funds obesity-related prevention and reduction programs. These efforts are currently 100% funded through local and federal grants, which restrict long-term viability and sustainability.

4. Develop the Oregon Employee Wellness Action Plan in 2009 and prioritize and implement strategies Wellness Action Plan strategies in at least 50% of Oregon state agencies by 2010.

The Authority should partner with the Public Employees Benefit Board to develop an Oregon Employee Wellness action plan to address workplace conditions that encourage healthy behaviors, such as healthy eating and physical activity. The state should collaborate with private employers and health plans to establish best practices for effective workplace wellness programs.

[32] Lindblom E. 2008. Oregon cigarette excise tax increases: estimated new revenues, cost savings, and other benefits and effects. http://tobaccofreekids.org/research/factsheets/pdf/0148.pdf (Downloaded August 18, 2008). For more information on the Oregon Statewide Tobacco Control Program 2005-2010, see: www.oregon.gov/DHS/ph/tobacco/pubs.shtml

➢ HEALTH INFORMATION TECHNOLOGY

<u>Objective:</u> Accelerate widespread, effective use of health information technology (HIT) by clinicians and patients/consumers.

Strategy: Set quality, performance, and service standards that all health information technology vendors in Oregon are required to meet.
Health information technology encompasses a wide range of equipment and networks that when utilized efficiently can allow for the comprehensive management of medical information and its secure exchange between health care consumers and providers. In particular electronic medical records (EMR), as used in the context of this document, refers to an electronic record of health-related information on an individual that can be created, managed, and consulted by authorized clinicians in a variety of care settings. Personal health records are electronic records of health-related information on an individual that can be drawn from multiple sources while being managed, shared, and controlled by the individual patient.

A recent study conducted by the New England Journal of Medicine revealed that major barriers to adoption of EMRs include difficulties identifying a system that meets practice needs, uncertainty about the return on investment, and concern that a system would become obsolete.[33] There are a wide range of products on the market and it is often difficult for providers to determine the EMR functionalities that are needed to support improved patient care and which vendors will be able to provide them with a high-quality product and continued high-quality support and service. In addition, it is difficult for these practices to identify EMR service companies that will be able to provide ongoing support and technical assistances to practices as they integrate the use of EMR into their practice infrastructure. Where providers are using health information technology, different systems are often not interoperable, which limits opportunities to improve care coordination and ensure that complete health information is available to the patient when they want it and to the provider at the time of care. In an effort to aid providers in selecting effective health information technology vendors and maximize the impact that these technologies will have on quality of care across Oregon, the state must develop a common set of quality, performance, and service standards that apply to all health information products and services sold in Oregon.

Strategy: Set benchmarks for the adoption of Electronic Medical Records (EMRs), personal health records, decision support tools and e-prescribing and evaluate progress toward these goals.
While Oregon providers have adopted health information technology more readily than providers across the nation, there are still roughly over 40% of providers who do utilize electronic medical records (EMRs). The state should set ambitious goals to lead to full adoption of EMR systems and monitor progress toward these goals. The state should also set goals for more widespread utilization of electronic prescribing and decision support tools. In addition, every Oregonian should have the opportunity to have a personal health record and the state should set and monitor goals to make personal health records available to people across the state.

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[33] DesRoches C. 2008. Electronic Health Records in Ambulatory Care – A National Survey of Physicians. The New England Journal of Medicine. 359: 50-60.

Strategy: Coordinate public and private efforts across the state to accelerate adoption.
There are multiple organizations and entities working independently across the state to facilitate health information technology adoption, but these efforts are not collaborative and often result in duplicative and uncoordinated initiatives. Given the limited resources available, it is vital that public and private stakeholders across the state work collectively to develop a vision for the adoption of health information adoption and strategies to leverage public and private funds in a way that maximizes impact.

Strategy: Require the state, through their contracting process, to identify a small number of state-selected vendors able to provide high-quality Electronic Medical Record (EMR) products and service support to Oregon's provider community and to obtain affordable rates for these products and services.
Capital cost is the most commonly cited barrier to EMR and other health information technology adoption cited by providers, especially those in small practices, rural settings or underserved areas. Small practices do not have the same purchasing power as large hospitals and health systems and thus are not able to negotiate with vendors for reduced prices. Even if they are able to pay for initial installation of an EMR system, many of these practices cannot pay to maintain systems or provide ongoing support to staff to effectively use the products to improve patient care. The state can help practices overcome these barriers by identifying a small number of EMR vendors and service companies who meet quality, performance, and service standards set out by the state and utilizing the state's purchasing power to negotiate more affordable rates. In order to maximize the utility of these systems for providers and patients, it is important for the state to select systems which are interoperable with one another and with other systems used around the state.

Strategy: Subsidize small practices' use of state-selected Electronic Medical Record (EMR) vendors and service companies.
Even with reduced prices negotiated by the state, many practices will need financial support in order to purchase and maintain an EMR system. The state should first focus financial assistance on solo and small practices serving underserved and Medicaid populations. The state should only provide support for the adoption of EMR vendors and service companies selected through the RFP process.

Strategy: Ensure fee-for-service Medicaid providers are rightly compensated for installing and utilizing health information technology.
The state currently does not have funds available to increase Medicaid payments to providers who invested in electronic medical record (EMR) systems. Due to the high costs involved, many of these providers, especially those who see a high volume of Medicaid patients, have been forced to delay or cancel efforts to install and utilize EMRs.

ACTION STEPS

1. Authorize an oversight group to drive and monitor a health information strategy for the state and set standards for health information technology vendors and service providers operating in Oregon.

The Legislature authorizes the Governor's Health Information Advisory Committee (HIIAC), to act in conjunction with the Authority, to establish and monitor a health information technology strategy for Oregon. The group establishes ambitious goals for the adoption of electronic medical record (EMR) systems in all provider settings, leading to 100% adoption by a specified date. The

group establishes ambitious goals for making personal health records available to every Oregonian by a specified date. The group monitors progress toward these goals and adjusts activities and strategies to further facilitate health information technology adoption. The group develops quality, performance, and service standards for all health information technology vendors and service providers operating in Oregon, based on available and emerging national standards.

2. Convene public and private stakeholders to survey efforts underway in Oregon to facilitate health information technology adoption and develop collaborative efforts to leverage available resources.

The state authorizes the HIIAC, acting in conjunction with the Authority, to convene public and private stakeholders from every region in the state to survey current work and establish a collective effort to facilitate the adoption of health information technology.

3. Use the state's contracting process to select a small number of state selected and supported Electronic Medical Record (EMR) vendors and service companies that meet quality, performance, and service standards and offer the most aggressive price.

The Legislature authorizes the HIIAC, acting in conjunction with the Authority, to establish a state contracting process to select EMR vendors and a separate process to select EMR service companies able to support providers using the selected EMR products. The contracting process should be built on quality, performance, and service criteria, as well as cost, and selected vendors must have a proven track record of providing good products and services to customers. In addition, the contracting process must establish a mechanism for monitoring vendors' performance and remedying noncompliance with contract specifications.

Standards to be considered for inclusion in the contracting process' Request for Proposals (RFP) for electronic medical record *vendors* should include, but not be limited to:

- Meeting or exceeding current CCHIT standards
- Ability to connect with personal health records
- Valuable clinical decision support tolls to be used by providers at the point of care
- Interoperable data exchange with other EMRs, personal health records, and the Oregon Health Records Bank
- Adherence to HIIAC privacy and security principles
- Ability to record, store, and report quality of care and health outcomes measures
- Ability to be utilized in a range of care setting
- Other standards as determined by HIIAC/public forum

Requirements to be considered for inclusion in the contracting process' Request for Proposal (RFP) for electronic medical record *service companies* should include, but not be limited to:

- Ongoing support of the EMR systems selected by the EMR *vendor* contracting process
- Implementation support
- Conversion from paper records or another EMR to one of the state-selected EMRs
- Interface support
- Support practices in optimizing use of EMR

- Support quality reporting
- Support participation in health information exchange
- Other standards as determined by HIIAC and through public forums

EMR service companies must also meet HIIAC privacy and security principles. The contracting RFP process should be completed by January 1, 2010.

4. Establish a program to subsidize provider use of state-selected electronic medical record (EMR) vendors and service companies

The Legislature establishes a program to provide subsidies, in the form of grants or low-interest loans, for small providers who cannot afford to purchase and/or maintain and EMR system. The HIIAC, acting in conjunction with the Authority, should be responsible for designing the subsidy programs and the program will be administered by the Department for Human Services. Subsidies must be used to purchase products from state-selected EMR vendors or support services from state-selected EMR service companies. Amounts of subsidies will be determined on a sliding scale, based on service to underserved populations and service to Oregon's Medicaid population, as well as other factors such as size of practice and practice location.

5. Determine a fair and appropriate way to reimburse Medicaid providers for their use of electronic medical records (EMRs).

The Legislature determines how to fairly and appropriately compensate providers for costs associated with using health information technology to improve quality of care for Medicaid patients.

<u>Objective:</u> Increase the use of technology to support clinical decision making (CDM) and evidence based medicine (EBM).

<u>Strategy</u>: Ensure that electronic health records are aligned with a common set of health quality measures and common sets of clinical guidelines, as to be developed across public and private health plans, providers, and purchasers.

Currently, providers are required to report on a range of quality measures to various health plans and purchasers, which burdens health care practices, reduces efficiency, and makes it impossible to compare performance across providers. In addition, there is currently not a standard set of clinical guidelines used across the state and often different health plans utilize different sets of guidelines for the same conditions. By working with public and private partners, the state could lead an effort to improve health care across Oregon by standardizing health quality measures and combining resources to develop a uniform set of evidence-based clinical guidelines for the state. Oregon should not duplicate efforts of national organizations in this area, but should align Oregon measures and guidelines with evidence-base measures most widely utilized across the country.

The Governor's Health Information Infrastructure Advisory Committee (HIIAC) supports the efforts established by the Oregon Health Fund Board to convene a range of health plans, purchasers, providers, consumers, government officials, and other stakeholder groups around common sets of health care measures and clinical guidelines. They encourage the adoption of state measures and guidelines. The utility of health information technology is dependant on the availability of this type of standardized measures and guidelines. Health information technology vendors can most effectively design CDM and EBM tools to support providers and patients if

standardized uniform standards and best practices are developed and utilized across all stakeholder groups.

Strategy: Encourage and support providers in utilizing technology that supports clinical decision making (CDM) and Evidence-Based medicine (EBM).
Once standardized clinical guidelines are endorsed for the state, it is vital that providers have access to health information technology that will maximize their access to related information at the time of care. In addition, electronic medical records and other technology utilized by providers must allow for easy reporting of important quality information so that it can be used for statewide, as well as practice-based improvement efforts. When providers, health plans, and other stakeholder groups invest in the installation and utilization of health information technology systems, it is vital that these systems include useful CDM and EBM components to support high-quality patient care.

ACTION STEPS

1. **Encourage the adoption of clinical decision making (CDM) and evidence-based medicine (EBM) tools that support the utilization of state clinical guidelines and allows for reporting on state quality measures.**

The HIIAC, in collaboration with the Authority, will ensure that clinical decision making and evidence-based medicine tools that are aligned with the common set of health quality measures and clinical guidelines are imbedded into the health information technology contracting process. This will be included as criteria in its Request for Proposals (RFP) when selecting state-supported electronic medical record (EMR) vendors.

2. **Explore opportunities to use pay for performance and/or other incentives to encourage the utilization of clinical decision making (CDM) and evidence-based medicine (EBM) tools based on a common set of state clinical guidelines**

PEBB, Medicaid and other state sponsored health plans explore opportunities to implement pay for performance programs that provide incentives to practices that support clinical decision making (CDM) and evidence-based medicine (EBM) technology that leads to better health outcomes. These incentive programs could first reward providers for utilizing health information technology with CDM/EBM functionality, but should move toward rewarding providers for using CDM/EBM tools to improve health outcomes.

Objective: Have a statewide Health Information Exchange system in place by 2012.

Strategy: Support the use of DMAP's (Division of Medical Assistance, Department of Human Services) Health Record Bank (HRB) as a fundamental building block for a statewide system for health information exchange which ensures that patients' medical information is available and accessible when and where they need it.

Health information exchange facilitates the electronic movement of health-related information among patients and authorized providers and organizations.

DMAP's Health Record Bank project provides an opportunity for the state to build upon the investment and work that is already being done in the area of health information exchange. The HRB is Oregon's Medicaid Transformation grant project funded through a $5.5 million grant from the Centers for Medicare and Medicaid Services. The HRB project is currently in the planning stage, but will eventually store Medicaid clients' health information electronically and make it available on a secure-web site. Goals of HRB Oregon are to: assemble existing patient

information from multiple sources and provide one place for patients and their providers to share that information; provide a reliable and trusted repository of patient-specific health information; improve quality and coordination of care by providing patient-specific historical health information and decision support tolls and resource information to enhance patient participation in their health and health care; and protect patient privacy.

The input of the private sector will be a key to ensuring the HRB will be interoperable with those outside Medicaid. Ensuring the DMAP Health Record Bank is built to be interoperable with the commercial insurance plans that currently service the Public Employees' Benefits Board, Oregon Educators' Benefits Board, and the Department of Corrections will lay the ground work for eventual widespread use throughout the state.

The HRB should also encompass strong privacy and security protections and resolve the issues of patients' rights with respect to the use and ownership of their personal health information. A public education program targeted at both providers and patients will be necessary to allow patients and providers to have trust and confidence in the system, thereby increasing participation.

ACTION STEPS

1. **The state designates the Authority as the oversight entity for the statewide health information exchange with a charge that by December 31, 2012 a statewide health information exchange system will exist.**
2. **The Authority ensures support of the Health Record Bank project and requires that the system be built with interoperability as a main focus.**
3. **The state allocates the appropriate funding to create a statewide health information exchange.**

Objective: Ensure the highest level of privacy and security protections for Oregonians' personal health information in an electronic exchange environment to promote widespread participation by providers and patients in these systems

Strategy: Provide patient control over when, what and with whom personal health information is shared. In order to ensure the privacy of personal health information, patients -- consumers of health care -- need to choose what personal health information they want shared electronically, when that information can be shared and with whom it is permissible to share their information. This control will allow patients to trust that their personal health information will be available when and where it is needed; but not misused to the patient's detriment. This control will result in more widespread participation in electronic exchange systems.

Strategy: Create and/or strengthen state law in the area of protections for the privacy and security of personal health information. Ensuring clear law and rules for patients and providers involved in electronic health information exchange will increase the use and effectiveness of these systems. Identifying and consolidating current statutes pertaining the privacy and security of health information in one location in the Oregon Revised Statutes would also provide clearer guidance for providers and patients with respect to these issues.

Strategy: Provide for strict enforcement of state law with meaningful penalties for the negligent, reckless or intentional release or misuse of personal health information. The existence of penalties for the misuse – including negligent misuse – of information and a strict

enforcement policy will result in more secure systems being adopted and more privacy and security safeguards being instituted from the beginning.

ACTION STEPS

1. Update Oregon law to ensure the privacy and security of Oregonians' health information

The Legislature passes legislature to limit when and with whom an individual's personal health information may be exchanged electronically. Legislation should address:

- Notice to and authorization from the patient or patient's personal representative prior to sharing a patient's data through a health information exchange (HIE)
- An opportunity for the patient to NOT agree to share data through a HIE without penalty
- A patient request that part of that patients' record NOT be shared and that request must be honored
- Providers not being penalized by a patient's unwillingness to allow their data to be shared through a HIE
- Timely notification to patient of a breach and a meaningful remedy
- A private right of action for the consumer and patient after breach has occurred
- State Attorney General right of action on behalf of individuals to seek remedy
- Patient access to their record in a timely manner with an opportunity to correct errors
- No third party access to information for commercial or commodization of health information
- Emergency "break the glass" procedures
- Penalties for negligent, reckless and intentional privacy and security breaches and an a strict policy for the enforcement thereof
- Consolidation of existing law and rules pertaining to the privacy and security of personal health information
- Definition of "de-identified" information

BUILDING BLOCK 4: UNIFY PURCHASING POWER

➢ Coordinated Purchasing Policies Among Public Entities

Objective: Influence the direction and pace of system transformation in local markets and statewide through coordinated and aligned purchasing policies by the state and other government entities. Encourage voluntary adoption and participation by private purchasers.

As noted in the Executive Summary:

The overarching strategy is for the State – in partnership with communities – to act as a ***smart purchaser****, an* ***integrator*** *of health care and community services, and an* ***instigator*** *of community-based innovation.*

The State, as a major purchaser of health care must first align and coordinate its purchasing standards and contract requirements to maximize its influence in local health care markets in terms of performance standards, innovation in care delivery and cost. It must then partner with other government entities – counties, cities and other local governments – to form the market influence to shape the direction and pace of system transformation.

Strategy: Develop and implement uniform contract standards and policies for the State of Oregon (Oregon Health Plan, PEBB, OEBB).
The Authority will lead the development of uniform purchasing standards and contract requirements for use by state agencies that buy health care services. The State must be an instigator for and early adopter of the major system transformation strategies outlined in this plan, including:

- Common clinical coverage guidelines and standards
- Comparative effectiveness research to evaluate the appropriate use of new technologies
- Standard clinical and service quality measures to compare provider performance and patients' experiences
- The Integrate Health Home, behavioral health integration and other new models of care delivery that promote wellness, prevention, early intervention and comprehensive management of chronic diseases
- Employee wellness programs that align with strategic public health objectives and focus on behavioral risk factors that contribute to chronic disease
- Health information technology requirements (electronic medical records, electronic prescribing, etc.) that comply with national and state standards
- Decision support programs that inform and empower patients to be involved, with their provider, in critical, preference-sensitive health care choices
- The Oregon Prescription Drug Program (OPDP) as a benchmark for purchasing and managing prescription drug benefits

Strategy: Create a Public Employers Health Cooperative

The Authority will organize and manage a Public Employers Health Cooperative. State agencies, counties, cities, other local governments (and their associations) will be invited to participate. The Cooperative will encourage wide adoption of uniform purchasing standards and contract requirements. The Cooperative will collaborate whenever possible with private purchasers (labor trusts, self-insured employers, Oregon Coalition of Health Care Purchasers, association plans, etc.) in the development and implementation of uniform similar standards and policies.

The pace of innovation in local delivery systems rests, in large part, with the goals and requirements expressed by purchasers – public and private – either through their respective insurers, or, alternatively, directly to the provider community through collaborative and cooperative actions.

The objective of the Cooperative, its members and collaborators, is to consolidate purchasing power in local markets and transform the purchaser-payer-provider relationships to achieve improved quality and value. Employees of state government, state education institutions, and local governments and their dependents exceed 500,000 lives. Enrollment in the Oregon Health Plan currently stands at close to 420,000 people. With the coverage expansions proposed in this plan, the combined populations of non-federal public employees (and dependents) and the OHP will approximate 1,000,000.

The Integrated Health Home concept and other new models of care can be quickly introduced in communities if purchasers collectively bring membership scale (members using IHHs) to providers in support of the business/clinical model. In the case of IHHs and other models of chronic disease management, public employers should provide financial incentives to members to use an IHH or community-based chronic disease program. Incentives could include waived or lower co-pays, lower co-insurances, or services not subject to a deductible.

This strategy does not suggest that public employers who adopt model contract standards must have similar benefit designs or cost sharing. The collective action envisioned is around performance requirements for providers and health care systems (clinical and service standards and reporting), the use of common evidence-based guidelines for utilization management and comparative effectiveness guidelines for new technologies. The long-term goal is for every Oregonian to have the Essential Benefit Package of covered health services.

Based on the interests of the participating public employers, the Public Employers Health Cooperative could eventually contract directly with providers for specified services such as Centers of Excellence contracts such as cardiac or cancer services.

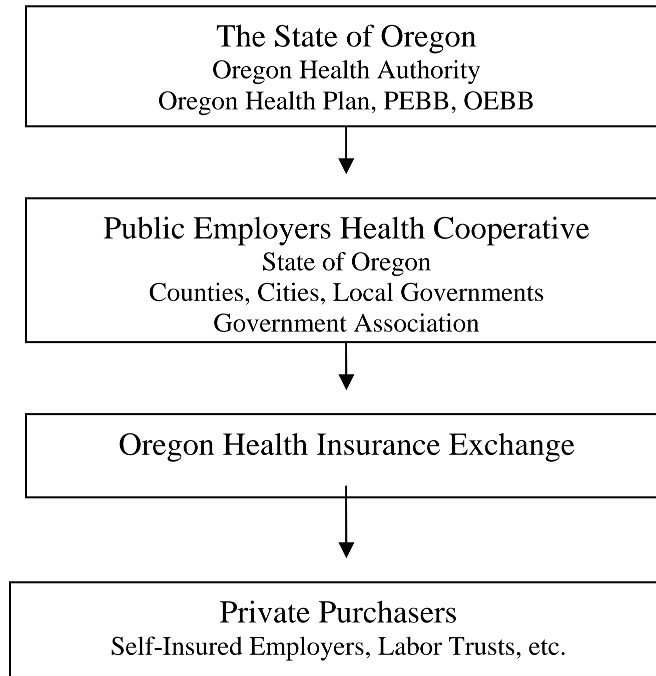
The Oregon Prescription Drug Program (OPDP) is an innovative joint contract for pharmacy benefits that includes both the State of Oregon and Washington State. As of July 31, 2008, OPDP has enrolled 83,560 Oregonians in a prescription discount card and 18,671 persons in group contracts. On October 1, the group number will increase to 104,000 with the inclusion of Oregon Educators Benefit Board members. State policy should require all health plans contracting with the state, county, city and local governments to provide their pharmacy benefit management (PBM) services through OPDP unless they can demonstrate greater savings through an alternative arrangement.

Strategy: Expand the scope and reach of Public Employers Health Cooperative

The Authority and the Cooperative will seek new partners in this collective and collaborative effort:

- The Oregon Health Insurance Exchange
- Private purchasers, including large self-insured employers, labor trusts, etc.

These strategies are intended to evolve over time as follows:



ACTION STEPS:

1. Authorize the Authority to develop and implement uniform contracting standards.
The Legislature authorizes the Authority to develop uniform contracting standards for state agencies that purchase health care services. Working with and through the Health Services Commission, the Health Resources Commission and organizations involved in clinical quality metrics, the Authority initially focuses on the development of: a) a standardized set of quality performance measures; b) evidence-based guidelines for major chronic diseases, services with unexplained variations in frequency or cost and "supply sensitive" services; and c) comparative effectiveness guidelines for select, new technologies.

2. Convene public employers to implement purchasing strategies to improve the value of health care purchased.
Legislative direction to the Authority includes broad authority to convene representatives of public employers to collaborate with the state in the development and implementation of joint, voluntary purchasing policies, standards and programs to improve the value of health care services purchased by public employers and effectuate the reforms contained in this Action Plan.

3. Require the use of the Oregon Prescription Drug Program by state agencies, county, city and local governments.

The Legislature directs state agencies, county, city and local governments that purchase health care services to implement contracting standards that require the use of the Oregon Prescription Drug Program unless the contractor or prospective contractor can demonstrate greater savings through alternative arrangements.

➢ Health Insurance Exchange

Objective: Stabilize the current individual health insurance market and establish a foundation for future market reforms.

Strategy: Create an Insurance Exchange to consolidate the Individual Market.

The state will develop an insurance exchange infrastructure that can grow in capacity over time. An exchange would initially consolidate the individual market in an effort to standardize and stream administration, promote transparency for consumers, improve quality and stem cost increases for individual insurance purchasers. Over time it could be used as the platform for the state to provide premium assistance to low and moderate income Oregonians.

The Board's Exchange Work Group recommended that an exchange be implemented as part of a larger set of market reforms, including an individual requirement for insurance, guaranteed issue, and state premium participation for low and moderate income Oregonians.[34] The Board recognizes the importance of these reform proposals, but believes an exchange could provide immediate value while Oregon implements delivery system improvements that will make sustainable coverage expansions affordable for the state and its residents. Therefore, in the short-term, current medical underwriting requirements would remain in effect in the individual market. Individuals denied coverage would continue to have the option of enrolling in the Oregon Medical Insurance Pool.

Exchange Structure and Participation

The state will create an Oregon Health Insurance Exchange (OHIE), either as a new entity or through an existing agency, board or commission. All individual market purchasers will buy insurance through OHIE.

OHIE will develop a request for proposals from licensed insurers interested in participating in the exchange. Participating insurers must comply with OHIE's contract standards, including but not limited to:

- Offering a range of specified plan options;
- Meeting provider network requirements;
- Participating in standardized contract requirements, such as uniform evidence-based utilization standards, disease management programs, etc.;
- Meeting transparency rules;
- Use of a medical screening tool and common rejection rules; and

34 For the recommendations of the Exchange Work Group, please see Appendix D.

- Meeting additional standards in areas such as administrative costs, rating rules, etc.

OHIE's operating expenses will be supported through a premium-based monthly per-member fee.

Benefits for Consumers and Insurers

An exchange will be the organizer of a new individual market. Participating insurers will offer a range of health plan choices, attractive to consumers based on benefit design and price, but the total number of plan choices will be smaller to lessen consumer confusion. An exchange can improve information transparency for consumers. An interactive web-site will facilitate shopping with comparative information by insurer, plan and network. Costs, benefits and ultimately performance reports will be available to current and prospective enrollees.

By standardizing and streamlining contracting and administrative functions, an exchange will work to reduce administrative costs. In addition, participating insurers would benefit from a risk adjustment mechanism that can limit financial exposure associated with members with high-cost medical claims. Risk adjustment frees insurers from risk selection (through benefit design) to focus on risk management.

Transitioning to an Exchange-Based Market

All current individual market purchasers will transition through a "roll over" schedule into OHIE coverage. Those currently insured will choose an insurer and plan and enroll without medical underwriting, since they were previously medically underwritten into the current market. Some restrictions on plan entry may be necessary to avoid adverse selection.[35] After the transition period, the current individual market will cease to exist.

The role of insurance agents and brokers in the individual market will be affected by this change. Currently insurers contract with agents and pay them fees for each enrollee. The OHIE will provide many of the services agents and brokers now offer in this market. The role for agents and brokers will be established by the governing body of OHIE.

An Exchange as Structure for Future Reforms

The exchange will form a structure that can be used to support medium- and longer-term coverage expansions through premium assistance, tax credits and the use of Section 125 plans. As many people at the Board and Committee level have expressed an interest in the benefits an exchange can have for small-group purchasers, over time the exchange could be expanded to allow entry by employer groups. This could provide choice to employees and reduce administrative costs for employers.

The OHIE is also the venue through which the development of a publicly-owned health plan could be investigated. As described by Dr. Jacob Hacker, a public health plan could become an option for individual insurance coverage along with regulated private plans.[36] All would be offered through the exchange, offering consumers the choice of a non-commercial, publicly-accountable plan that meets all the standards set by the exchange.

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35 Individuals wishing to transition without medical underwriting may be limited to purchasing insurance that is at a similar level of comprehensiveness to their previous coverage. Purchasers may apply for more comprehensive coverage, but such a "buy up" in coverage may require a new medical screening.

[36] Hacker, Jacob S. *Health Care for America*. Economic Policy Institute Briefing Paper #180. January 11, 2007.

A publicly owned plan could be an attractive option due to its lower administrative costs (similar to Medicare). Administrative costs could be as much as 23% less than in private sector plans. In addition, a public plan could advance efforts to improve quality and cost effectiveness through the use of:

- integrated health home;
- a focus on continuity of care;
- built-in comparative effectiveness review; and
- quality standards.

A public plan would create competition within the exchange and would be offered alongside private sector options. As envisioned by Dr. Hacker, a public plan could even work with Medicare to increase purchasing power.

Structurally, the public plan could be created through an agency or agency-like structure within state government or as a separate risk pool within the state's public employee plan. In the first option the agency would negotiate rates and administer benefits. In the second, the Public Employees Benefits Board (PEBB) would administer the program on behalf of enrollees.

A public plan could achieve savings through negotiation with providers, administrative savings (significantly lower marketing costs, no profit margins), and effective administration. Negotiation power would be increased if the plan was linked to the programs currently run for state and education employees through PEBB and Oregon Educators Benefits Board. The state plan may not need extremely large reserves and surplus if it were guaranteed by the full faith and credit of the state or through a regular legislative funds appropriation.

Over time, the Essential Benefits Package (EBP) discussed under the first building block would apply to insurance purchased through the exchange, ensuring that all individual market insurance purchasers would have access to an essential set of benefits. People would be able to purchase more than the EBP, but no one would get coverage that did not meet this standard.

2. **Evaluate the role of publicly-owned health plan option.**

The Legislature authorizes the OHIE governing body to evaluate the need for and, if warranted, development of, a publicly-owned health plan option that will operate within OHIE. Included in the assessment will be analysis of the potential for administrative and other savings, the cost of developing and maintaining a public plan, and other potential benefits for consumers. A public plan option could improve care for enrollees through delivery system efforts (including the use of integrated health homes, improved continuity of care, and high quality standards) and decrease costs for both consumers and the state through decreased administrative costs and improved purchasing efforts.

ACTION STEPS:

1. Create an Oregon Health Insurance Exchange.

The Legislature creates an Oregon Health Insurance Exchange (OHIE), either as a new entity or through an existing agency, board or commission. OHIE's governing body designs and builds the exchange for Oregon's current individual (non-group) insurance market. The Legislature authorizes OHIE to develop and implement a risk adjustment mechanism applicable to insurers participating in the exchange. In addition, the authorizing legislation grants OHIE the option to develop and implement a reinsurance program applicable to all participating insurers.

The Insurance Division, working with the OHIE governing body, continues enforcing rating and market conduct regulations applicable to insurers participating in the exchange. The Insurance Division reviews and approves rates proposed by insurers participating in OHIE. The OHIE's governing body develops an insurance exchange within current individual market.

The Legislature authorizes the OHIE governing body to work with insurers and other state agencies to access insurer, plan and network information in order to provide comparative information to consumers.

2. Evaluate the role of publicly-owned health plan option.

The Legislature authorizes the OHIE governing body to evaluate the need for and, if warranted, development of, a publicly-owned health plan option that will operate within OHIE.

➢ Regulatory Options

The actions proposed for transforming Oregon's health care systems, generally align with the recommendations of the Institute of Medicine's, *Crossing the Quality Chasm*, and the strategies and programs advocated by the Institute for Healthcare Improvement, specifically the IHI *Triple Aim* that focuses on community-based development of new systems of care through transparent information and continuous process improvement.

The two recommendations that follow depart from the others in that they are regulatory in nature. The Board is considering these strategies because of the significant increases in health care premiums in the recent past. There is deep concern among many Oregonians about the sustainability of the small group (fewer than 51 employees) and individual health insurance markets in light of increases that range from 11% to 20% or more.

<u>Objective:</u> **Control the increases in administrative expenses included in premiums by health insurers.**

<u>Strategy:</u> **Authorize the Department of Consumer & Business Services, Insurance Division, to regulate the annual growth rate in administrative expenses charged by health insurers.**

The premiums charged by regulated Oregon health insurers in the small group and individual markets are filed, reviewed and approved by the Insurance Division. The Division ascertains that the rates are appropriate and necessary given incurred claims history, medical trends, etc.

The Legislature will authorize the Insurance Division to review the overall growth rate in a health insurer's administrative expenses and determine if the rate of growth is unreasonable. Historically, administrative expenses have been reported as a percent of total premium (e.g., 12%). This approach "indexes" administrative expenses to increases in medical costs. In reality, the cost drivers of insurers should be more closely aligned with the general Consumer Price Index or the cost pressures in the financial sector generally.

The Insurance Division will monitor increases in administrative costs on a per-member-per-month (PMPM) basis, which accounts for marginal cost increases or decreases associated with an insurer's increase or loss of membership. Increases in administrative expenses in excess of a published standard (e.g., Consumer Price Index + 1%) will be denied unless there are extenuating circumstances.

ACTION STEP:

1. **The Legislature authorizes the Insurance Division to develop methodologies and standards for reviewing the administrative expenses of health insurers and to deny proposed increases in the administrative expense portions ("loads") of premiums subject to appeals procedures.**

<u>Objective:</u> **Control the annual increases in prices charged by providers.**

<u>Strategy:</u> **Authorize an appropriate state agency to establish annual maximum limits ("ceilings") on price increases charged by health care providers in a similar class (e.g., licensed health care facilities).**

Health care claims costs incurred by an insurer and paid for by a purchaser are a function of allowable unit prices multiplied by utilization. Anecdotal evidence suggests that provider unit prices are increasing at rates several times general inflation. There are many explanations for

price increases higher than CPI: costs of care delivered to the uninsured, under-funded public programs, wage and salary costs related to workforce shortages, etc.

Some will contend, however, that the absence of price competition in many Oregon markets is a contributing factor. In addition, the Board has heard concerns that price increases may not decline even after major investments by the state in expanded coverage and improved provider reimbursement.

One of two approaches could be adopted to limit price increases. The state will limit the increase in prices charged by a provider to the general public ("self-pay") or negotiated between a provider and a third-party payer:

- To an increase of no more than a fixed percentage (CPI + 1%) from a base year; or
- To a fixed multiple of the provider's Medicare reimbursement rates (e.g., 130% times Medicare reimbursement)

ACTION STEP:

1. **The Legislature considers the merits of proposed legislation authorizing the state to regulate the annual increases in provider prices using one of the methodologies noted above or an alternative approach that achieves the same objective.**

BUILDING BLOCK 5: TRAIN A NEW HEALTH CARE WORKFORCE

Objective: Ensure that Oregon's health care workforce is sufficient in numbers and training to meet the demand that will be created by proposed coverage expansions, system transformations and an increasingly diverse Oregon population.

Strategy: Identify needs, resources and gaps, and develop recommendations for attaining the training, recruitment and retention of all levels of health care providers in all regions of Oregon.

There are approximately 160,000 jobs in the health care sector of Oregon's labor market, excluding those employed by state, county, municipal or tribal governments. Between March 2007 and March 2008, Oregon's health labor force grew an additional 5,600 jobs. Even with a slowdown in the economy, the number of health care jobs overall is predicted to grow nearly 27% by 2016.[37]

Oregon's population is projected to grow by 13% over the next decade, and the population over 65 is expected to grow by an estimated 33%. Add to this the anticipated growth from the access expansion contemplated in other Board recommendations and it is apparent that we are facing a workforce crisis. The impending workforce shortages may dramatically undermine access to care and adversely impact the delivery system. The human capital shortages could erode patient care and outcomes, and overwhelm the clinical workforce. Ironically, "guessing" about the anticipated shortage is largely where Oregon is today; particularly in primary care.

Oregon lacks a coherent strategy to assure an adequate and highly trained health care workforce to meet the needs of the 21st Century. Data available are primarily the result of occasional, one-time projects or grants financing data collection sporadically and inconsistently. Currently the best data exists on the nursing workforce by virtue of information collected through the licensing process and analyzed by University of Portland's Oregon Center for Nursing.[38] Other health care professions' licensure does not include parallel activities. Collecting key additional data through the licensing process could provide much needed insight into the characteristics of our current on-the-ground workforce and clarify challenges to assure future supply and detect trends.

A study conducted by the Office for Health Policy and Research for the Department of Human Services Division of Medical Assistance Program (DMAP), in collaboration with the Oregon Medical Association showed the following:

- Oregon's physician workforce is less racially and ethnically diverse than the state's population;
- The northern coast region has on average an older physician workforce, with 25% over age 60;
- Twenty-two percent of the state's physicians have plans to retire within five years;
- Small practices (3 to 10 physicians) are the most commonly reported practice size (35.6%); and
- Sixty-eight percent are single specialty practices;

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[37] Oregon Healthcare Workforce Institute. *2008 Profile: Oregon's Health Care Workforce.*
[38] Oregoncenterfornursing.org

- The percentage of physicians reporting their practice as completely closed to new Medicare patients increased from 11.8% in 2004 to 23.7% in 2006.

With the exception of comprehensive workforce data available about nurses from the Board of Nursing, we lack complete and consistent data that tells us if physicians and other health professionals are engaged in direct patient care, where they are practicing, whether they practice full-time or part-time, and if they are contemplating retirement. It is difficult to solve a problem without accurate and ongoing information about its scope. Numerous Oregon groups look at workforce issues in health care, including the Office of Community College Workforce Development, the Oregon University System, the Oregon Workforce Investment Board, the K-12 system, the Center for Nursing and others. However, there is no accountable entity that is directed to develop a coordinated strategy to meet the health care workforce needs of Oregon. The Oregon Healthcare Workforce Institute was established with that in mind three years ago. Set up as a private not-for-profit corporation, and envisioned as a public/private partnership, it has been hobbled by a lack of consistent, dedicated funding from the state and various stakeholders in the health care industry.

While many organizations have important roles in workforce development, it is essential to have a designated entity responsible for coordinating efforts and sharpening focus. Mitigation of our workforce shortage challenge lies is combining strategies to use our existing workforce more efficiently, increase our supply and retention, and change the incentives in our payment system which work to exacerbate an inappropriate mix between specialists and primary care providers. Recommendations for integrated health homes and the implicit critical role of primary care in chronic care management will depend on how effectively we are able to respond to the workforce supply challenge

Why an emphasis on primary care? Probably this is best answered by the following: “Within the United States, states with more primary care physicians per capita have better health outcomes, including mortality from cancer, heart disease, or stroke. In the United States, states with higher proportions of specialist physicians have higher per capita Medicare spending. Conversely, [having] a greater number of primary care physicians [is] associated with increased quality of health services, as well as a reduction in costs . . .”[39]

Oregon’s safety net is a significant provider of primary care in many communities. It is critical to have data on the safety net workforce to assure that these community organizations can meet the needs of their patients. It is also essential to support innovative approaches to bridging the community with the health care provider. Community Health Workers (CHWs), also known as promotores/as, Community Health Representatives (CHRs), lay health advisors, and outreach workers, among other names, are trained members of medically underserved communities who work to improve health outcomes. CHW programs have proven effective in teaching disease prevention, reducing barriers to care, improving patient-provider communication, and improving community health**.** A comprehensive Oregon workforce strategy must address the full range of professional disciplines: dentists, dental hygienists and other dental care workers, behavioral health professionals and the technical workforce that supports frontline care givers.

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[39] Position Paper, American College of Physicians, *Annals Intern Med* 148: 1, 2008.

ACTION STEPS:

1. **The Legislature funds the Authority to develop a statewide health care workforce strategy.**
2. **The Legislature authorizes the Authority, in coordination with the Oregon Workforce Institute and other groups, to collect adequate data through the licensure process that will provide Oregon with an on-going database about its current workforce.**
3. **The Authority, in coordination with the Oregon Workforce Institute and other groups, develops a comprehensive, dynamic planning process to assure Oregon has an adequate, highly trained health care workforce and coordinate with existing groups focused on workforce issues. Elements of the strategic plan will include but need not be limited to the following:**
   - Collect, analyze and report on current work force statistics
   - Identify emerging trends and issues related to workforce supply;
   - Develop methods to project and forecast supply and demand through 2020 in Oregon;
   - Develop an on-going database of training activities within Oregon and forecast production schedules and volumes;
   - Develop recommendations for changes in the design and funding of training programs to maximize the impact of state investments;
   - Increase the in-state production and retention of health care workforce in Oregon, with emphasis in primary care providers;
   - Develop recommendations for incentives to recruit & retain providers from outside of Oregon, particularly in primary care;
   - Develop licensure strategies for a 21st Century health care workforce
   - Advocate for improved federal work force policies and funding, including increased medical residency positions;
   - Develop target ratios for various categories of health care provider-to-population to direct goal-setting.
4. **The Authority, in coordination with the Oregon Workforce Institute, health professional schools and other groups, implements strategies to train, attract and retain an appropriate supply of primary care providers in all geographic areas of Oregon.**
5. **The Legislature authorizes the expanded use of Community Health Workers in Oregon. The Authority, in coordination with appropriate state, local and other government agencies, encourages the use of Community Health Workers.**

Oregon can stimulate this innovative strategy to increase the health care workforce while delivering culturally competent health care by providing a variety of funding sources, including direct reimbursement for Community Health Workers. Establishing direct reimbursement may involve developing a certification system for CHWs. Any certification system should be designed and governed by CHWs and CHW advocates to ensure fidelity to this very successful model.

Strategy: Ensure that Oregon health care providers are prepared to be culturally competent providers and reflect the diversity of Oregon.

Oregon statutes provide a guiding definition of cultural competence that must be reflected in the practice of health care in Oregon. Cultural competence refers to the process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, disabilities, religions, genders, sexual orientation and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families and communities and protects and preserves the dignity of each (OAR 415-056-0005).

Part of cultural competence is ensuring the Oregon health care work force reflects the diversity of Oregonians. Special efforts must be made to recruit and retain minority health care workers. Ultimately, our patients pay the price when there are insufficient providers from backgrounds similar to theirs. Geographic, economic, educational, and cultural factors, with their effects on patient mortality, underscore the critical need for providers from disadvantaged backgrounds and with superior cultural sensitivity training, to improve health care for the underserved throughout Oregon. They will then be able to serve those who are now underserved, improving access to care. In addition, these individuals will function as role models for youth in their communities.

ACTION STEPS

1. **The Authority works in coordination with appropriate health professional schools to develop a plan to ensure appropriate education designed to increase cultural competence for all health care providers.**
2. **The Authority takes steps to ensure a health care workforce that reflects the diversity of Oregonians.**
   - Expand educational institution capacity at health professional schools where more training opportunities are needed across the board from community college to university and postgraduate levels.
   - Increase financial aid in health professional schools for students needing more financial aid (grants, scholarships, loan forgiveness).
   - Strengthen the pipeline to health profession schools; intervention needs to start early and focus on retention. Support mentoring program models that have been demonstrated to be effective in retaining students.
   - The statewide health care workforce strategy should include Naturopathic providers, dentists, mid-level providers, behavioral health professionals, and Community-Health Workers.
   - Improve the climate for diversity at individual health professional schools by striving for cultural and linguistic competence throughout the institution.

BUILDING BLOCK 6: ENSURE HEALTH EQUITY FOR ALL

Objective: Achieve health equity in Oregon across all populations through a variety of sustainable strategies that support the health of individuals, families, and communities.
The social determinants of health must be acknowledged in any explicit effort to reduce health disparities. Social determinants of health acknowledge that an individual's health is not solely understood by determining insurance status or by isolating the experience between patient and provider. Neither can it be adequately addressed by focusing on individuals and individual responsibility. Health is more than health care. A review of population health factors determined that non-medical factors (genetic predispositions, social circumstances, environmental conditions, and behavioral patterns) are responsible for a large proportion of preventable mortality in the United States, perhaps 85-90 percent.[40,41]

In the acclaimed PBS documentary series, *Unnatural Causes: Is Inequality Making Us Sick*?, Dr. David Williams aptly frames the scope necessary to truly address health inequities through social policy when he argues: "Housing policy is health policy, educational policy is health policy, anti-violence policy is health policy, neighborhood improvement policies are health policies. Everything that we can do to improve the quality of life of individuals in our society has an impact on their health and is a health policy". Other states have acknowledged this by passing legislation giving members of the legislative body or other policy-makers an opportunity to request an assessment of how any proposed policy might impact the health of vulnerable populations. Health impact-assessment tools provide policy-makers with information to evaluate how education policy, housing policy, economic policy, land-use policy or other policy choices might benefit or harm the health of individuals, families, or communities.[42]

Oregon must create avenues for racial, ethnic, and cultural minorities to participate in an on-going effort to address health disparities in Oregon. These communities are the first to identify and understand the problems that affect them and will have the best ideas about how to address these problems effectively. Health care is experienced locally and solutions for health care dilemmas must be addressed by engaging, supporting, and allowing the impacted communities to lead the way.

Recommendations to reduce health disparities are integrated within all of the building blocks outlined in this report but are called out separately here as a testament to the importance of this strategy in reforming Oregon's health care system.

Strategy: Prevent Health Disparities before they occur through Health Promotion and Chronic Disease Prevention and Management
Eliminating health disparities in chronic disease will have a profound economic impact on the state's health care system and will increase earnings over a lifetime as well as lower poverty rates, particularly for ethnic minorities.[43] Oregon can target the sustainability of the health care

[40] Schroeder S, *We Can Do Better—Improving the Health of the American People,* (The New England Journal of Medicine, 357(12):1221-1228, September 20, 2007;).
[41] McGinnis JM, Williams-Russo P, and Knickman JR, *The case for more active policy attention to health promotion,* (Health Affairs, 21(2):78-93, March/April 2002).
[42] B. Smedley, B. Alvarez, R. Panares, C. Fish-Parcham, and S. Adland*, Identifying and Evaluating Equity Provisions in State Health Care Reform* (New York: The Commonwealth Fund, April 2008).
[43] E.D. Crook and M. Peters, *Health Disparities in Chronic Diseases: Where the Money Is,* (The American Journal of Medical Sciences, 335(4):266-270, April 2008).

system by recognizing that the health of the individual begins at home and within the context of families, cultures, and communities (both locational and relational). Many chronic diseases have had a disproportional impact on communities of color.[44] Eliminating these disparities requires culturally-specific approaches to promoting health and preventing chronic disease.

ACTION STEPS

1. The Legislature promotes population-based approaches with an on-going, substantial investment in public health activities that will prevent disease and promote the health of Oregonians. Culturally-specific approaches to disease prevention and health promotion must be part of this investment.

2. The Division of Medical Assistance Programs (DMAP) and the Oregon Health Insurance Exchange strengthen the relationship between health-focused Community-Based Organizations and the health care delivery system through integrated health homes. DMAP designs a contracting mechanism that will empower primary care clinics who primarily serve vulnerable populations to build financial agreements with health-focused community-based organizations that provide culturally-specific health promotion and disease management services.

Strategy: Reduce Barriers to Health Care

Low-income individuals, who are disproportionately from communities of color, are more likely to be uninsured and to experience other barriers to accessing health care.[45] Reducing these barriers also impacts many other aspects of people's lives. In California, parents of children newly enrolled in the State Children's Health Insurance Program reported that their children performed better in school, felt better physically, and were able to get along better with their peers than they did before they had insurance.[46]

ACTION STEPS:

1. The Oregon Health Authority implements universal eligibility.

It is a long-held Oregon value that all Oregon residents have equal opportunity to support their families, pay taxes, and contribute to the State's economy. To maintain the health of that workforce, it is fair, wise, and in the State's economic interest that the ultimate expansion of health care shall be available to all Oregon residents.

2. Oregon's federal delegation addresses citizenship documentation barriers.

3. DMAP conducts targeted and aggressive outreach to multicultural communities.

A media-only approach to outreach for the Oregon Health Fund program is not an adequate response to reducing disparities in health insurance status in Oregon. The Health Equities Committee recommends a sustainable funding mechanism, with additional Medicaid matching

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[44] A. C. Beal, M. M. Doty, S. E. Hernandez, K. K. Shea, and K. Davis, *Closing the Divide: How Medical Homes Promote Equity in Health Care: Results From The Commonwealth Fund 2006 Health Care Quality Survey* (New York: The Commonwealth Fund, June 2007).

[45] Agency for Healthcare Research and Quality, *National Healthcare Disparities Report*. 2003–2006; Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Washington, D.C.: National Academy of Sciences, 2003).

[46] M. Seid, J.W. Varni, L. Cummings and M. Schonlau, *The Impact of Realized Access to Care in Health-Related Quality of Life in the California State Children's Health Insurance Program,* (Journal of Pediatrics, 149:354-61, September, 2006).

funds, to support community-based organizations in delivering culturally-specific and targeted outreach and direct application assistance to members of racial, ethnic, and language minority communities; individuals living in geographic isolation; and populations that encounter additional barriers such as individuals with cognitive, mental health or sensory disorders, physical disabilities, chemical dependency, and individuals experiencing homelessness.

100% enrollment of individuals who are eligible to participate in the Oregon Health Fund program is the object, and resources and interventions must be targeted towards this goal.

Strategy: Improve the Quality of Care

There are several strategies that have been demonstrated to be effective at reducing the disparities of care that occur within the context of health care delivery.[47]

ACTION STEPS

1. The state agency authorized to certify integrated health care homes makes the integrated health home model an essential element of restructuring the health care delivery system. Elements of the integrated health home model have been demonstrated to reduce health disparities.

2. The Legislature and DMAP authorize direct reimbursement for Community Health Workers (CHWs) for publicly-sponsored health programs.

3. The Legislature ensures language access. DMAP seeks federal waiver approval for this change.

4. The Authority, in coordination with the Oregon Workforce Institute and other groups builds a culturally competent workforce that reflects the diversity of Oregonians.

5. The Legislature supports Community Health Worker programs that recruit and train members of underserved communities to provide culturally and linguistically competent health services within that community.

6. The Legislature develops a plan to ensure appropriate education designed to increase cultural competence for all health care providers.

7. The Authority expands data collection efforts.

All health care providers and health plans participating in Oregon must be required to collect and report data on race, ethnicity, and primary language. These measures need to be included when assessing quality and ensuring transparency.

8. The Quality Institute implements initiatives to enhance quality.

- The state shall train provider organizations and health plans on protocols for collecting race, ethnicity, and primary language data based on the highest national standards. This will ensure consistency and comparability among data sources, increase cultural competency, and reduce provider discomfort with collecting this kind of information from patients.

[47] A. C. Beal, M. M. Doty, S. E. Hernandez, K. K. Shea, and K. Davis, *Closing the Divide: How Medical Homes Promote Equity in Health Care: Results From The Commonwealth Fund 2006 Health Care Quality Survey* (New York: The Commonwealth Fund, June 2007).

- Develop a Health Disparities strategy that utilizes data to identify disparities and assist communities with evaluating interventions to reduce disparities.
    - Aligning resources to support quality healthcare across all demographic populations in Oregon.
    - Disseminating meaningful and accurate information on health quality and utilization of healthcare resources in a manner that is accessible and understandable to individuals from a variety of cultural, ethnic, and educational backgrounds.

BUILDING BLOCK 7: ADVOCATE FOR FEDERAL CHANGES

Objective: **Seek alignment of federal policy requirements with Oregon's reform efforts to expand coverage, optimize population health, and otherwise improve Oregon's health care system. In particular, achieve equitable provider reimbursement from the Medicare program and flexibility for innovation through federal waivers.**

For decades, Oregon has played a leading role in health care reform with its unique approach to rationalizing services under the Oregon Health Plan's prioritized list. By implementing the actions presented in this plan, Oregon will continue to be an innovator among states and will be well-positioned to advocate for change at the federal level that is needed to support state health reform efforts.

Strategy: **Advocate for change at the federal level to remove barriers to Oregon's health reform strategies.** The Federal Laws Committee identified several areas of federal policy that impact Oregon's health reform efforts. Action is needed at the federal level to remove barriers to state efforts to expand coverage and improve health care delivery systems. Key barriers include:

Inequitable Medicare reimbursement: The most critical federal barrier to health reform in Oregon relates to the low Medicare reimbursement rates paid to Oregon's providers compared to other states and regions. Low rates could undermine the reform efforts of the Board due to the growing number of physicians who are not accepting Medicare patients. More than 571,000 seniors and people with disabilities receive Medicare coverage in Oregon.

- Congress should reform the process for setting Medicare rates to more equitably align reimbursement across the country. Without rate reform, Oregon will be confronted with a crisis in access to health care for some of our most vulnerable citizens.
- The Centers for Medicare & Medicaid Services (CMS) should pursue Medicare payment reform that emphasizes evidence-based care, integrated health homes and the array of services that support these models.

The opportunity of Medicare Advantage HMO and PPO plans: Medicare Advantage HMO and PPO plans play an essential role in serving Oregon's senior and disabled population.

- Congress should preserve this option for Medicare beneficiaries and permit the expansion of Medicare Advantage Special Needs Plans.
- Congress and CMS should consider significant reforms to Private Fee-For-Service (PFFS) Medicare Advantage plans, including more rigorous state and federal oversight.

Additional Medicaid waivers needed: Oregon covers more than 386,000 low-income individuals under its Medicaid program and more than 10,000 citizens receive premium assistance. To expand these programs as recommended in this plan, Oregon will need to request approval from CMS. Without CMS's federal matching funds, program expansions will be much more expensive to implement.

- CMS should approve Oregon's waiver requests. Further, CMS should review, renew and approve state Medicaid waivers in a collaborative and timely manner.
- CMS should adopt a framework for expedited approval to assist states that want to launch demonstration projects in payment reform within the Medicaid program.

<u>Threats of ERISA lawsuits:</u> The Employee Retirement Income Security Act of 1974 (ERISA) creates an obstacle to health reform efforts by preempting state laws that "relate to" private sector, employer-sponsored benefit programs, including self-insured employers' health plans.

- Congress should create "safe harbor" policies for state health care reform elements (such as "pay or play" payroll taxes) that would protect states from ERISA court challenges.

<u>Inequitable federal income tax incentives for health insurance:</u> Self-employed individuals and individuals buying health insurance on the open market are not able to obtain the same federal income tax benefits as those receiving employer-sponsored health insurance. Enhancing tax benefits for these purchasers can increase the affordability of insurance.

- Congress should modify the federal personal income tax code to provide equal tax benefits to all taxpayers purchasing health insurance. Low-income individuals should be offered the option of a refundable credit against their tax liability for health insurance premiums. In modifying the tax code, Congress should preserve tax incentives for employers offering insurance.

<u>Shortages in Oregon's health care provider workforce:</u>

- Congress should oppose any efforts to reduce federal funding for the education of citizens seeking careers in health care. Moreover, Congress should enhance such funding in select critical shortage areas.
- In addition, Congress should raise the federal limitations on Medicare funding for Graduate Medical Education residencies.

<u>Under-funded Indian Health Services programs:</u> Oregon's American Indian/Alaskan Native (AI/AN) population is woefully underserved and suffers significant health disparities, partly due to inadequate federal funding. Unlike other racial or ethnic minority groups, Tribes are sovereign entities that operate in a unique government-to-government relationship with the United States government. The United States has a federal obligation to provide health services to American Indian/Alaskan Native people.

- Congress should adequately fund Tribal health services.

<u>Strategy:</u> Investigate additional federal funding of health care services. Federally-Qualified Health Centers (FQHCs) receive enhanced Medicaid and Medicare reimbursement and have access to federal grants to serve the uninsured. Additional resources associated with FQHC designation can encourage local community innovation in serving those without access to affordable health care.

- Oregon should investigate expanding the number of FQHCs and FQHC "look-alikes" in the state. Additional federal participation in Community Health Center funding would provide short-term assistance to alleviate some of strain in Oregon due to its low Medicare and Medicaid reimbursement.

<u>Strategy:</u> Investigate barriers to open dialogue among provider organizations about delivery system change.

Provider entities, such as hospitals, have been reluctant to openly discuss some aspects of delivery system change out of a concern that they may violate federal anti-trust laws.

Strategy: Seek opportunities for Oregon to influence the national health reform debate. Oregon's reputation as a health care innovator offers opportunities for state leaders to participate in the national health reform debate.

ACTION STEPS:

1. Provide Legislative authorization for the Authority to pursue change at the federal level. The Legislature authorizes the Authority to advocate at the federal level for the recommendations developed by the Federal Laws Committee.

2. Develop a strategy to advocate for equitable Medicare reimbursement and rate reform. The Authority develops a concentrated, strategic approach to pursue Medicare rate reform in Congress. Possible approaches could include: directing state representatives in Washington, D.C. to advocate for rate reform; partnering with other states suffering under low reimbursement rates; and working with Oregon's Congressional delegates to sponsor legislation to more equitably align Medicare reimbursement across the country.

3. Investigate expanding the number of FQHCs and FQHC "look-alikes" in the state. The Authority evaluates whether Oregon can add new FQHCs and FQHC "look-alikes" to bring additional federal funding to Oregon's delivery system. Additional federal participation in Community Health Center funding would provide short-term assistance to alleviate some of strain on Oregon due to its low Medicare and Medicaid reimbursement.

4. Investigate barriers to open dialogue among provider organizations about delivery system change. The Authority examines anti-trust laws to identify barriers to provider involvement in delivery system change and recommend solutions.

5. Advocate for federal change to remove other barriers to reform. The Authority, in collaboration with other agencies in the executive branch, seeks opportunities within the federal health care reform debate to advance Oregon's health care priorities.

4. Advocate for state-level changes recommended by the Federal Laws Committee. The Federal Laws Committee identified several areas for action at the state level to address barriers to the goals of SB 329. The Authority advocates for the following:

- The expansion of Medicare Advantage HMO and PPO plans into all areas of the state.
- An examination of EMTALA implementation issues related to inter-hospital transfers based on the availability of appropriately trained physicians.
- Education of providers on HIPAA provisions that allow treating providers to exchange patient information without consent.
- Honoring the federal trust relationship with Tribes when undertaking health reform.

BUILDING BLOCK 8: OREGON HEALTH AUTHORITY

Objective: Establish a single entity within state government that is responsible to the Governor, Legislature and the citizens of Oregon for the performance of Oregon's health care system with respect to access, cost, quality, and value.

Strategy: Create an Oregon Health Authority.

The Oregon Health Authority will have broad accountability for oversight of Oregon's health care system and explicit authority in select areas to develop and implement policies that will achieve the goals outlined in SB 329.

Oregon has a long history of citizen boards, commissions and task forces in the area of health care policy. In most cases they have been charged with specific, focused duties, usually advisory. SB 329 created the Oregon Health Fund Board and assigned it one task: develop a comprehensive plan for health care reform in Oregon for consideration by the Governor and Legislature in 2009. In the absence of legislative action in 2009, the Board and The Healthy Oregon Act will sunset on January 2, 2010.

To successfully implement the recommendations of this Action Plan and to further develop the changes beyond 2009- 2011, there must be an entity within state government with broad powers of accountability. The Board recommends, building from the framework and experience of the Oregon Health Policy Commission (see ORS 442.035), **establishing an Oregon Health Authority which would replace the Health Policy Commission and the Oregon Health Fund Board.** The composition, duties and authorities, and administrative support structure are summarized below.

ACTION STEP:

1. The 2009 Oregon Legislative Assembly adopts legislation creating an Oregon Health Authority with the necessary accountabilities, authorities and resources to oversee the implementation of the comprehensive plan developed by the Oregon Health Fund Board.

Statutory Duties of the Authority:

1. Act as the policy-making and governing body for a health care data collection program established within the Department of Human Services or among state agencies as appropriate for the acquisition, compilation and analysis and public reporting of data from health care providers, other state and local agencies including the state Medicaid program, third-party payers and other appropriate sources.

2. Develop strategic policy and business plans and legislative proposals for implementing the OHFB's comprehensive plan from 2009 to 2015.

3. Act as the policy-making and oversight body for the following divisions of the Department of Human Services responsible for Oregon Health Plan (physical, behavioral and oral health) and Oregon's public health programs and activities:

   A. Division of Medical Assistance Programs (DMAP)
   B. Addictions & Mental Health Division (AMHD)
   C. Public Health Division (PHD)

4. Act as the policy-making and oversight body for the Office of Private Health Partnerships (OPHP) responsible for the Family Health Insurance Assistance Program (FHIAP).

5. Establish policies, standards, and performance criteria for health care contracts administered by DMAP, AMHD, and OPHP. Develop goals, baseline performance measures and policies and programs that eliminate health inequities associated with gender, race, ethnicity, and socioeconomic status. Receive routine reports from managing agencies on contractor performance, trends, member satisfaction, and related issues.

6. Collaborate with Public Employees' Benefit Board (PEBB) and the Oregon Educators Benefit Board (OEBB) to achieve optimal policy coordination among state agencies that purchase health care benefits.

7. Develop and oversee a public employer health coalition that includes leadership from PEBB, OEBB, cities, counties, other local government entities and the associations of such entities to work cooperatively to obtain increased value from local and regional provider systems. The Authority will be authorized to undertake cooperative/joint contracting for health care services on behalf of public entities that elect to participate. The public employer health coalition will collaborate with the Oregon Coalition of Health Care Purchasers and other similar organizations to improve the quality, cost effectiveness and value from local and regional provider systems.

8. Convene a Payment Reform Council to investigate opportunities in both public and private sector programs to develop and implement new methodologies of provider reimbursement that reward comprehensive management of diseases, quality outcomes and efficient use of resource inputs.

9. Act as the policy-making body responsible for the development, adoption and continuous refinement of uniform, statewide health care quality standards (metrics) that will be used by all purchasers, third-party payers and providers as the quality performance benchmarks in Oregon. The Authority will achieve this objective through the Quality Institute of Oregon.

10. Act as the policy-making body for the development of clinical standards and guidelines for use by providers and insurers. The Authority will achieve this objective through the Health Services Commission (HSC) and the Health Resources Commission (HSC). The initial work should focus on clinical services with unexplained variation in utilization, services that are deemed to be "supply sensitive," new technologies for which comparative effectiveness evaluations hold promise for more appropriate use of the technology. The activities and work products developed through this process will be subject to state action protection defense against claims of anti-trust.

11. Act as the policy-making and oversight body of the activities of the Public Health Division. In this capacity, the Authority will authorize and guide development of Community-Centered Health Initiatives designed to address critical behavioral risk factors, especially those that contribute to chronic disease. In consultation with the Public Health Division, the Authority will establish a set of public health goals, strategies, programs and performance standards to improve the health of all Oregonians. The Authority will monitor the investments and activities designed to achieve such goals, report regularly to the Legislature and public on accomplishments and direct changes in policy and strategy where necessary.

12. Be responsible for the development and implementation of a first-generation Oregon Health Insurance Exchange (OHIE) to serve the individual health insurance market. The Authority will

consult and work closely with the Department of Consumer & Business Services, Insurance Division in designing, implementing and governing OHIE to assure minimum disruption to Oregonians participating in the individual health insurance market.

13. Serve as the state entity accountable for the development of Oregon's Health Care Workforce strategy. Activities will include collection of data from responsible licensing boards and commissions, determine of long-term needs in Oregon based on provider and population demographics and projected capacity of Oregon educational and training institutions to meet those needs, and develop recommendations to recruit, train and retain qualified individuals into the health care professions. An important aspect of this work will be to promote a wide understanding of a 21st Century health care workforce in light of emerging new models of care.

14. Collaborate with the Governor's Health Information Infrastructure Advisory Committee to assure that Oregon is a national leader in the adoption and interoperability of electronic health records.

15. In close coordination with the Executive and Legislative branches, work with Oregon's Congressional delegation to advance adoption of, or changes in, federal policy that will promote Oregon's health reform plans.

16. Brief the Governor and legislative leadership on the performance of Oregon's health care system relative to the goals established by the Authority. Propose changes to or new statutory initiatives as necessary and appropriate to achieve the goals of SB 329.

17. The Authority may promulgate administrative rules to carry out its statutory powers.

18. Carry out other duties delegated by statute or upon the request of the Governor.

<u>Membership & Organization of the Authority:</u>

There are two alternative models for the Authority: 1) a public utility commission framework with a limited number of full-time, paid members; or 2) a citizen board model comprised of volunteer, part-time members who receive only expense reimbursements typical of many boards and commissions. This model includes a strong executive manager.

The Board believes there are advantages and disadvantages to either organizational model and defers to the Legislature on which model is best for the duties outlined in this report.

Certain characteristics are applicable, however, in either model:

1. The members are nominated by the Governor and confirmed by the Oregon Senate.

2. The size of the Authority should be large enough to provide for diverse representation, but small enough to get the work done efficiently (e.g., 9 to 11 members).

3. A majority of the members should not be gainfully employed in health care delivery or finance (similar to the Oregon Health Fund Board).

4. Members should have demonstrated leadership skills in their professional and civic lives.

5. Terms of office should be established statutorily, on a staggered basis, with a maximum limit of years of service.

6. The Authority should be authorized to adopt bylaws relating to officers, meeting policies and related operational procedures.

7. The Office for Oregon Health Policy & Research (OHPR) serves as the administrative agency supporting the activities and operation of the Authority.

8. The Authority will meet regularly with a minimum number of annual meetings provided for in statute. Based on available funding, the Authority should meet in each of Oregon's five congressional districts at least once every 2 years.

9. The Authority may establish subcommittees of its members and may appoint advisory and technical committees to assist it in carrying out its statutory duties.

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