Oregon Health Fund Board

Aim High: Building a Healthy Oregon

Final Report

November 2008

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EXECUTIVE SUMMARY

The Oregon Health Fund Board

In June 2007, the Oregon Legislature passed the Healthy Oregon Act,[1] 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, **"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 health care professionals who commented on the work as it progressed.

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; and
- Reasonable per capita costs shared in an equitable way by the entire population.

[1] Senate Bill 329, Chapter 697 OR Laws 2007.

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

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

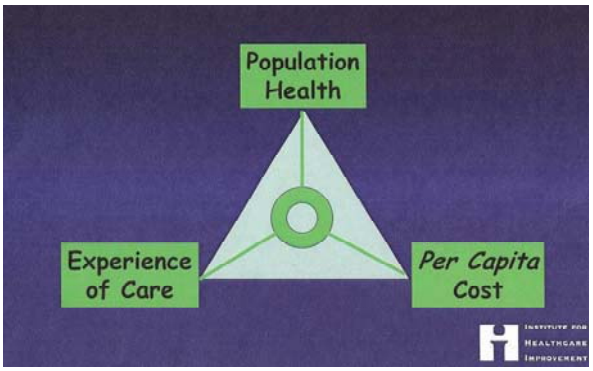
It is clear to your Board that Oregonians cannot simply put more good money into a broken system and expect that it will work. It is also clear to us that Oregon has the creative spirit, the scientific talent, and the leadership to become a world leader in health and health care. Setting this as a goal 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 work together. It will take creative thinking and shared effort of 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.[2] 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 Healthcare 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] "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.

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) 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.

4) Stimulate System Innovation & Improvement. Insisting on *new models of care* including prioritizing prevention, management of chronic disease, shared decision making at end-of-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.

5) 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.

6) 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*.

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, an essential benefit package and other strategies designed to achieve 100% access to healthcare for all Oregonians.

Once cost containment and system improvement strategies are in place to reduce health care costs and increase its quality, the state will begin implementing a requirement that all Oregonians have health insurance coverage and transition the state's individual health insurance market to a guaranteed-issue market in which no one can be denied coverage because of a pre-existing medical condition.

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 market exchange. It is our recommendation that all plans within the individual market 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. [3]

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.

[3] Your Board recognizes that any future alternative financing system must ensure both that costs are not shifted from employers to employees, and 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 seven citizens to a new Oregon Health Fund Board ("Board"). This Board was tasked with developing a comprehensive plan to ensure access to health care for all Oregonians, contain health care costs, and improve health care quality.

The Board's comprehensive action plan, *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 listed in SB 329 into the following four goals:

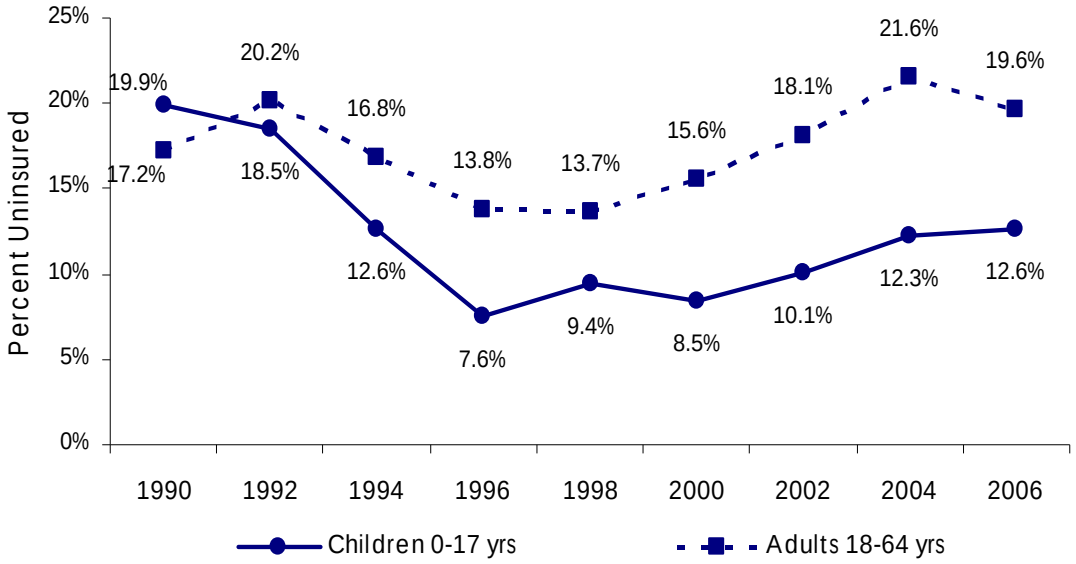
- Expand coverage to Oregon's uninsured populations;
- Contain the annual increases in health costs in Oregon;
- Continuously improve quality, safety, efficiency and patient satisfaction in Oregon's health care systems; and
- Improve the health of ALL Oregonians.

The Board heard from some Oregonians that the only way to achieve these goals is through a single-payer system. While the Board appreciates this input, the members do not believe that it is possible for a state to create a single-payer system at this time. The federal government constrains states' actions in this respect though the law known as the Employee Retirement and Income Security Act (ERISA). The Board members agree that this may be a potential solution to problems of the national health system, but that it is unlikely to be successful at the state level.

Symptoms of the Problem

- **Over a half-million Oregonians do not have access to health care.**

Percent Uninsured in Oregon, 1990-2006[4]



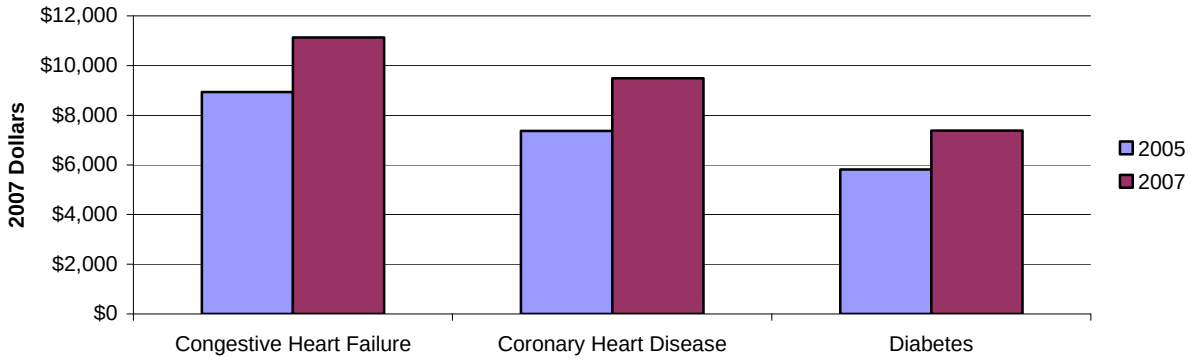
One in six Oregonians are without health insurance coverage—this represents about 576,000 individuals of all ages, and about 116,000 are children under the age of 19.[5] More than 71,000 may be eligible for the Oregon Health Plan (Medicaid) or the State Child Insurance Program (SCHIP), but are not enrolled. 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 at least 25% for three chronic conditions.

[4] Oregon Population Survey, 1990-2006.
[5] Oregon Population Survey 2006, Analysis performed by the Office for Oregon Health Policy & Research.

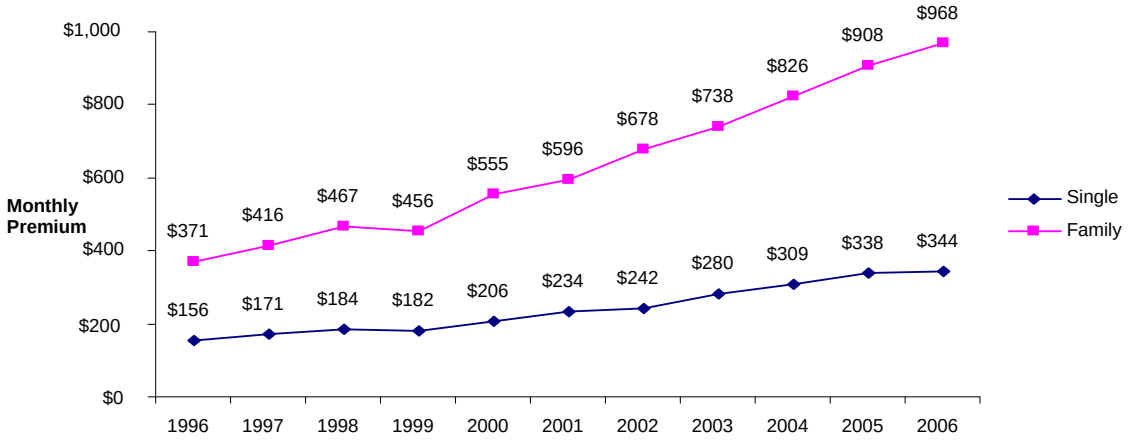
Increases in average Oregon hospital costs for commercial payers for select inpatient chronic disease care*, 2005-2007



Source: Office for Oregon Health Policy & Research[6]
*Includes all 3M APR-DRG risk categories

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]

Oregon average monthly premiums for private sector employee, 1996-2006



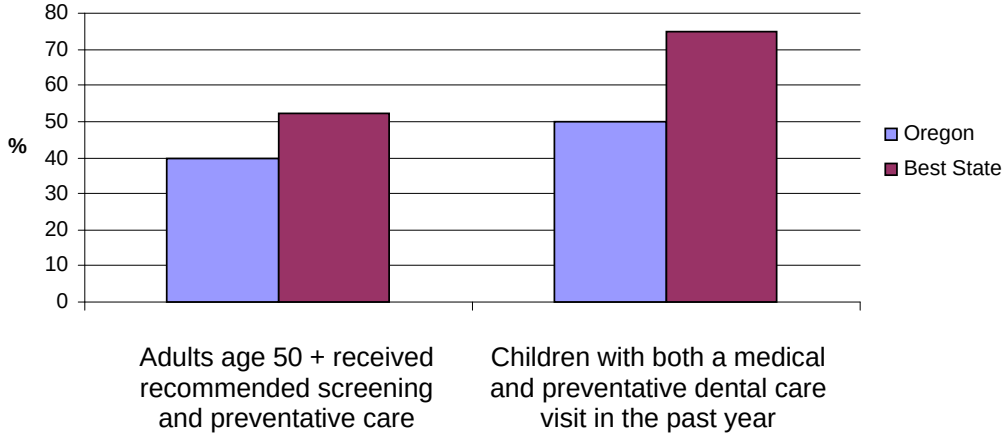
Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 1997-2008

[6] Office for Oregon Health Policy and Research. (2008, August). Compare Hospital Costs. Available: http://www.oregon.gov/OHPPR/RSCH/comparehospitalcosts.shtml. CHF=APR-DRG 194, CHD=APR-DRG 198, Diabetes=APR-DRG 420
[7] Regional Economic Information System, Bureau of Economic Analysis, U.S. Department of Commerce. (2008, September). Available: 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**

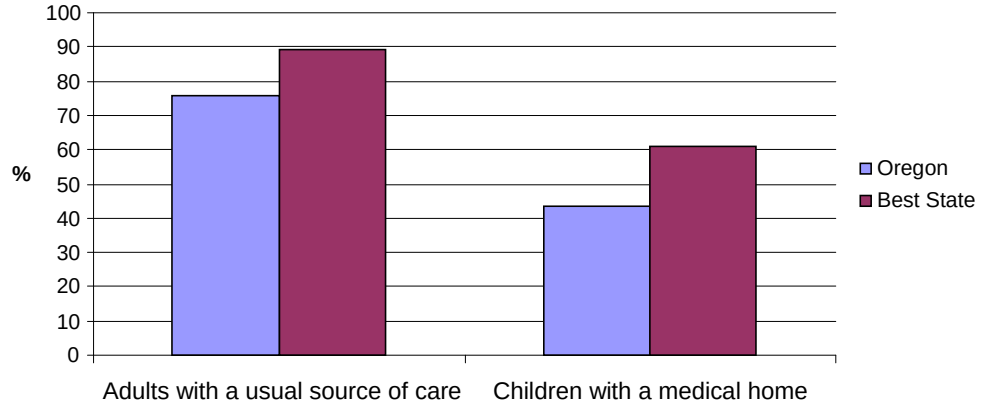
According to the Commonwealth Fund State Scorecard, Oregon ranks 36th nationally in the quality of care the health care system delivers and 42nd for quality of care provided to children.[9]

Oregon ranks low in preventive care for older adults (24th) and children (40th)



Source: Commonwealth Fund State Scorecard. 2007
http://www.commonwealthfund.org/statescorecard/statescorecard_show.htm?doc_id=496095

Oregon ranks in the bottom half of states for adults (40th) and children (36th) having a usual source of primary care



Source: Commonwealth Fund State Scorecard. 2007
http://www.commonwealthfund.org/statescorecard/statescorecard_show.htm?doc_id=496095

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

[9] Cantor, J. C., Schoen, C., Belloff, D., How, S. K. H., & McCarthy, D. (2007, June). Aiming Higher: Results from a State Scorecard on Health System Performance, *The Commonwealth Fund Commission on a High Performance Health System*.

100% access, that would include establishing a requirement for all Oregonians to have health insurance and getting rid of medical underwriting so that no one could be denied coverage because of a pre-existing medical condition. 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. All of these actions are part of a comprehensive health system reform plan. To pick and choose actions would diminish the strength of the plan as a whole and hinder its ability to effect system-wide, lasting transformation.

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 input was collected in September. After considering the public's input and any final revisions, the Action Plan was completed in October and sent to the Governor and legislative leadership in November.

For an implementation timeline of the proposed activities outlined in this report, please see the graphic on the following page.

Building Block Timelines

	Health Care Reform Strategy	2009	2010	2011	2012	2013	2014
Keystone for Reform							
Oregon Health Authority	Act as an integrator of health care and community services, a smart purchaser, and an instigator of community-based innovation.						
Building Blocks							
Bring Everyone Under the Tent	Expand coverage for all children and low-income adults.						
	Expand coverage for all Oregonians.						
Set High Standards	Establish an all payer, all claims data collection program.						
	Establish an Oregon Quality Institute.						
Unify Purchasing Power	Create a Public Employers Health Cooperative.						
	Establish a health insurance exchange.						
	Implement regulatory actions to contain health care costs.						
Stimulate System Innovation & Improvement	Implement the integrated health homes.						
	Integrate behavioral health services with physical health services.						
	Establish a Payment Reform Council.						
	Provide high quality and dignified end-of-life care to all Oregonians.						
	Establish programs to promote community based innovation.						
	Expand public health throughout Oregon.						
	Establish a Medical Liability Reform Council.						
	Promote the adoption of health information technology throughout Oregon.						
Ensure Health Equity for All	Prevent health disparities before they occur, reduce barriers to care, and improve quality of care.						
Train a New Health Care Workforce	Ensure Oregon's health care workforce is sufficient.						
Advocate for Federal Change	Align federal policy with Oregon's reform efforts.						

NOTE: See Appendix D for more details on each building block's timeline.

BENDING THE COST CURVE IN OREGON
COST CONTAINMENT RECOMMENDATIONS

With health care costs rising unsustainably in Oregon, the Health Fund Board has taken seriously the goal of reducing costs while maintaining quality. There is evidence to suggest that implementing the following ambitious cost containment strategies could yield up to $10 billion in savings in ten years, or 3.6% of aggregate spending over the same period of time (See Appendix C). Many other countries experience lower health care costs per person than the United States while having better health care outcomes. Containing costs is possible, but requires political courage, deep commitment from our leaders, and cooperation from all stakeholders. Maintaining a focus on the "triple aim" of improving population health, controlling inflation of per capita costs, and improving the patient and provider experience of care, the Board has outlined many actions that will enable the state to reach this cost savings goal.

The actions can be divided into two categories: direct cost containment actions and actions to establish the foundational delivery system infrastructure that is required for a strategic, coordinated cost containment effort. Some of the cost containment actions could potentially yield savings in two to three years. Others lay the groundwork to leverage cost savings in the future. The foundational infrastructure actions may not immediately produce direct, measurable savings, but they are critical components of the broader, sustainable cost containment strategy.

In addition to addressing the dollar costs associated with the health care system, the Board's policies are also aimed at reducing human costs, which include loss, sacrifice, suffering, and human effort; however the following estimates are focused on dollar cost savings.

Direct Cost Containment Actions

- **Continue to Develop and Implement Evidence-Based Guidelines and Best Practice Clinical Standards:** Providers should have the best available evidence to care for their patients. Based on accepted research on clinical effectiveness, the state, through the use of expert organizations, should expand its role in developing and endorsing evidence-based guidelines for the use of new and existing technologies and treatments. Where the evidence does not yet exist, the state should expand its role in identifying best clinical practices widely accepted and followed in the field, while encouraging and supporting further research to confirm these standards. Uniform implementation of these guidelines and clinical standards will reduce unexplained variation in utilization among providers, reduce unnecessary care, and improve the quality and value of care delivered. Guidelines will be used to design evidence-based benefit packages. An added benefit of establishing these guidelines is the potential reduction in defensive medicine.

    - Policy Action: The Legislature empowers the Authority to endorse and/or develop clinical quality measures, health outcomes targets, clinical guidelines where evidence-exists and best practices where evidence is still being developed. With oversight and direction from the Health Authority, the Health Resources Commission (HRC) and the Health Services Commission (HSC) expand their capacity to develop evidence-based guidelines based on the best available evidence for the use of medical technology and pharmaceuticals and best practice clinical standards. The Legislature increases the budgets of the HRC and HSC to meet these needs. The Authority creates a database of all claims from all payers across the state. This will allow the

Authority to monitor providers, purchasers and policymakers to determine if evidence-based guidelines and best practice clinical standards are being followed and if they are affecting cost and quality. This, and other proposed cost containment policy actions, will not be successful without a statewide all-payer, all-claims data collection program (See All-Payer, All-Claims Data Collection Program on Page 20).

- Implementation Strategy: The Authority approves, publishes, and disseminates evidence-based guidelines and best practice clinical standards. The Authority requires health plans contracting with the state to utilize guidelines and best practices and to adhere to uniform contracting standards, with processes and procedures for justifying care that does not meet evidence-based guidelines or best practice clinical standards. This policy will have the most power to improve quality of care and reduce costs if all purchasers and health plans, both private and public, utilize uniform evidence-based guidelines and best practice clinical standards.
- See pages 44-48 for more details.

- **Reduce the Growth in Administrative Spending by Health Insurance Plans:**
  - Policy Action: The Insurance Division must report to the Authority on an annual basis the average administrative per-member-per-month rate for the individual and small-group health insurance markets. In addition, the Insurance Division will report total premiums earned, average per-member-per-month administrative rates, and percent growth in administration as a percent of premiums by company for the dominant insurers in Oregon.
  - Implementation Strategy: The Authority sets benchmarks for the maximum allowed increase in administrative spending on a per-member-per-month basis for health insurers. The Legislature authorizes the Insurance Division to review the administrative expenses of health insurers for individual and small group lines of business and reject increases in administrative expenses that are determined by the Insurance Division to be unjustified or excessive. After two years, the Authority evaluates whether new regulation is needed to hold administrative spending to targets.
  - See pages 62-63 for more details.

- **Reduce Spending on Health Care Administrative Transactions:**
  - Policy Action: The Legislature requires the Insurance Division to convene a work group to develop uniform forms and processes for administrative transactions. The Insurance Division is authorized to require licensed health plans to utilize such forms and processes.
  - Implementation Strategy: Applies broadly to Oregon's insured market.
  - See pages 49-50 for more details.

- **Primary Care, Prevention, and Chronic Disease Management:** Enroll Oregon Health Plan beneficiaries with chronic and/or comorbid conditions in designated integrated health homes and require case management payments. Integrated health homes improve care coordination and service integration, which can reduce duplicative tests and services and avoid costly hospitalizations through better disease management.

- Policy Action: The Legislature authorizes the Health Authority to direct the Department of Human Services to modify its contracts with managed care organizations and providers to ensure that all OHP beneficiaries with chronic and/or comorbid conditions have integrated health homes. The Legislature appropriates sufficient funds to DHS to allow for case management payments to integrated health homes.
- Implementation Strategy: Health Authority directs state programs (PEBB, OEBB) and other public employers to implement integrated health homes in their contracting and benefit design. The Authority will encourage private purchasers to implement integrated health homes.
- See pages 66-69 for more details.

- **Reduce Pharmaceutical Spending:** Expand the use of the Oregon Prescription Drug Program in state-sponsored health programs to take advantage of group purchasing discounts.
  - Policy Action: The Legislature authorizes the Health Authority to direct state-sponsored health programs (PEBB, OEBB, OHP) to use their contracting authority to require health plans to provide pharmacy benefits through the Oregon Prescription Drug Program (OPDP), unless they can demonstrate greater savings through an alternate arrangement.
  - Implementation Strategy: Based upon legislative action, other public employers could be required to use OPDP as the benchmark pharmacy benefits program unless alternative arrangements demonstrate greater savings. The Authority will encourage private sector purchasers to evaluate OPDP as an alternative pharmacy benefit program.
  - See pages 53-56 for more details.

- **Long-Term Prevention and Population Health:** Reduce the burden of chronic disease and improve individual and community health. This will reduce the need for expensive, invasive treatment in the future. Support community stakeholder collaboratives to develop and implement evidence-driven prevention initiatives that improve the quality and cost of delivery. The goal is to support community innovation for controlling costs and increasing the quality and outcome of care throughout the community. This can be achieved by enabling health care providers, consumers and payers to work collaboratively to continuously improve the delivery system, patient experience and public health. This action can also help reduce inequities resulting from health disparities.
  - Policy Action: Pursuant to legislative action, the Health Authority provides grants to communities for evidence-based public health initiatives and invests in tobacco cessation, obesity prevention, and wellness.
  - Implementation Strategy: The Authority directs the Public Health Division in the development, award, and monitoring of community grants.
  - See pages 82-86 for more details.

- **Institute Common Contracts:** Combine the purchasing powers of state-sponsored health plans to drive down rates, reduce waste, and improve quality. These contracts would include elements such as discounted group purchasing, integrated health homes, the use of evidence-based clinical guidelines and comparative effectiveness research to design benefit packages, utilization of health information technology, and the use of OPDP. A Public Employers Health Cooperative, including state agencies, counties, cities, and other local governments will facilitate the creation and utilization of common contract standards.
    - Policy Action: Pursuant to legislative action, the Authority develops and directs agencies to adopt policies for state-sponsored health programs (PEBB, OEBB, OHP) relating to uniform contracting standards. In addition, the Authority is authorized to organize a Public Employers Health Cooperative to encourage local and county governments to adopt similar uniform contracting standards in their health benefits contracts.
    - Implementation Strategy: The Authority establishes benchmarks for uniform contracting standards initially within state-sponsored health programs and works with other public employers through the Cooperative to adopt such standards on a voluntary basis. The Authority also collaborates with private purchasers through the Oregon Coalition of Health Care Purchasers to encourage adoption by the private sector.
    - See pages 53-56 for more details.

- **Facilitate Statewide Use of Health Information Technology:** Reduce errors and duplication, save time, and increase the use of evidence-based medicine by helping providers and patients utilize health information technology. This will ensure that patient information is available at the right time and the right place to reduce medical errors, improve the quality of care and reduce costs.
    - Policy Action: The Legislature authorizes the Authority to accelerate the adoption and use of fully deployed electronic health records by endorsing a set of high quality electronic health record vendors and service vendors and leveraging group purchasing power to negotiate reduced prices for these products. The Authority provides subsidies for the purchase and maintenance of these products to small, primary care, and rural providers. The Authority also develops and implements a strategic plan for creating a statewide system of health information exchange. Payment policies are updated to encourage providers to adopt and utilize health information technologies.
    - Implementation Strategy: The Authority utilizes the Governor's Health Information Infrastructure Advisory Committee (HIIAC) or another technical advisory group for developing policy recommendations that are implemented and monitored by the Authority and its staff.
    - See page 90-98 for more details.

See Appendix C for estimated potential cost savings from these strategies and suggested 2009-2011 investments.

Infrastructure Required for a Strategic, Coordinated Cost Containment Effort

- **Oregon Health Authority:** Consolidate current state agencies and commissions into the Oregon Health Authority. The Authority will be responsible to the Governor and the Legislature, and thereby accountable to the citizens of Oregon. The Health Authority would coordinate efforts across the state to implement cost containment initiatives. The Authority will be a state-wide "integrator" that is accountable for improving population health, controlling the per person cost of health care and ensuring the implementation of delivery system changes to improve patients' experience of care. Empowering a single entity so that it is accountable on all three fronts will help to prevent costs being saved in one area only to be increased in another. See pages 23-28 for more details.

- **All-Payer, All-Claims Data Collection Program:** Develop a statewide, all-payer, call-claims data base of all claims paid by all payers across the state. The data base will provide a more complete picture of the patient experience with the health care system. We know that health care quality varies across the state and that patients sometimes receive unnecessary or inadequate care, but it is currently not possible to identify where these unexplained variations in Oregon's health care system exist. Without more information on how and where money is spent in the system and how patients move through the system, the state will not have the tools to recoup the savings outlined above. Without comprehensive data about the quality and cost of health care, the state cannot determine if it is succeeding in reducing the cost of health care and improving quality of care and the health of the population. This data show variation in care on a state-wide basis and could be aggregated by accountable care community to show variations across communities, counties, regions, or other groupings. See pages 41-43 for more details.

BENEFITS OF AN ALL-PAYER, ALL-CLAIMS DATA COLLECTION PROGRAM

Businesses:
- Helps businesses to know where they stand with respect to their coverage's costs and included services.
- Provides access to information that gives businesses a better negotiating position.
- Allows businesses to choose insurance products for employees based on price and quality.

Consumers:
- Provides consumers with access to information to help them make informed decisions with their health care providers about which providers and treatments are most effective and efficient.

Providers:
- Supports provider efforts to design targeted quality improvement initiatives.
- Enables providers to compare their own performance with those of their peers.

Policymakers (led by the Health Authority):
- Enables the Authority to identify communities that provide cost-effective care and learn from their successes.
- Allows for targeted population health initiatives
- Allows reform efforts to be evaluated so that successful initiatives can be identified and replicated.
- Allows for the identification of opportunities for further reform.

- **Quality Institute:** Align stakeholders around a common vision and strategy for quality improvement by establishing a Quality Institute. The Quality Institute will set quality standards and lead and coordinate statewide quality improvement strategies. This includes giving consumers and purchasers of health care the tools they need to compare the cost and quality of health care services provided across the health care system. Information will also

be made available at the community level to assist communities in designing health programs that maximize impact on population health. See pages 45-48 for more details.

- **Community Collaboration:** Create and support statewide and local stakeholder collaboration on cost containment strategies and share best practices related to system transformations that improve care and contain costs. Collaboration can facilitate rapid transfer of information, data, and best practices.

  In particular, this includes:

  1. **Integrated Health Home Collaborative:** Create an Integrated Health Home Collaborative to share best practices on integrated health home models. See pages 67-69 for more details.
  2. **Community-Based Collaboratives:** Support community based collaboratives through grants. Community planning collaboratives link communities to public health and medical care services, identify and target specific community needs, and develop and implement community-driven innovation. They act as "learning laboratories" for the transformative change called for in this Action Plan. See pages 77-79 for more details.
  3. **Public Health Community Collaboration**: Support through grants, community processes to identify public health needs and design and implement public health initiatives aligned with statewide goals. See pages 82-86 for more details.

- **Health Insurance Exchange:** A health insurance exchange would initially consolidate the individual market in an effort to standardize and streamline administration, promote transparency for consumers, improve quality, and stem cost increases for individual insurance purchasers. Cost savings from the establishment of an exchange are difficult to determine, but the value of this mechanism for individual health insurance consumers is clear. It is also a key infrastructure piece for coordinating premium assistance that will be needed to expand coverage to low and middle income Oregonians in the future. See pages 57-59 for more details.

  - **Public Plan:** A publicly-owned health plan option offered through an exchange would provide consumers with the choice of a non-commercial, publicly-accountable plan that meets set standards, such as the Essential Benefits Package. A public plan could improve care for enrollees, while decreasing costs for both consumers and the state through lower administrative expenses and improved purchasing efforts. The exact magnitude of the savings is difficult to determine, but one recent study showed that administrative costs in a public plan could be as much as 23% less than in private sector plans.[10] See pages 60-61 for more details.

- **Financial Reporting:** Increase transparency by ensuring comprehensive financial reporting by insurers and health facilities. This will allow communities to weigh the benefits of certain health facility investments against other priorities and guard against costly unwanted capital improvements. See pages 42-43 for more details.

[10] The Lewin Group. (2008, February 15). Cost Impact Analysis for the "Health Care for America" Proposal. Prepared for the Economic Policy Institute.

- **Payment Reform**: Establishes a Payment Reform Council to modify the payment system to reward cost-effective providers who are able to deliver high-quality, high-value care. Payment reform can be used to encourage the types of cost-effective practices that will improve population health and reduce spending over time, as increased payment for primary care, prevention and chronic care management. The Payment Reform Council will study, evaluate and develop recommendations concerning new payment methodologies under consideration at the national level including, but not limited to, bundled payments, gainsharing, pay-for-performance and capitation. The payment system could also be altered to set maximum annual increases in health care provider prices. See pages 73-74 for more details.
- **Workforce Strategy:** Establish a strategy for attaining the training, recruitment, and retention of health care providers in all regions of Oregon. Cost containment strategies cannot be effective without an appropriate workforce trained to provide care in a transformed system. See pages 105-109 or more details.
- **Medical Liability Reform:** Reform the medical liability system to reduce waste in the system created by physicians practicing defensive medicine for fear of litigation. See pages 87-89 for more details.
- **Coverage Expansion:** Expanding coverage to low-income adults and children will require a long-term state investment; however, it will reduce uncompensated care and will lead to more Oregonians having access to primary and preventive care. Access to these types of care will reduce the need for uninsured individuals to receive costly care in the emergency room and will likely save the system money in the long-term. It will also reduce the cost-shift to private payers, which some believe will reduce premiums, and bring additional federal dollars into the state. See pages 30-39 for more details.

See Table 3 in Appendix C for suggested 2009-2011 investments in these infrastructure needed for a strategic, coordinate cost containment effort.

KEYSTONE FOR REFORM: OREGON HEALTH AUTHORITY
ACCOUNTABILITY AT THE STATE AND COMMUNITY LEVELS

The Oregon health care system mirrors our national health system in its fragmentation. This fragmentation has created a system that is inefficient, unresponsive to individual and population health needs, and slow to change.

At the state level, there are a multitude of agencies, commissions, and other entities responsible for shaping the state's health policy, purchasing health care services, and training Oregon's health care workforce. But these activities are not coordinated even though the state pays approximately 20% of the aggregate cost of health care in Oregon.

As taxpayers, as well as proponents of health care reform, the Board believes that the current state organizational approach is not cost-effective or accountable to the people of Oregon.

In order to achieve any meaningful health care reform, much less world-class health for all, Oregon must coordinate its patchwork system of purchasing and delivering health care, community services, and workforce training.

If Oregon is going to be a leader in health system transformation, the state needs a bold group to lead the charge. The Board recommends the creation of an Oregon Health Authority to do just that.

The Authority would not be yet one more state agency, but would consolidate and expand on the existing statutory powers of both this Board and the Oregon Health Policy Commission.[11] The Authority is needed to coordinate the activities of all state agencies responsible for health care purchasing and delivery. By consolidating and reorganizing current state agencies and commissions, the Authority would be the single entity within state government that is responsible to the Governor and the Legislature. Through a strong citizen Board and by creating forums for public discussion of health policy issues, the Authority will be accountable to the people of Oregon. The Authority would also collaborate and coordinate with private stakeholders to develop and implement a unified statewide health care strategy that addresses performance in respect to access, cost, quality, and value.

In particular, an Authority is needed to develop and carry out policies that will make the state a **smart purchaser**, an **integrator** of health care and community services, and an **instigator** of community-based innovation.

To facilitate *smart purchasing* the Authority will:

- Align contracts for all state purchased health care to ensure that resources are spent wisely to buy the care Oregonians want and need.
- Ensure that data and information are available to purchasers that allow them to make purchasing decisions based on performance and value.

[11] In the absence of legislative action, The Healthy Oregon Act and the Oregon Health Fund Board will sunset on January 2, 2010.

To facilitate *the integration of health care and community services* the Authority will:

- Support the development and reimbursement of new models of care that integrate physical, behavioral, and oral health as well as other social services.

To *instigate community-based innovation* the Authority will:

- Set ambitious statewide public health goals that can drive change at the local level.
- Provide communities with the resources they need to act. This includes information and data that can help communities identify their biggest health problems and develop initiatives to improve care and use resources more efficiently.

Oregonians need a common vision for health and health care. We need a shared sense of the total resources available in the system and agreement on the priorities where those resources should be focused. We must learn to live within reasonable budgets for health care, in order to maintain a competitive economic place in the world and to preserve funds for other important needs, such as education, economic development, and public safety. The Authority will have a major role in developing a new shared vision.

The Authority will play a major role as a collaborator with local communities and the private sector. All health care purchasers and providers must be aligned around efforts to restructure payment systems to encourage the type of care that will bring us closer to our goal of a healthier population. Incentives in the system must support providers in developing efficient ways to deliver care that maximizes patient health. Communities must be encouraged to develop innovative programs to improve population health that are aligned with the overall system goals.

Governance and Structure

This Authority must be truly accountable to the people of Oregon and is thus envisioned as a citizen board. The group will be advised by industry and technical experts, but the decision-making power will lie in the hands of citizens whose livelihoods are not tied to the health care system. This will allow the Authority to hold the industry accountable for the way it uses resources and ensure that the decisions made reflect the best interest of Oregonians and their health.

This is not a new idea, as Oregon has a strong history of creating citizen boards to drive policy in other areas. The Oregon Transportation Commission was created to establish state transportation policy and to see that the policies are implemented by state and local executive agencies. The Port of Portland Commission, a State agency, sets maritime, shipping, aviation, commercial and industrial policy for the state's major transportation and industrial hub.

The Board recommends that the following structure for the new Health Authority:

- The members are nominated by the Governor and confirmed by the Oregon Senate.
- 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).
- A majority of the members should not be gainfully employed in health care delivery or finance (similar to the Oregon Health Fund Board).
- Members should have demonstrated leadership skills in their professional and civic lives.

- Terms of office should be established statutorily, on a staggered basis, with a maximum limit of years of service.
- The Authority should be authorized to adopt bylaws relating to officers, meeting policies and related operational procedures.
- The Office for Oregon Health Policy & Research (OHPR) serves as the administrative agency supporting the activities and operation of the Authority.
- 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.
- The Authority may establish subcommittees of its members and may appoint advisory and technical committees to assist it in carrying out its statutory duties. These subcommittees should include, but not be limited to:
    - The Public's Health
    - Public Employers' Health Coalition
    - Payment Reform Council
    - Health Care Workforce Council
    - Medical Liability Reform Council
    - Oregon Quality Institute
    - Health Information Technology Oversight Council

Powers of the Authority

The Oregon Transportation Commission and the Port of Portland Commission are not just advisory, but actually have the ability to establish and enforce state policy and drive change in areas where the Legislature has delegated authority to them. These commissions use the state's contracting power to drive much of the policy they control. In the same respect, the Oregon Health Authority will need to have actual authority and substantial delegated power to develop, implement, and enforce health policy for the state, to oversee all aspects of health reform, and to implement health care purchasing and other state policies by contract and contract standards.

Duties and Responsibilities of the Authority

The Health Fund Board has developed seven building blocks for reform. The Health Authority will implement these building blocks. The Authority is the keystone needed to hold the building blocks together and oversee the implementation of comprehensive reform. The Authority will be charged with facilitating the change prescribed by each individual building block, as well as aligning efforts with the private sector and the federal government to create meaningful transformation that simultaneously addresses all of the components of the "Triple Aim": population health, individual experience, and cost per capita. In leading this charge, the Authority will focus on continuous quality improvement as a core value in implementing health care reform.

Over time, the Authority will have to develop strategic policy plans and legislative proposals for implementing the Oregon Health Fund Board's comprehensive plan. To do this, the Authority will have full charge responsibility and operating authority to manage all aspects of the following seven building blocks, each of which is described in greater detail in the body of the report:

Building Block 1: "Bring Everyone Under the Tent"

- Ensure every Oregonian has access to affordable, quality health care.

Building Block 2: Set High Standards – Measure and Report

- Collect and disseminate uniform and complete information on which to make policy decisions and set standards for system improvement.
- Improve consumers' and others' ability to compare coverage based on cost and quality; reduce unexplained variation in care.
- Decrease administrative spending by simplifying and standardizing administrative processes.
- Make comparable information about provider performance and costs widely available.

Building Block 3: Unify Purchasing Power

- 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.
- Stabilize the current individual health insurance market and establish a foundation for future market reforms.
- Improve efficient purchasing on behalf of Oregonians through a publicly-owned health plan option.
- Control the increases in administrative expenses included in premiums by health insurers.
- Control the annual increases in prices charged by providers.

Building Block 4: Stimulate System Innovation and Improvement

- Create community health care and public health systems that are coordinated, integrated and equitable.
- Provide high-quality, dignified end-of-life care to every Oregonian.
- Foster innovation in health care delivery in local communities.
- 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.
- Ensure effective investment in Oregonians to prevent and reduce tobacco use, obesity and other major chronic diseases.
- Reduce costs and improve health care quality by reforming the current medical liability system and reducing the use of defensive medicine.

- Stimulate, coordinate, and support as a priority statewide efforts to increase the utilization of interoperable health information technology.
- Accelerate widespread, effective use of health information technology by health care providers and patients/consumers to improve health outcomes and health care quality.
- Have by 2012 a statewide system for electronic exchange of health information.
- 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.

Building Block 5: Ensure Health Equity for All

- Achieve health equity in Oregon across all populations through a variety of sustainable strategies that support the health of individuals, families, and communities.

Building Block 6: Train a New Health Care Workforce

- 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.

Building Block 7: Advocate for Federal Changes

- 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.

In order to carry out this work, the Health Authority will be delegated by the Legislature broad policy-making and operational authority for all initiatives within the seven building blocks. This should include, but not be limited to, the specific powers listed below:

- Act as the policy making and governing body for a health care data collection program. Require licensed health insurance carriers and third party administrators (TPAs) to participate and have the ability to issue penalties to entities that fail to meet requirements of the programs and to publicly report data.
- Act as the policy making and oversight body for the Division of Medical Assistance Programs (DMAP), Addictions and Mental Health Division (AMHD), Public Health Division (PHD), and the Office of Private Health Partnerships (OPHP).
- Develop strategic and legislative proposals to expand coverage to Oregon's uninsured and underinsured populations.
- Develop coordinated health care contract goals, performance measures, policies and programs to be implemented by state purchasers of health care (the process for implementation to be determined).
- Enforce a mandate that all health insurance carriers and third party administrators use common forms and processes for administrative transactions.
- Establish an integrated health home designation program and an integrated health home collaborative.

- Develop and implement a Healthy Oregon Action Plan to support communities in developing and implementing evidence-based community initiatives to improve population health.
- Convene a Public Employers' Health Coalition to implement strategies that increase value purchased by state and local government entities in coordination with private purchasers.
- Convene a Payment Reform Council to investigate and implement new provider payment methodologies to reward comprehensive management of diseases, improve quality outcomes, and use resources efficiently.
- Act as a policy making body for development, adoption, and continuous refinement of uniform, statewide health care quality standards.
- Act as the policy making body to guide the development of clinical standards and guidelines for use by providers and insurers.
- Convene a Medical Liability Reform Council to develop legislative recommendations to improve Oregon's medical liability system.
- Together with the Department of Consumer and Business Services, develop and implement an Oregon Health Insurance Exchange for the individual and small group insurance markets.
- Together with the Department of Consumer and Business Services, more tightly regulate the health insurance industry, especially in regards to administrative spending and financial reporting.
- Develop Oregon's health care workforce strategy through the Health Care Workforce Council.
- Establish a Health Information Technology Oversight Council to expand the use of health information technology and the interchange of electronic health information exchange to improve quality and health outcomes
- Work with Oregon's delegation to advance changes in federal policy that will support Oregon's health reform plans.
- Brief the Governor and legislative leadership on the performance of Oregon's health care system and reform efforts and make recommendations for policy change.
- Oversee an evaluation of reform as carried out by the Office for Oregon Health Policy and Research, in collaboration with the Oregon Health Research and Evaluation Collaborative.
- Report biennially to the Legislature with recommendations to improve the organization and oversight of state agencies involved in health care policy, finance, administration and regulation.
- Explicitly delegated the oversight authority by the Legislature to provide state action protection in policy areas such as the development of alternative payment methodologies, clinical guidelines and quality standards.
- Other powers defined under the seven Building Blocks.

BUILDING A HEALTHY OREGON: THE 7 ESSENTIAL BUILDING BLOCKS

1. Bring Everyone Under the Tent

The Vision
- Affordable Health Care For All Oregonians
- An Essential Benefit Package

Stage I: 2009 Expansion Objectives
- Children <200% FPL
- Adults <100% FPL (<185% with appropriate waiver)

Stage I: 2009 Financing Plan
- Alternate Provider Taxes

Stage II: 2011 – 2015 Expansions
- Premium Assistance Plan: Linked to cost containment & available funding

2. Set High Standards – Measure and Report

Trusted Information
- Uniform, Statewide Data (Quality, Clinical, Financial)

Set High Standards
- Clinical Quality Measures
- Clinical Guidelines
- Population Health Targets
- Insurance Administration Practices

Measure & Report
- Public Reporting to: Consumers, Providers, Purchasers, Insurers, Policy Makers

3. Unify Purchasing Power

Coordinated Purchasing
- State & Local Governments
- Common Contract Standards Purchasing Cooperative

Oregon Health Insurance Exchange
- Begin with current Individual Market
- Stage II, Individual Market: Guaranteed Issue, Premium Assistance

Regulatory Options
- Review & Approve Insurer Administrative Expense Increases
- Set Ceilings on Provider Price Increases

4. Stimulate System Innovation & Improvement

New Models of Care
- Integrated Health Homes
- Behavioral Health Integration
- End-of-Life Care

Community-Based Innovation
- Community Collaboratives
- Community Safety Net
- Accountable Care Communities

The Public's Health
- Healthy Oregon Action Plan
- Community-Centered Health Initiative
- Tobacco and Alcohol Taxes

Medical Liability
- Medical Liability Reform Council

Health Information Technology
- Widespread adoption of electronic health records
- Clinical decision support tools
- Statewide health information exchange
- Privacy and security of personal data

5. Ensure Health Equity for All

- Outreach and Education
- Translation Services
- Culturally Appropriate Disease Management
- Provider Recruitment and Training

6. Train a New Health Care Workforce

- Reliable Data
- Resources for Training
- Licensing
- Long Term Needs
- Recruit, Retain
- New Models
- Practice at "Top of License"

7. Advocate for Federal Changes

- Federal Laws Committee Recommendations
- Seek Opportunities under Federal Reforms

BUILDING BLOCK 1: "BRING EVERYONE UNDER THE TENT"

How Building Block 1 Can Lead to Improved Population Health and Individual Experience of Care, While Reducing Cost per Capita

Improves population health by:

- Increasing access to preventive and early care, which limits the impact of disease on the population as a whole

Improves the individual's experience of care by:

- Helping more people access high quality care when they need it and in more appropriate settings
- Allowing individuals to stay insured in the long-term, allowing them to form continuous relationships with their providers

Reduces per capita costs by:

- Expanding access to primary care services, reducing the utilization of costly and inefficient care in the emergency room and preventing unnecessary hospitalizations
- Reducing the cost shift to private payers – as more people have coverage, providers no longer need to recoup the cost of care for the uninsured by charging the insured more

OBJECTIVE

Every Oregonian has access to affordable, quality health care.

STRATEGY

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 health insurance exchange for Oregonians who do not have access to health insurance from their employers and for those who receive 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; and
- The individual (non-group) health insurance market, through the exchange.

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 from 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.

Table 1
Estimated Annual State Costs & Revenue Requirements for Full Expansion[12]

	Annual Amount (in millions)
Oregon Health Plan	$389 - $422
Insurance Exchange	$628 - $1,184
Total State Cost	**$1,017 - $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 programs (alcoholic beverages tax).

[12] 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. The web site link is available in Appendix B.

➢ Phase I Coverage Expansion

OBJECTIVE

Improve access to care for children and low-income adults.

STRATEGIES

Strategy: Expand coverage 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.[13] 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.[14]

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.

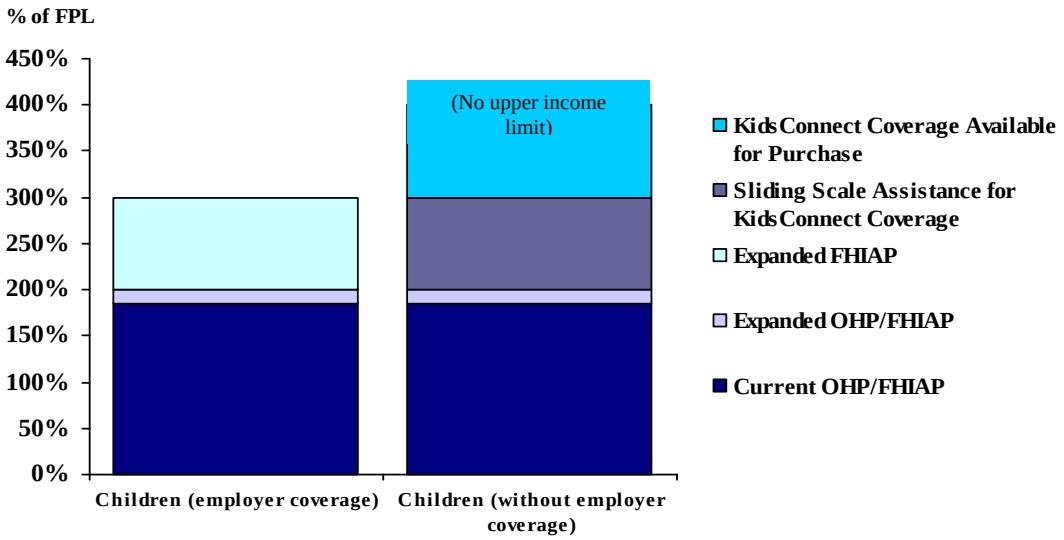
In 2009-11, the state will expand coverage to all Oregon children:

- 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.
  - 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 (called "Kids Connect" under the Governor's proposal) 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.

[13] Institute of Medicine. (2003). *Hidden Costs, Value Lost*. Washington: National Academy Press, p. 112.
[14] 2000 dollars adjusted to 2008 dollars using the United States Department of Labor, Bureau of Labor Statistics Inflation Calculator available: http://www.bls.gov/data/inflation_calculator.htm

- Families with incomes above 300% FPL who do not have access to employer-sponsored insurance for their children will have access to this product for their children. These families will be responsible for the full premium cost.

Chart 1: Expand Coverage for Children in 2009-2011 Biennium



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 incomes 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 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.

While current federal waivers allow the state to open OHP Standard only to adults up to 100% FPL, the Board believes the state should maximize potential waivers that would allow the entire program, not just the premium assistance program, to be open to adults up to 185% FPL. Budget estimates and enrollments in this section reflect the 100% FPL income limit of the first phase.

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: 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) and require that all health insurance plans offered in the state meet or exceed the EBP. The EBP will be based on the principles outlined by the OHFB Benefits Committee. No health plan in the state will be allowed to offer coverage less than the EBP, although levels of cost sharing may differ.

As the EBP is equivalent to the OHP Plus benefit package, a requirement that no insurance plans offer less than the EBP benefit level will not change the benefits received by individuals currently accessing OHP Plus.[15] The OHP Plus benefits will 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:

- 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.

[15] The one difference between the EBP and the OHP Plus package is that the EBP includes cost-sharing. Individuals currently eligible for OHP Plus would not be subject to cost-sharing.

- 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.
- Coverage of conditions should not be segregated based on the part of the body affected or the type of qualified health care provider delivering the service. Evidence and public values will drive coverage decisions.

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

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 product, 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. The Legislature will also need to authorize DHS to apply for federal waiver authority to expand OHP to adults up to 185% FPL.

   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, maximizing 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. **Define and maintain the Essential Benefits Package.**
   The Legislature authorizes the Authority to continue the work of the Health Fund Board and oversee the development and ongoing updating of an Essential Benefits Package based on the latest evidence-based research. The Authority will utilize the expertise of the Health Services Commission to carry out this work.

➢ Phase I Financing

OBJECTIVE

Ensure sustainable financing for coverage expansions.

STRATEGY

Strategy: Finance coverage expansions in 2009 with provider taxes.

The cost of expanding health insurance coverage to all Oregonians is not insignificant. See Table 2 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 2: Estimated State and Federal Funds Needed to Support Coverage Expansions (2009 – 2013)
(in millions)

	’09 – ’11		’11 – ’13	
	State Funds	**Federal Funds**	**State Funds**	**Federal Funds**
Coverage for Kids[16]	$125	$124	$162	$162
OHP Standard[17]	$355	$603	$566	$849
Coverage Subtotal	*$480*	*$727*	*$728*	*$1,011*
Improved OHP Standard Benefits[18]	$51	$85	$78	$131
Increased Provider Rates[19]	*$69*	*$114*	*$69*	*$114*
System Transformation[20]	$35	$23	$35	$23
Total	**$635**	**$949**	**$910**	**$1,279**

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

[16] Department of Human Services and Office for Public Health Partnerships, Submitted budget and forecasting projections as of 10/1/2008.
[17] Department of Human Services, Submitted budget and forecasting projections as of 10/1/2008.
[18] Department of Human Services, Submitted budget and forecasting projections as of 10/1/2008.
[19] Department of Human Services, Submitted legislative concepts and associated policy option packages (#207, 217, 267, 277, 301, 317) as of 10/1/2008.
[20] Oregon Health Policy & Research and Oregon Health Fund Board, Submitted legislative concepts and associated policy option packages as of 10/1/2008.

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.

ACTION STEP

1. **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.

➢ Phase II Coverage Expansion

OBJECTIVE

Continue to expand coverage once cost containment efforts are in place.

STRATEGY

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

The first phase of state-sponsored coverage expansions targets children of all income levels, and adults with income below 100% FPL (or 185% if a federal waiver is approved). The Board recognizes that individuals above 100% often have difficulty affording health insurance. The Board's goal is to create a system that offers affordable coverage to all Oregonians. The Board envisions coverage expansions that would include premium assistance on a sliding scale, as well as more available affordable products.

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. **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.
2. **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.

BUILDING BLOCK 2: SET HIGH STANDARDS – MEASURE & REPORT

How Building Block 2 Can Lead to Improved Population Health and Individual Experience of Care, While Reducing Cost per Capita

Improves population health by:

- Painting a complete picture of where Oregon is doing well and where there is room for improvement so that effective, targeted initiatives aimed at improving population health can be developed
- Coordinating a statewide strategy to improve quality of care
- Reducing variation in care by making sure people across the state are all treated according to the best available research
- Giving communities information about resource utilization that is needed to make health planning decisions that maximize population health

Improves the individual's experience of care by:

- Giving people the information they need to compare available health plans
- Giving providers the evidence-based tools they need to deliver high quality care
- Simplifying and reducing the number of forms individuals need to fill out when utilizing the health care system
- Allowing health care consumers to make informed decisions about the providers they see based on the quality of care they provide

Reduces per capita costs by:

- Painting a clear picture of how resources are used in health care
- Allowing for the identification of providers/regions that are providing cost-effective and high-value care and those that are utilizing more resources without achieving better outcomes, thereby reducing variations in care patterns and the provision of unnecessary care
- Increasing public accountability for the way health dollars are spent
- Encouraging competition between health plans and between providers based on the value of services provided and thus allowing health care purchasers to make informed purchasing decisions
- Reducing resources dedicated to administrative services
- Giving providers the information they need 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

➢ Trusted Information

OBJECTIVE

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

STRATEGIES

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 nor 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.[21] In addition, quality of care, utilization of specific procedures, and treatment options vary significantly depending on where in the state a patient receives care.[22] 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.

An all-payer, all-claims data collection 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 better 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 a database that includes information about all claims paid across the state, Oregonians will have

[21] Op. cit. Cantor, J. C., Schoen, C., Belloff, D., How, S. K. H., & McCarthy, D. (2007, June).
[22] Performance Report for Chronically Ill Beneficiaries in Traditional Medicare: Hospitals – Oregon. Provided by Elliot Fischer and the Dartmouth Atlas Project.

access to comprehensive, uniform information, which will help shape successful strategies for providing consistent, high-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 facilities.

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 and 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.[23]

- 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

[23] Senate File No. 3780, 2007-2008 Legislative Session.

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 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 a specified amount in a capital project. 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 that creates a database of claims paid by all payers across the state. 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 TPAs, the Authority develops data protocols and requirements in 2009 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 accountability 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 blocks 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: Improve Quality

OBJECTIVE

Improve consumers' and others' ability to compare coverage based on cost and quality; reduce unexplained variation in care.

STRATEGIES

Strategy: 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 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.

Strategy: 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 evidence-based guidelines and best practice clinical 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 these diseases, 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's experience for lessons and best practices.

Strategy: Establish an Oregon Quality Institute.

In order to maximize its impact on quality of care across Oregon, the 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. An Oregon Quality Institute, serving as an advisory body of 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 Quality Institute would be responsible for setting the quality agenda for Oregon and setting ambitious goals for increased transparency and quality improvement. The Institute would coordinate public and private efforts to: convene public and private stakeholders to align all groups around common quality metrics for a range of health care services; ensure 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; and ensure 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. This will require the Institute to convene regular meetings with the leadership of organizations such as the Oregon Health Care Quality Corporation (Quality Corp) and the Patient Safety Commission in order to share best practices, develop shared strategies, and coordinate statewide quality improvement planning.

As imagined by the Board, The Institute would contract and partner with other public and private organizations to carry out the technical work associated with these efforts. In order to maximize

the potential influence of these relationships, the Institute would need the ability to fast-track contracting with specific organizations, such as Quality Corp, and other organizations that meet specific criteria. In addition, the Institute should have the ability to provide indemnity to organizations that carry out quality work on its behalf.

An initial role of the Quality Institute will be to partner with the Quality Corp in further developing established efforts to develop a common payer data set of quality measures. The public and private sectors will separately fund the analysis of this data to suit their needs, but all data should be housed with one vendor with multiple analysis capabilities or a common suite of vendors. The Quality Corp should continue to raise private sector resources to fund this aspect from private and public purchasers with an interest in having access to information about quality. Over time, this dataset should be expanded to reflect not only the quality, but the value of care delivered across the state.

ACTION STEPS

1. **Empower the Authority to set standards.**
   The Legislature empowers the Authority to develop clinical quality measures, health and outcomes targets, evidence-based guidelines and best practice clinical 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 and other stakeholders, similar to efforts in Minnesota, to agree to a common set of evidence-based guidelines based on clinical effectiveness research for the use of new and existing technologies and treatments. Where the evidence does not yet exist, providers can identify best clinical practices widely accepted in the field, while encouraging and supporting further research to confirm these standards. 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 will assist providers in having 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 do not exist. Where the evidence does not yet exist, the HRC will identify best clinical practices widely accepted and followed in the field, while encouraging and supporting further research to confirm these best practice clinical standards. All providers in the state will have access to these evidence-based guidelines and best practice clinical standards, 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 best practice clinical standards, 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 evidence-based guidelines and best practice clinical standards, 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 will 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 and best practice clinical standards for conditions with high variability or expense. The state then encourages the adoption of these guidelines and clinical standards. Strategies for adoption could include mandating the use of evidence-based guidelines and best practice clinical standards by state sponsored insurance programs, voluntary adoption by private insurers, or publishing the guidelines as best practices throughout the state. Wherever evidence-based guidelines and best practice clinical standards are not used, there must be **processes** and procedures for justifying care that does not meet evidence-based guidelines or best practice clinical standards.

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 establishes an Oregon Quality Institute to serve as its advisory body for quality improvement and contracts 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 possible initiatives to engage consumers, providers, purchasers, state government, and other stakeholders in utilizing this data to improve health care quality.

➢ Set High Standards: Simplifying and Standardizing Administrative Processes

OBJECTIVE

Decrease administrative spending by simplifying and standardizing administrative processes.

STRATEGY

Strategy: Develop standard formats and processes for eligibility, claims, and payment and remittance transactions.

Administrative expenses account for a significant percentage of total health care spending. There are 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.[24] Based on Minnesota's methodology, Oregon can reasonably expect to save over $400 million over ten years if similar standards were adopted.

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.

[24] Golden, J. (2008, February 7). Health Information Technologies and Health Care Transformation. Presentation at the State Coverage Initiatives Winter Meeting. Nashville, TN.

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

OBJECTIVE

Make comparable information about provider performance and costs widely available.

STRATEGY

Strategy: 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 deliver 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 Quality Institute, with oversight from 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.

BUILDING BLOCK 3: UNIFY PURCHASING POWER

How Building Block 3 Can Lead to Improved Population Health and Individual Experience of Care, While Reducing Cost per Capita

Improves population health by:

- Promoting primary care, prevention, and wellness services through public contracting
- Expanding access to insurance coverage
- Promoting the use of evidence-based clinical standards

Improves the individual's experience of care by:

- Increasing the use of patient-centered models of care that engage patients in decision making
- Using contract standards to increase quality of care

Reduce per capita costs by:

- Building efficiency and value standards into public health care contracting
- Reducing pharmaceutical spending

➢ Coordinated Purchasing Policies Among Public Entities

OBJECTIVE

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

STRATEGIES

Strategy: Develop and implement uniform contract standards and policies for the State of Oregon (Oregon Health Plan, PEBB, OEBB).

The state – in partnership with communities – must act as a smart purchaser of health care. As a major purchaser of health care, the state must align and coordinate its purchasing standard and contract requirements to maximize its influence in local health care markets in terms of performance standards, innovation in care delivery, and cost. 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 evidence-based guidelines and best practice clinical 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 Integrated 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;[25]
- 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, along with their provider, in critical, preference-sensitive health care choices; and
- 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, and other local governments along with 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 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 be about 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

[25] This is in line with the Governor's recently announced Wellness Initiative. For more details, see http://governor.oregon.gov/Gov/pdf/letters/wellness_initiative_103108.pdf.

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 cardiac or cancer services. The Cooperative could also contract directly with providers at designated facilities such as Centers of Excellence.

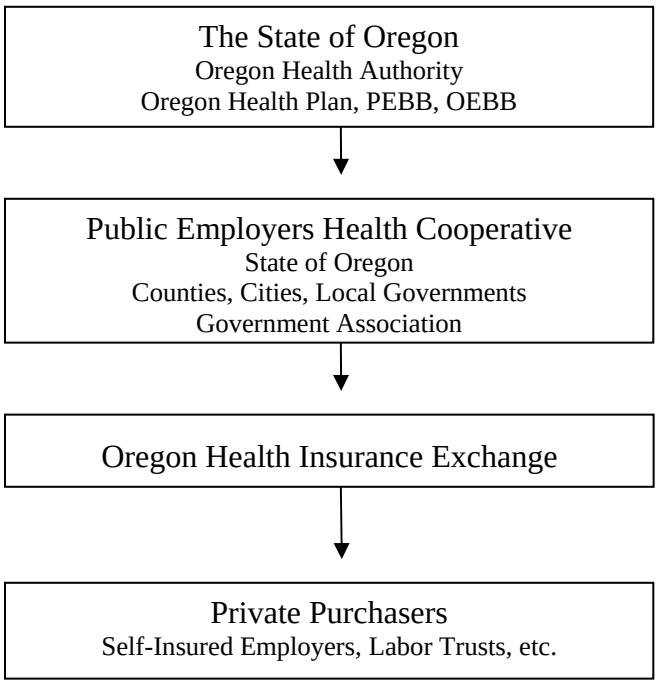
The Oregon Prescription Drug Program (OPDP) is an innovative joint contract for pharmacy benefits that includes both the State of Oregon and the State of Washington. As of July 31, 2008, OPDP has enrolled 83,560 Oregonians in a prescription discount card program and 18,671 persons in group contracts. 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 the 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:



Strategy: Create opportunities for city and county governments and private entities to use uniform contracting standards.

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 and best practice clinical standards for major chronic diseases, services with unexplained variations in frequency, or cost and "supply sensitive" services; and c) evidence-based guidelines for select, new technologies based on comparative effectiveness research.

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. **Provide opportunities for other public and private purchasers to use uniform contracting standards.**

4. **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

Strategy: Create a Health Insurance Exchange to consolidate the individual market.

The state will develop an insurance exchange infrastructure that can grow in capacity over time. Initially, an exchange will help consolidate the individual market in an effort to standardize and streamline 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 insurance requirement, guaranteed issue, and state premium participation for low and moderate income Oregonians.[26] 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 will remain in effect in the individual market. Individuals denied coverage will continue to have the option of enrolling in the state's high risk pool, the Oregon Medical Insurance Pool.

Exchange Structure and Participation

The state will create an Oregon Health Insurance Exchange under the Oregon Health Authority. All individual market purchasers will buy insurance through the exchange

The exchange will develop a request for proposals from licensed insurers interested in participating in the exchange. Participating insurers must comply with the exchange'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;
- Using a medical screening tool and common rejection rules; and
- Meeting additional standards in areas such as administrative costs, rating rules, etc.

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

[26] For the recommendations of the Exchange Work Group, please see Appendix D.

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. To lessen consumer confusion, the total number of plan choices available will be smaller than at present. An exchange can improve information transparency for consumers. An interactive website 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 coverage through the exchange. 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.[27] 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 exchange 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 the exchange.

An Exchange as Structure for Future Reforms

The exchange will form a structure that can be used to support medium- and long-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 provide 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.

An exchange is also a venue through which common contract standards could be implemented. Insurers participating in the exchange could benefit from a standardized contract that would reduce administrative burden associated with providers negotiating the wide variation in contracts and requirements now in place.

The exchange can also become the venue for a statewide reinsurance effort. While additional work is needed to identify the functional barriers and development issues surrounding the establishment of a statewide reinsurance program, a system in which all individual insurance is provided through an exchange would simplify the administration of such a program.

[27] 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.

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.

The exchange is also the venue through which the development of a publicly-owned health plan could be investigated. For more on a publicly-owned health plan, see the next section.

ACTION STEP

1. Create an Oregon Health Insurance Exchange.

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

The Insurance Division, working with the exchange's 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 the exchange. The exchange's governing body develops an insurance exchange within the current individual market.

The Legislature authorizes the exchange's 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.

➢ Publicly-Owned Health Plan

OBJECTIVE

Improve efficient purchasing on behalf of Oregonians through a publicly-owned health plan option.

STRATEGY

Strategy: Develop a business strategy for a publicly-owned health plan option.

Many Oregonians have indicated their support for the creation of a publicly-owned health plan option for individual insurance purchasers. As described by advocates and researchers, a public health plan could become an option for individual insurance coverage along with regulated private plans and expand choice for individuals seeking coverage. All plans would be offered through an exchange, offering consumers choice of a non-commercial, publicly-accountable plan that meets all the standards set by the exchange. If the Legislature is planning to implement an individual mandate in the future, maximizing choice for consumers must be a priority.

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.[28] Like private plans offered through the exchange, a public plan could implement efforts to improve quality and cost effectiveness through the use of integrated health homes, evidence-based guidelines, and best practice clinical standards and quality standards. The public plan would not have the same profit motive as private plans offered through the exchange, allowing it to create price and quality competition within the exchange. In addition, a public plan could work with Medicare to increase purchasing power.

A public plan would have a citizen governing body and 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' Benefit Board (PEBB) would administer the program on behalf of enrollees.

In Oregon's current medically-underwritten system, the existence of a publicly-owned plan could also have unintended consequences. If private insurers saw the public plan as an entity that would enroll the people other plans do not see as good risks, adverse selection would likely occur. Such movement of high cost enrollees into a public plan would both increase costs for a public offering and not help the market as a whole manage the costs of all individual purchasers. In order to avoid such a situation, the Oregon Health Fund Board believes that implementation of a public plan would require additional market changes, including the implementation of a guaranteed issue individual market and a statewide individual insurance requirement. Other strategies to prevent adverse selection are also likely to be necessary.

[28] Op. cit. The Lewin Group.(2008, February 15).

ACTION STEP

1. **Develop a strategy for a publicly-owned health plan option.**
   The Legislature authorizes the Authority to develop a business strategy for the development and implementation of a publicly-owned health plan. The Authority assesses how a public plan would function in Oregon and delivers a business strategy to the legislature by 2011. Included in the report will be analyses of the potential for administrative and other savings, the cost of developing and maintaining a public plan, and other potential benefits for consumers. This business strategy will outline how a publicly-owned health plan would be designed to work within a reformed health system in Oregon that includes an individual insurance requirement.

➢ Regulatory Options: Control Increases in Administrative Spending

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.

OBJECTIVE

Control the increases in administrative expenses included in premiums by health insurers.

STRATEGY

Strategy: 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 for insurers should be more closely aligned with the general Consumer Price Index or the cost pressures in the financial sector in general.

The Insurance Division will monitor increases in administrative costs on a per-member-per-month 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 STEPS

1. The Authority sets benchmarks for the maximum allowed increase in administrative spending on a per-member-per-month basis for health insurers. 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.

2. **The Legislature requires the Insurance Division to report to the Authority, on an annual basis, the average administrative per-member-per-month rate for the marketplace. In addition, the Insurance Division will report, by company, for the dominant insurers in Oregon (currently the eight insurers that represent 90% of insured lives in aggregate) total premiums earned, average administrative per-member-per-month rate, and the percent growth in administration as a percent of premiums.**

➢ Regulatory Options: Control Provider Prices

OBJECTIVE

Control the annual increases in prices charged by providers.

STRATEGY

Strategy: 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% of 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 4: STIMULATE SYSTEM INNOVATION & IMPROVEMENT

How Building Block 4 Can Lead to Improved Population Health and Individual Experience of Care, While Reducing Cost per Capita

Improves population health by:

- Focusing on wellness, prevention, and chronic disease management to improve population health
- Supporting communities in developing local solutions to community health problems
- Allowing local delivery systems to evaluate the health of the populations they serve and identify opportunities to develop community-based initiatives to address population health needs
- Supporting development of community-based initiatives to reduce chronic disease in the population
- Allowing for the analysis of population-level data

Improves the individual's experience of care by:

- Encouraging individuals to establish personal, continuous relationships with patient-centered health practices, engaging individuals in improving their own health, making it easier for people to access culturally appropriate mental health and physical health services, and improving the quality and safety of care they receive
- Ensuring that individuals' wishes about end-of-life care are followed, supporting providers to explain care options to patients and their families, and ensuring that people have access to palliative care to reduce pain and suffering at the end-of-life
- Making services people want and need available to them in their own communities
- Improving access to community-based preventive services to reduce disease risk factors in individuals
- Allowing patients to be more engaged in their own health care
- Ensuring that patients' health information will be available to them and their providers at the time it is needed
- Increasing access to behavioral health services and integrating physical and behavioral health services

Reduces per capita costs over time by:

- Reducing duplication by increasing care coordination
- Reducing utilization of expensive acute services with better disease management
- Allowing health resources to be spent more effectively and efficiently at the local level
- Reducing utilization of health care services by decreasing chronic disease
- Reducing duplication of services and reducing medical errors
- Reducing spending in the medical malpractice system

➢ New Models of Care

OBJECTIVE

Create community health care systems that are coordinated, integrated, and equitable.

In developing new models of care that better meet Oregonian's health needs, the state should pursue a range of strategies each focused on a different aspect of the delivery system. The strategies aimed at meeting this objective are broken into several different categories: integrated health homes, integrating behavioral and physical health, eliminating health disparities, and payment reform.

INTEGTRATED HEALTH HOME

STRATEGIES

Strategy: 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.[29]

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.[30] Implementation of a care-management based integrated health home model at Intermountain Health Care in Salt Lake City resulted in

[29] 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: http://www.oregon.gov/OHPPR/docs/The_Medical_Home_Model_Final.pdf.

[30] Eby, D. (2006, December). Healthcare Transformation. Southcentral Foundation Alaska Native Medical Center. Presentation at the Oregon Community Health Meeting, Portland, OR.

significant health improvements, including improved glycemic control, decreased hospitalization rates, and decreased death rates in elderly patients with diabetes as compared to patients at control clinics.[31]

Experience from other states reflects significant savings from enrolling people in integrated health homes. 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 Medicaid program has been able to save $34 million annually.[32] 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.[33] Similar policies for Oregon could lead to savings of $190 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 $3.3 billion in ten years. Although the Board envisions that all Oregonians will eventually have an integrated health home, due to the state's ability to drive change as a purchaser, the Board proposes establishing integrated health homes within state-sponsored programs as a first step.

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. Working 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 among the providers and staffs, working closely to identify and assist in removing barriers to systematic improvement. Along with a strong patient-centered approach, 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. The integrated health home model is still

[31] McConnell, J., Dorr, D., Radican, K., et al. (2007, April 10). Creating a Medical Home Through Care Management Plus. Presentation at Academy Health Annual Meeting.
[32] Press release from the Office of Illinois Governor Rod Blagojevich. (2008, April 28). Available: http://illinois.gov/PressReleases/ShowPressRelease.cfm?SubjectID=19&RecNum=6784 [2008, August 1].
[33] Lorito, K. (2007). CCNC/Access Cost Savings – State Fiscal Year 2005 and 2006 Analysis. Mercer Government Human Services Consulting. Available: http://www.communitycarenc.com/PDFDocs/Mercer%20SFY05_06.pdf [2008, July 15].

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 Integrated Health Home 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.

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, especially those with chronic diseases, to utilize IHHs.

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) implements and evaluates strategies to provide incentives for OHP participants who enroll with integrated health homes, seek preventative and wellness services, practice healthy behaviors, and 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 Payment Reform Council to provide incentives for 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 the 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 IHHs.**
   The Legislature directs the Authority to establish a collaborative for all designated integrated health home 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.

INTEGRATING BEHAVIORAL AND PHYSICAL HEALTH

STRATEGY

Strategy: Integrate behavioral health services with physical health services.[34]

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.[35] 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.[36] 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 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 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

[34] The term "physical health services" refers to the treatment of all body systems, including oral health and vision care.

[35] Whelan, R., Josephson, A., & Holcombe, J. (2008). The Economic Costs of Alcohol and Drug Abuse in Oregon in 2006. EcoNorthwest. Available: http://www.econw.com/reports/ECONorthwest_Costs-AlcoholDrugs.pdf [2008, July 15].

[36] Institute of Medicine. (2005). *Improving the Quality of Health Care for Mental and Substance-Use Conditions.* Washington: National Academy Press.

cracks, thereby 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 contracting with Mental Health Organizations (MHOs) to 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.

Substance abuse contributes to high health care costs and lost worker productivity. In Oregon (which has the fourth highest rate of alcohol-related deaths in the nation), the direct costs of alcohol abuse are estimated at $3.244 billion in 2006. This is 8 times greater than the revenue received from current taxes on alcohol in the state.[37]

The Institute of Medicine strongly recommends that states institute higher alcohol taxes. [38] Numerous studies suggest that higher taxes will decrease drinking, especially among underage youth, decrease health care costs associated with alcohol abuse, decrease violent crime, and increase economic revenue to deal with the costs of alcohol abuse.[39-40]

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. **Institute a higher alcohol tax.**
   The revenue from this additional tax will be dedicated to fund both prevention and treatment programs for addiction. This revenue will support public health departments and community organizations offering addiction prevention and outpatient treatment services.

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[37] Op. cit. Whelan, R., Josephson, A., & Holcombe, J. (2008).
[38]. Institute of Medicine. (2003). Reducing underage drinking: a collective responsibility. National Academies Press: Washington, D.C.
[39] Ibid, Institute of Medicine. (2003).
[40] Center for Science in the Public Interest. Beer Consumption and Taxes. Alcohol Policies Project. Available: www.cspinet.org/booze. [2008, August 19].

3. **Restructure systems so that patients with multiple conditions can receive care in one clinical location.**
   Relevant state government entities 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.

4. **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.

ELIMINATING HEALTH DISPARITIES

STRATEGY

Strategy: 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.[41] 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.[42] 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 misdiagnoses 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.

[41] Crook, E. D., & Peters, M. (2008, April). Health Disparities in Chronic Diseases: Where the Money Is. *The American Journal of Medical Sciences*, 335(4):266-270.
[42] Beal A. C., Doty, M. M., Hernandez, S. E., Shea, K. K., & Davis, K. (2007, June) 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.

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.

PAYMENT REFORM

STRATEGY

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

The state's role as a convener allows for protection of the private health care sector from the potential threat of violating antitrust laws by participating in payment reform activities. Generally, antitrust laws exist to prevent concerted activities that are in "restraint of trade" and that create "monopoly power" where the effect is to "substantially lessen competition". Specific examples include:

- Price discrimination
- Tying or exclusive dealing contracts
- Corporate mergers among competitors
- Interlocking directorates among competitors

The United States Supreme Court has reasoned that, in passing the Sherman Antitrust Act of 1890,[43] Congress intended to protect competition, not to limit the sovereign regulatory power of the states. The Court held, therefore, that regulatory conduct that could be attributed to "the state itself" is immunized from antitrust scrutiny. This rule, and its objectives, seem clear enough at first, but become substantially less clear when applied to delegations of state authority to private parties. It is clear, for example, that the Sherman Act was not intended to reach the conduct of a state legislature. It is less clear that it was not intended to reach, for example, the conduct of a group of providers meeting to discuss payment reform or evidence-based practice, which may be dominated by market participants with vested financial interest in particular regulatory outcomes.

The Supreme Court provided some guidance on this issue with its 1980 opinion in *California Retail Liquor Dealers Association v. Midcal Aluminum, Inc*.[44] The *Midcal* case established two

[43] 15 U.S.C.A. § 1 et seq.
[44] 445 U.S. 97 (1980).

important limitations on the scope of state action immunity, both of which are intended to ensure that the conduct at issue is truly that of "the state itself." First, the proponent of immunity must demonstrate that the conduct in question was in conformity with a "clearly articulated" state policy. And second, the proponent must demonstrate that the state engaged in "active supervision" of the conduct.

ACTION STEPS

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 Payment Reform Council will study, evaluate, and develop recommendations concerning new payment methodologies under consideration at the national level including, but not limited to, bundled payments, gainsharing, pay-for-performance and capitation. The work of this group builds on the efforts to set standards and restructure payment systems to support 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.

2. **Provide opportunities for the private health care sector to discuss and develop new strategies for reforming health care payment systems and to promote evidence-based practice under clearly articulated state policy and active supervision.**
   The creation of the Health Authority will include statutory language that shall not prevent health care purchasers and providers from entering into agreements that establish strategies for reforming health care payment systems and advancing evidence-based medicine, as long as these agreements follow clearly articulated state policy. This allows such organizations the flexibility to innovate on ways to reduce health care costs while improving overall quality of care and health outcomes. The creation of the Health Authority will also include statutory language that permits the director of the Health Authority or another designated person to convene working groups of private sector health care payers and providers to discuss and develop new strategies for reforming health care payment systems and advancing evidence-based practice to promote innovative care delivery that reduces health care costs and improves quality.

➢ End-of-Life Care

OBJECTIVE

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

STRATEGIES

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 without medical orders, but the POLST form provides those necessary 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 for 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.

STRATEGIES

Strategy: Support community-based collaboratives.

Community collaboratives function as key partners that link communities to public health and medical care services. Many collaboratives across Oregon seek to identify and target specific community needs in order to increase access to services and provide outreach, education, and advocacy. Strengthening community partners' role in identifying and promoting best practices for addressing chronic disease will increase the public's sense of ownership and create more effective interventions. Community collaboratives will use the existing resources and relationships of community organizations to address the social determinants of health and reduce the burden of chronic disease in the long-term, thus improving the overall health of the public.

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;[45]
- 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;

[45] This is in line with the recently announced Governor's Wellness Initiative. See http://governor.oregon.gov/Gov/pdf/letters/wellness_initiative_103108.pdf for more details.

- 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.

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 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 $1 to $5 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 initiatives to address 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.[46]
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

46 Fisher E.S., Staiger, D. O., Bynum, J. P. W., & Gottlieb, D. J. (2007). Creating Accountable Care Organizations: The Extended Medical Staff. *Health Affairs*; 26(1):w44-w57.

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

4. **Include the safety net in all 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.

➢ Accountable Health Communities

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

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 Systems 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.[47] 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" links 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.

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. 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.

47 Ibid, Fisher E.S., Staiger, D. O., Bynum, J. P. W., & Gottlieb, D. J. (2007).

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 agencies 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 major chronic diseases.

STRATEGY

Link population health to the health care delivery system and communities by creating a statewide comprehensive plan for public health.

Efforts to improve individuals' health and reduce chronic diseases hold tremendous potential to improve overall population health, increase productivity, and reduce health care costs in order to make cost containment more attainable. Creating and maintaining a bridge between population health, the health care delivery system, and communities is an essential part of health care transformation. 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 must actively involve public and private sector public health professionals in population evaluation and decision-making, particularly on strategizing how to effectively promote health and prevent disease. The Authority will ensure that health impacts are evaluated and addressed through multiple sectors. This includes conducting health impact assessments of projects in non-traditional health care delivery sectors such as transportation and education. In order to fully integrate population-based public health strategies, a strategic approach involving policymakers, schools, businesses, and community organizations must be developed and maintained to create a comprehensive, multi-sector, multi-level approach to improving population health.

A series of reports have been released by key national groups (Centers for Disease Control, Institute of Medicine, Commonwealth Fund, and others) detailing the evidence-based recommendations for effective public health interventions, including multi-sector interventions that engage state-level regulation and policy, communities, health care organizations, and individuals. The key priorities identified involve tobacco use reduction, physical activity promotion, and healthy food consumption. Recommendations to deal with obesity include a nutrition focus: setting school nutrition standards, requiring menu labeling, and increasing access to healthy foods. Increasing physical activity requires changes to the built environment, institution of workplace wellness programs, establishment of physical activity standards in schools, and funding for social marketing campaigns. Tobacco use can be reduced by increasing the tobacco tax to fund prevention activities at a high enough level to deter smoking rates, creating legislation for smoking bans and restrictions, requiring insurance providers to cover tobacco cessation and prevention services, and supporting community wide-campaigns.

Community collaboratives are key partners in coordinating the connection between access to clinical care and improved population health, as they ensure members of the community get access to the services they need. Many collaboratives across Oregon have identified and are working to target specific community needs by increasing access to services and providing outreach, education, and advocacy. Strengthening community partners' role in identifying and promoting best practices for addressing chronic disease will create a broader buy-in by the public

and create more effective interventions. Community collaboratives will use existing resources and relationships with community organizations to address the social determinants of health and reduce the burden of chronic disease in the long-term. As they are developed, integrated health homes can coordinate across clinical needs, but strong partnerships with community-based public health efforts is integral to improving community health.

Tobacco use and obesity are the two most influential modifiable risk factors for the five leading causes of death in Oregon[48]. 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. The Trust for America's Health recently 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.[49]

Workplace wellness is another key arena for improving population health. The state's Public Employees Benefit Board has initiated work on workplace wellness across state agencies. Several private companies and a variety of cities, towns, and municipalities have taken their own steps. Collaborating around best practices and broadening those efforts around the state are priorities of the Governor's Office as well. In fact, the Governor recently announced a Wellness Initiative that will have three components: local community-based projects, a business initiative and a focus on state employee wellness. The Authority will work to ensure its efforts and those of the Governor are complementary.

Nationally, similar efforts have shown marked reduction in absenteeism, improved work productivity, and reduced healthcare costs for employers. A recent meta-analysis showed that companies that had implemented a minimum of three wellness measures for at least a year experienced significant benefits. Those benefits included an average decrease of 27% in sick leave, an average decrease of 26% in health care costs, and an average decrease of 32% in Workers Compensation/Disability Management.[50,51]

ACTION STEPS

1. **Authorize the Authority to coordinate the development of the Healthy Oregon Action Plan in 2009 and 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 on major chronic diseases. This plan incorporates and builds on steps identified in

[48] Mokdad, A. H., Marks, J. S., Stroup, D. F., & Gerberding, J. L. (2004). Actual Causes of Death in the Unites States, 2000. *JAMA*, 291(10):1238-1245.
[49] Trust for America's Health. 2008. Prevention for a healthier America: investments in disease prevention yield significant savings, stronger communities. Available: http://healthyamericans.org/reports/prevention08/Prevention08.pdf [2008, August 11]
[50] The U.S. Department of Health and Human Services. (2003). Prevention Makes Common Cents. Available: http://aspe.hhs.gov/health/prevention/ [2008, August 15]
[51] Chapman, L.S. (2005, July/Aug). The Art of Health Promotion: Meta-evaluation of worksite health promotion economic return studies: 2005 update. *American Journal of Health Promotion*, 19 (6).

the Oregon Public Health Division's Oregon Statewide Tobacco Control Plan 2005-2010 and the Statewide Physical Activity and Nutrition Plan 2007-2012, and relies on 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;
- Increase 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;
- Ensure all school and child care settings implement policies requiring all food served meets or exceeds current age-appropriate USDA Dietary Guidelines;
- Increase by 10% the number of Oregon children who meet minimum recommendations for physical activity; and
- 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 Community-Centered Health Initiatives Fund projects which would include, but are not limited to one or more of the following:

   - Require a minimum level of community investment to match state investment;
   - Be based on community input;
   - Be based on evidence and data and include reporting on population health measures and an evaluation component;
   - 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 require evaluation 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, uses policies and guidelines approved by the

Authority to fund and continuously evaluate initiatives at the state, regional and community level to encourage innovation and effective programs.

3. **Increase tobacco and alcoholic beverages taxes to fund action steps #1 (Healthy Oregon Action Plan) and #2 (Community-Centered Health Initiatives Fund), and help fund 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.[52] An alcoholic beverages tax will help improve access to mental and behavioral health. The funding will help county public health programs prepare for the eventual loss of timber funds over the next couple of years.

   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 Wellness Action Plan strategies in at least 50% of Oregon state agencies by 2010.**
   The Authority partners with the Public Employees Benefit Board to develop an Oregon Employee Wellness action plan to create and support workplace conditions that encourage healthy behaviors, such as healthy eating and physical activity. The state collaborates with private employers and health plans to establish best practices for effective workplace wellness programs.

5. **Create a social marketing approach that supports public health efforts to make it easier for Oregonians to make healthy choices.**
   Individuals are ultimately responsible to make healthy decisions and maintain healthy behaviors; however, information about how to make healthy choices and creating an environment that is supportive of those behaviors are critical components of any health reform. The Authority works with organizations in the community that have an impact on health such as exercise facilities, community centers, restaurants, grocery stores, other businesses, health providers, and others to take responsibility for the dissemination of social marketing campaign messages. The Authority could model its social marketing approach on successful campaigns in Oregon that have promoted the "Make the Healthy Choice the Easy Choice" tag line.

6. **Develop private-public partnerships to implement the Healthy Oregon Action Plan.**
   Individuals, communities, businesses, health care organizations, and policymakers work together to promote community health by developing a comprehensive action plan for reducing tobacco use, increasing physical activity, and promoting health nutrition. Key

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

potential interventions to improve health in the focus areas include: setting nutrition standards for school foods, instituting menu labeling in chain restaurants, increasing access to healthy foods, improving the built environment, including health impact assessments in major projects, instituting workplace wellness programs, further legislation for smoking restrictions, and community-wide campaigns. These types of evidence-based population health promotion programs will require collaboration among private and public sectors.

➢ MEDICAL LIABILITY

OBJECTIVE

Reduce costs and improve health care quality by reforming the current medical liability system and reducing the use of defensive medicine.

STRATEGY

Strategy: Convene stakeholder group to examine the medical liability problem, examine current state medical liability laws and policies, and develop reform proposals for consideration by the Oregon legislature.

The Institute of Medicine reported in 1999 that medical errors are the eighth leading cause of death in the United States.[53] As many as 98,000 people die each year as a result of medical errors.[54] In order to prevent errors so that deaths and injuries seldom or never occur, the health care system must have a coordinated strategy to integrate the medical liability system and quality improvement efforts. The liability system's main objectives are to recognize sources of medical error, correct those causes to avoid reoccurrence, and pay damages to those who are affected by medical negligence. Nevertheless, only one medical liability claim is filed for every eight medical injuries, and the average duration of a liability claim resolution is between four and eight years.[55,56] The current health care liability system is at times an ineffective method for the resolution of medical errors and can impede expeditious communication between health care professionals and patients, thus obstructing efforts to improve patient safety and quality of care.

At the same time, Oregon health spending has reached unprecedented levels, with no clear sign of slower growth ahead. For much of the 1990s, Oregon was among the states with the fewest problems with medical liability costs and practice changes associated with these costs. At this time Oregon had a cap on non-economic damages; however, in 1999, the Oregon State Supreme Court ruled that the cap was unconstitutional. Since then, premiums for medical liability coverage have risen sharply. The last several years have seen a more stable medical liability premium environment, but this stability is due to large returns in the stock market for insurers. This stabilizing influence is expected to have reduced influence in the next few years.

The rising cost of medical liability premiums is of concern for the state for several reasons. First, as premiums rise, so does the cost of defensive medicine. Defensive medicine is the ordering of tests, procedures, and visits, or avoidance of certain procedures for patients because of concern about medical liability risk.[57] Estimates of the increased cost of health care due to defensive medicine vary. A 1984 study calculated that the cost of these practices designed to reduce the

[53] Institute of Medicine. (1999) *To Err is Human*. Washington: National Academy Press.
[54] Ibid., IOM, (1999).
[55] Harvard Medical Practice Study Group. (1990). *Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York.* Cambridge, Mass.: Harvard University,
[56] Sloan F.A., Githerns, P. B., Clayton, E. W., Hickson, G. B., Gentile, D. A., & Partlett, D. F. (1993). *Suing for Medical Malpractice*, Table 2.4. Chicago: University of Chicago Press.
[57] Defensive Medicine and Medical Malpractice. (1994). Washington DC: US Congress, Office of Technology Assessment; OTA-H-602.

likelihood of being sued for malpractice was equal to 14.1% of physicians' revenue.[58] Studies have found that tort reform efforts, particularly caps on non-economic damages, can reduce the cost of defensive medicine. One study showed that in states with such caps, health care costs for Medicare patients with certain heart conditions were 5.3% to 9.0% lower than those for similar patients in states without such caps.[59] Other analyses have shown that laws limiting medical liability payments lower state health care expenditures by 3% to 4%.[60] However, other analyses of rising health care costs and review of the literature came to the conclusion that the liability system is not an important driver of cost trends or even a large factor in high costs.[61]

As medical liability costs rise in the state, health care providers leave less profitable practice environments, particularly in rural areas, and stop providing high risk services such as maternity care. [62] Such changes can lead to access problems for vulnerable populations, such as rural residents and pregnant women. Lack of ability to access medical services in a timely manner can lead to poorer health outcomes and complications that are more expensive to treat. Currently, the state subsidizes the premiums of rural providers, particularly those who provide maternity care. However, this subsidy is set to sunset in 2011.

Rising medical liability costs also impact patient safety initiatives. Hospitals, health systems, and medical groups regularly review unexpected medical outcomes to determine if any avoidable mistakes were made. Once a mistake or system issue is identified, then steps can be taken to redesign the system to help prevent such mistakes in the future. However, increased pressures on providers from rising premiums can inhibit the open disclosure of errors which is essential to this process. Protections have been enacted covering such disclosures, but these protections are incomplete and at risk in a highly litigious environment. If errors are not disclosed and steps not taken to make the system safer, expensive medical errors continue and patient outcomes are put at risk. Fortunately, the state Legislature established the Patient Safety Commission, which collects information on medical errors from hospitals, nursing homes, and ambulatory surgery centers. This program and many others are critical steps toward resolving problems in medical liability and improving quality.

Innovative solutions to the problems involved with medical liability costs have been proposed. For example, providers who care for OHP/Medicaid patients could be given some state immunity for the liability involved in such care. This would improve health care access for low-income Oregonians and provide relief for providers. Some other solutions include re-instatement of a cap on non-economic damages, a medical liability pool, and changes in the tort litigation system.

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[58] Reynolds R. A., Rizzo J. A., Gonzalez, M. L. (1987). The cost of medical professional liability. *Journal of the American Medical Association*,.257:2776-2781.

[59] Kessler, D. P., & McClellan, M. B. Do doctors practice defensive medicine? (1996). *Quarterly Journal of Economics*, 111:353-390.

[60] Hellinger, F. J., & Encinosa, W. E. (2006). The Impact of State Laws Limiting Malpractice Damage Awards on Health Care Expenditures. *American Journal of Public Health*, 96(8): 1375-1381.

[61] Ginsburg, P. B. (October 2008). High and rising health care costs: Demystifying U.S. health care spending. The Robert Wood Johnson Foundation Research Synthesis Report No. 16..

[62] Smits, A. K., Clark, E. C., Nichols, M., & Saultz, J.W. (2004, July/Aug). Factors affecting cessation of pregnancy care in Oregon. *Family Medicine*, 36(7): 490-495.

ACTION STEP

1. **Establish a Medical Liability Reform Council.**
   The Authority establishes a Medical Liability Reform Council composed of physicians, plaintiff attorneys, and other stakeholders, including a representative from the Patient Safety Commission. The Council investigates opportunities to reform the current medical liability issues in Oregon including, but not limited to: structured attorney fees, periodic payments, expert witness disclosure, pre-screening panels, collateral source disclosure, and catastrophic insurance funds for awards in excess of specific maximum limits. This group addresses the effectiveness and viability of possible solutions, as well as various state and federal policy solutions. The work of this reform council culminates in recommendations for the Legislature for state action as well as the Oregon Congressional delegation for federal action. Work on medical liability reform will coordinate with efforts to improve the use of evidence-based practice in medicine.

➢ Health Information Technology: Increased Utilization

OBJECTIVE

Stimulate, coordinate, and support the increased utilization of interoperable health information technology to improve the quality, coordination, and cost-effectiveness of health care services.

STRATEGIES

Strategy: Bring public and private stakeholders together to develop a strategic health information technology plan, provide oversight for the implementation of this plan, and maximize the impact of resources being spent on health information technology across the state.

Strategy: Set specific goals for the adoption of electronic health records (EHRs), personal health records (PHRs), decision support tools, e-prescribing, and other health information technology as well as the establishment of a system for state health information exchange.

The state must set ambitious goals for Oregon in all areas of health information technology that align with the statewide health information technology strategic plan and must monitor progress toward these goals.

ACTION STEPS

1. **The Authority establishes a Health Information Technology Oversight Council charged with focusing state, federal, and private sector resources and activities to accelerate the adoption of personal health records (PHR), electronic health records (EHR), and electronic data interchange among healthcare providers, patients, and consumers.** The Governor created the Health Information Infrastructure Advisory Committee (HIIAC) by Executive Order in 2008. The HIIAC represents the diversity of the state and a wide range of stakeholders from the public and private sectors. Rather than create a duplicative group, the HIIAC, either with its current membership or with revised membership, should be re-established as the health information technology oversight council for the Authority.

   The Council:

   - Serves as the oversight council for a purchasing collaborative designed to help providers obtain affordable rates for EHR, PHR, and interoperability infrastructure;
   - Identifies and selects the industry standards required for all subsidized HIT products based, where available, on existing national standards and the current Certification Commission for Healthcare Information Technology certification requirements;
   - Selects, supports, and monitors HIT vendors contracting with the state purchasing pool for the provision of HIT hardware, software, and support services;
   - Enlists and leverages community resources to advance HIT adoption;

- Educates the public and providers on the benefits and risks of HIT infrastructure investment;
- Educates providers and assists with pre-selection and implementation planning to assist in ensuring that value (cost savings and quality) is realized following EHR installation and that EHRs remain interoperable so as to support the exchange of health information in Oregon;
- Coordinates health care sector activities that move HIT adoption forward and achieve HIT interoperability;
- Defines, catalogs, and disseminates incentive-based participation strategies to be funded by the state and other payers;
- Guides resource use;
- Reasonably ensures that any endorsed vendors' applications include appropriate privacy and security controls and that health data cannot be used for purposes other than patient authorized health care activity as allowed by law;
- Supports current state efforts to implement a personal health records bank for Oregon Health Plan enrollees;
- Develops a strategic plan for the development of a statewide health information exchange and closely monitor its implementation; and
- Incorporates the responsibilities as recommended by HIIAC for privacy and security (See privacy and security objective below).

2. Set health information technology goals for Oregon.

The Authority, advised by the Health Information Technology Oversight Council, develops ambitious goals for Oregon in all areas of health information technology, including: electronic health record and personal health record adoption; use of clinical decision making, evidence-based practice support, and population management tools; and e-prescribing. While Oregon providers have adopted health information technology more readily than providers across the nation, there are still over 40% of providers who do not utilize electronic health records (EHRs). The state should set ambitious goals to lead to full adoption of EHR systems and monitor progress toward these goals. In addition, incentives should be put in place to reward providers who are using EHRs in their practice to improve health outcomes and provide decision support consistent with the state's goals for more widespread utilization of electronic prescribing, evidence-based guidelines, and other 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 and used by people across the state.

The state sets ambitious goals for interoperability and health information exchange that would ensure the right information is available to the right people at the right time.

The goals should include, but not be limited to:

- Increase percent of Oregon practices with EHRs by 10% every year.
- All Oregonians have access to a personal health record by 2013.

- By 2013, 50% of Oregonians' health information will be included in systems that allow for electronic exchange. By 2014, 85% of Oregonians' health information will be in systems that allow for electronic exchange.

3. Evaluate progress toward these goals.

The Authority, advised by the Health Information Technology Oversight Council, monitors progress toward these goals. The Office for Oregon Health Policy and Research currently conducts a survey of Oregon's physicians to determine the rate of adoption of EHRs. This effort is expanded to allow the survey to capture more detailed information about the utilization of HIT and health information exchange across a wider range of providers. In addition to measuring statewide adoption of health information technology, the Council analyzes the impacts of health information technology on population health and quality of care, including: reduction in medical errors, increased consumer participation in their care, decreased costs, and the availability of appropriate information when and where it is needed.

➢ Health Information Technology: Accelerating Adoption

OBJECTIVE

Accelerate widespread, effective use of health information technology (HIT) by health care providers and patients/consumers to improve health outcomes, and health care quality.

STRATEGIES

Strategy: Restructure reimbursement systems to provide adequate incentives and compensate providers for utilizing health information technology to improve health outcomes.

The infrastructure and on-going maintenance costs associated with the use of health information technology is an enormous barrier to building an interoperable network of providers throughout Oregon. This barrier is felt at all levels of the delivery system but seems to have a profound effect on small practices and providers serving vulnerable populations, such as safety net and rural providers. Organizations that utilize health information technology to improve patient outcomes deserve the opportunity to recoup some of the added burden of these systems as many of the greater cost benefits are realized by other parts of the delivery system.

The public and private sectors in Oregon should build on efforts in Medicare to reward providers who utilize health information technology that can improve patient care and increase efficiency. Medicare's Physician Quality Reporting Initiative allows for 2% higher reimbursement for providers who meet a set of criteria, including the utilization of electronic health records and e-prescribing. Starting in 2009, e-prescribing alone will qualify Medicare providers for increased payments. Congressman Pete Stark has also proposed legislation that would provide financial incentives to Medicare providers utilizing electronic medical record systems certified to meet standards for interoperability, security, and clinical utility. These incentives would be phased out over time and eventually physicians not utilizing these systems would receive reduced reimbursements from Medicare.

Strategy: Create a public-private purchasing collaborative to assist solo providers, primary care providers, small and rural practices, and those providers who serve a large percentage of Medicaid patients, to obtain affordable rates for high-quality electronic health records (EHR) hardware, software, and supporting services. Set quality, performance, privacy, and service standards for the technology vendors that will contract with this collaborative.

A recent study conducted by the New England Journal of Medicine revealed that major barriers to adoption of EHRs include capital costs, difficulties identifying a system that meets practice needs, uncertainty about the return on investment, and concern that a system would become obsolete.[63]

Capital cost is the barrier to EHR and other health information technology adoption most commonly 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

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

to pay for initial installation of an EHR 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.

There are a wide range of products on the market and it is often difficult for providers to determine the EHR 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 EHR service companies that will be able to provide ongoing support and technical assistance to practices as they integrate the use of EHR 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.

The state can help practices overcome these barriers by leveraging the knowledge of the Health Information Technology Oversight Council in identifying a small number of EHR vendors and service companies who meet quality, performance, and service standards set out by the state. In addition, the state could create a purchasing collaborative or participate in a public-private purchasing pool that utilizes bulk 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 following implementation and with other systems used around the state.

Strategy: Encourage and support providers to utilize technology that supports clinical decision making (CDM), evidence-based practice (EBP), population-based management, and quality improvement.

It is important for providers to have access to health information technology that will maximize their ability to measure and report on quality metrics and take advantage of interoperable EHR chart information, clinical guidelines and other evidence that can improve the quality of care patients receive. In addition, while some of these tools have been developed, there is more work that needs to be done to ensure that the tools are easily integrated into practice workflow. In addition, electronic health records and other technology utilized by providers must allow for easy reporting of important quality and outcomes information so that it can be used for regional, statewide, and 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, EBP and population-based management components to support high-quality patient care.

Strategy: Subsidize installation and ongoing management of health information technology in small and rural practices.

Even with reduced prices negotiated by the state or a purchasing collaborative, many practices need financial support to purchase and/or maintain an EHR system. The state should first focus financial assistance on primary care solo and small practices serving underserved and Medicaid populations. The state should only support the adoption of EHR vendors and service companies that meet quality, performance, privacy, and service standards as determined by the state and should be careful not to undermine related community efforts. Grants for the purchase and installation should be matched by community foundations and other private partners to leverage public dollars.

ACTION STEPS

1. **Determine a fair and appropriate way to reimburse providers for their use of electronic health records (EHRs), starting with providers who serve a large percentage of Medicaid patients.**
   The Authority, advised by the Health Information Technology Oversight Council, makes recommendations on how to fairly and appropriately compensate providers for costs associated with using health information technology to improve patient care. Options that are considered should include, but not necessarily be limited to: allocating money to fund increased fee-for-service rate adjustments in Medicaid; requiring Medicaid MCO contracts to reimburse higher rates for health information technology adoption; and building pay for performance into the Medicaid reimbursement methodology and similar options to be used by other payers across the state. New reimbursement strategies should build on the momentum in the Medicare program to use payment incentives to encourage the use of health information technology. The possibility of the state using its bonding authority to support the acceleration and adoption of health information technology should also be explored, especially with respect necessary capital for infrastructure development. Without these types of policy and administrative changes, organizations will continue to delay adoption, discontinue technology use, and/or carry the misaligned burden of these costs.

2. **Create a purchasing collaborative to help small practices select from a small number of state-supported electronic health record (EHR) vendors and service companies that meet quality, performance, privacy, and service standards and offer the most aggressive price.**
   The Authority, advised by the Health Information Technology Oversight Council, establishes a public purchasing collaborative or collaborates with private partners to create a public-private purchasing pool. The collaborative should use the contracting process to select a small number of EHR vendors and a small number of EHR service companies able to support providers using the selected EHR products that will be offered through the collaborative. The contracting process should be built on quality, performance, privacy, and service criteria, as well as cost and value, 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 for *electronic health record vendors* should include, but not be limited to:

   - Meets or exceeds current Certification Commission for Healthcare Information Technology standards;
   - Valuable clinical decision support, evidence-based medicine, population management and quality improvement tools to be used by providers at the point of care and the ability to report on key quality metrics;
   - Interoperable data exchange with other EHRs, personal health records, and the Oregon Health Records Bank;
   - Adherence to privacy and security principles (See privacy and security objective below);

- Ability to record, store, and report quality of care and health outcomes measures;
- Ability to be utilized in a range of care settings; and
- Other standards as determined by HIIAC in conjunction with the Health Fund Board.

Requirements to be considered for state contracting with electronic health record *service companies* should include, but not be limited to:

- Ongoing support of the EHR systems selected by the EHR vendor contracting process;
- Implementation support for conversion from paper records or another EHR to one of the state-selected EHRs;
- Interface support;
- Support practices in optimizing use of EHR;
- Support quality reporting;
- Support participation in health information exchange;
- Adherence to privacy and security principles (See privacy and security objective below);
- Other standards as determined by HIIAC and through public forums; and
- The contracting request for proposal process should be completed by January 1, 2010.

3. Establish a program to subsidize provider use of state-selected electronic health record (EHR) vendors and service companies.

Establish a program through legislation to provide subsidies, in the form of grants or low-interest loans, for providers who cannot afford to purchase and/or maintain an EHR system. Priority should be given to small, rural and/or primary care practices and providers serving a large percentage of Medicaid patients. The Authority, advised by the Health Information Technology Oversight Council will 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 EHRs from state-selected EHR vendors or support services from state-selected EHR service companies available through the purchasing collaborative. 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. The subsidy program should be designed to maximize federal match, community matching funds, and other private funds. The health information technology oversight council should also explore opportunities to use the state's bond authority to finance the subsidy program.

➢ Health Information Technology: Health Information Exchange

OBJECTIVE

Have by 2012 a statewide system for electronic exchange of health information.

STRATEGIES

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' health 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 tools 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 electronic health records used by providers serving enrollees in health plans through the Public Employees' Benefits Board, Oregon Educators' Benefits Board, and the Department of Corrections will lay the ground work for eventual health information exchange 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.

Strategy: Facilitate ongoing planning for the development of a statewide system for exchange of health information.

The Health Record Bank is only the first step in creating a system that allows for health information to be effectively, efficiently, and securely exchanged between patients and their providers. The state should coordinate efforts across the public and private sectors to build capacity for health information exchange, promote the development of interoperable technology, and leverage available resources to support a system for statewide exchange. Over time, the state should consider opportunities to partner with private sector and other partners to develop a self-sustaining model for health information exchange.

ACTION STEPS

1. **The Health Information Technology Oversight Council ensures support of the Health Record Bank project and requires that the system be built with interoperability as a main focus.**
   The Authority, advised by the Health Information Technology Oversight Council, works with DMAP to ensure that the Health Record Bank is developed in line with the overall strategic goals for statewide health information exchange and that will allow it to interoperate with other systems used across the state.

2. **The state designates the Health Information Technology Oversight Council as the oversight entity for promoting a statewide system for exchange of health information technology.**
   The Authority, advised by the Health Information Technology Oversight Council develops a strategic plan for the development of a statewide system for the exchange of health information technology. This includes setting the goal of having a statewide system for health information exchange in place by 2012 and monitoring progress toward this goal. By 2013, 50% of Oregonians' health information should be able to be exchanged through this system and by 2014, 85% of Oregonians should be included.

3. **The state allocates the appropriate funding to create a statewide system for health information exchange.**
   Over time, the state should consider working with private and other partners to develop a self-sustaining model for health information exchange.

➢ Health Information Technology: Privacy and Security

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 as well as patients in these systems.

STRATEGIES

Strategy: Any policy developed related to health information exchange must reasonably ensure that systems are in place that protect people's security and privacy and provide for meaningful remedy if these policies are violated.

The federal Health Information Portability and Accountability Act (HIPAA) and current Oregon law offer strong protections for the security and privacy of people's health information. While additional safeguards will be needed over time, strict enforcement of current policies and the existence of penalties for the misuse – including negligent misuse – of information will result in more secure systems being adopted and more privacy and security safeguards being instituted from the beginning.

Strategy: Utilize an opt-in policy for health information exchange to give individuals' control over their information and who has access to it.

Ensuring clear law and rules for patients and providers involved in electronic health information exchange will increase the use and effectiveness of these systems. Requiring that consumers actively opt-in to a health exchange system will ensure that they know their information will be exchanged electronically.

Strategy: Ensure that required administrative, physical, and technical safeguards are in place to protect individuals' health information that is specially protected under federal and Oregon state law. Require patients to provide authorization for every instance of exchange of health information that falls within these specially protected categories.

ACTION STEPS

1. **The Authority, advised by the Health Information Technology Oversight Council, analyzes the policies and programs it develops to ensure that the privacy and security of health information is maintained, especially as health information exchange systems are established and expanded.**
2. **The Health Information Technology Oversight Council works on privacy and security issues as well as identifies opportunities for Oregon to strengthen state law to protect the privacy and security of Oregonians' health information.**

BUILDING BLOCK 5: ENSURE HEALTH EQUITY FOR ALL

How Building Block 5 Can Lead to Improved Population Health and Individual Experience of Care, While Reducing Cost per Capita

Improves population health by:

- Reducing health disparities

Improves the individual's experience of care by:

- Reducing barriers to health care and improve quality of care
- Promoting patient-centered care using the integrated health home model
- Ensuring language access
- Ensuring a workforce that can provide culturally and linguistically competent services

Reduces per capita costs over time by:

- Increasing the use of community health workers able to provide cost-effective care

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.[64,65]

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

[64] Schroeder, S, (2007, September 20). We Can Do Better—Improving the Health of the American People. *The New England Journal of Medicine*, 357(12):1221-1228.

[65] McGinnis, J.M., Williams-Russo, P., & Knickman, J. R. (2002, March/April).The case for more active policy attention to health promotion. *Health Affairs*, 21(2):78-93

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.[66]

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.

In an effort to achieve health equity, the state should pursue a range of strategies. The strategies presented below aimed at meeting this objective is broken into a number of different categories: health promotion and chronic disease prevention and management, reducing barriers to health care, and quality improvement.

HEALTH PROMOTION AND CHRONIC DISEASE PREVENTION

STRATEGY

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.[67] Oregon can target the sustainability of the health care 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.[68] 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-**

[66] Smedley, B., Alvarez, B., Panares, R., Fish-Parcham, C., & Adland, S. (2008, April). Identifying and Evaluating Equity Provisions in State Health Care Reform. New York: The Commonwealth Fund.
[67] Op. cit. Crook, E. D., & Peters, M. (2008, April).
[68] Op. cit. Beal, A. C., Doty, M. M., Hernandez, S. E., Shea, K. K., & Davis, K.. (2007, June).

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.

REDUCING BARRIERS TO HEALTH CARE

STRATEGY

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.[69] 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.[70]

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**. For more on this, see the discussion of citizenship documentation under Building Block 7 (page 111).
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 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.

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[69] Agency for Healthcare Research and Quality. (2003). *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.

[70] Seid, M., Varni, J. W., Cummings, L., & Schonlau, M. (2006, September).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.

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.

4. **The Legislature ensures language access by taking advantage of growing technological capacity in Oregon by creating a state-wide pool of qualified, certified interpreters and organizations that can utilize and build on technologies being developed for telemedicine or telehealth. DMAP seeks federal waiver approval for this change.**
   The Legislature will authorize DMAP to seek federal matching funds for interpreter services through Medicaid. DMAP will use funding to target provider organizations that serve Medicaid patients by making interpreter services affordable.

   The Authority will use state regulation to require that any plan participating in the Oregon Health Fund Exchange pays for interpreter services for its enrollees. The Legislature will authorize the funds to offset subsequent costs.

QUALITY IMPROVEMENT

STRATEGY

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.[71]

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 Authority, in coordination with the Oregon Healthcare Workforce Institute and other groups builds a culturally competent workforce that reflects the diversity of Oregonians.**
4. **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.**
5. **The Authority develops a plan to ensure appropriate education designed to increase cultural competence for all health care providers.**
6. **The Authority expands data collection efforts.**

[71] Op. cit. Beal, A. C., Doty, M. M., Hernandez, S. E., Shea, K. K., & Davis, K.. (2007, June).

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.

7. 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.
- Develop a Health Disparities strategy that utilizes data to identify disparities and assist communities with evaluating interventions to reduce disparities.
- Align resources to support quality healthcare across all demographic populations in Oregon.
- Disseminate 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 6: TRAIN A NEW HEALTH CARE WORKFORCE

How Building Block 6 Can Lead to Improved Population Health and Individual Experience of Care, While Reducing Cost per Capita

Improves population health by:

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

Improves the individual's experience of care by:

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

Reduces per capita costs over time by:

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

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.

The strategies aimed at achieving this objective are divided into two categories: attaining and training providers and ensuring a culturally competent workforce.

ATTAINING AND TRAINING PROVIDERS

STRATEGY

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.[72]

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

[72] Data from the Oregon Employment Department, cited in: Oregon Healthcare Workforce Institute. *2008 Profile: Oregon's Health Care Workforce.*

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.[73] 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%);
- Sixty-eight percent are single specialty practices; and
- 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 in combining strategies to use our existing workforce more

[73] Oregon Center for Nursing. Oregoncenterfornursing.org

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 . . ."[74]

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**.**

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 Healthcare 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 and will enable the Authority to analyze workforce needs in the future.**
3. **The Authority, in coordination with the Oregon Healthcare 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;

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

- 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; and
- Develop target ratios for various categories of health care provider-to-population to direct goal-setting.

4. **The Authority, in coordination with the Oregon Healthcare 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.** These strategies should include an expansion and state financial support of the Oregon Health and Science University (OHSU) Oregon Medicine Collaborative (ORMED), which allows third and fourth year medical students to complete rotations at regional campuses outside of Portland. ORMED will expand the state's capacity to train physicians and allow medical students to train in underserved areas of the state, increasing the likelihood that they will practice in these areas.
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 Community Health Workers. Any certification system should be designed and governed by Community Health Workers and their advocates to ensure fidelity to this very successful model.

ENSURING A CULTURALLY COMPETANT WORKFORCE

STRATEGY

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 7: ADVOCATE FOR FEDERAL CHANGES

How Building Block 7 Can Lead to Improved Population Health and Individual Experience of Care, While Reducing Cost per Capita

Reducing federal barriers to reform as described in this section:

Improves population health by:

- Increasing the proportion of providers accepting Medicare patients
- Increasing populations that are eligible for coverage through the Oregon Health Plan
- Increasing provider workforce by increasing Oregon's capacity for workforce education
- Advocating for federal policies to improve the health and health care delivered to Oregonians

Improves the individual's experience of care by:

- Preserving Medicare Advantage HMO/PPO option for Oregon beneficiaries while protecting them from unscrupulous enrollment practices
- Increasing funding to federally-qualified health centers to make more services available in communities across the state
- Improve access to culturally competent care for American Indians/Alaskan Natives

Reduces per capita costs over time by:

- Improving Oregon's ability to maximize federal participation in state efforts and allow the state to adopt money saving delivery system innovations
- Eliminating barriers to open dialogue among provider organizations that can lead to delivery reforms that will improve the efficiency of care delivery in Oregon
- Allowing all individuals to benefit from tax deductions for their health insurance premium costs

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.

STRATEGIES

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. Medicare rate reform is also a priority of Governor Kulongoski.
- The Centers for Medicare & Medicaid Services (CMS) should pursue Medicare payment reform that places a priority on primary care and 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 with active oversight to ensure that beneficiaries are protected. Further, Congress should 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.
- New CMS citizenship documentation requirements appear to be preventing eligible Oregonians, including children, from enrolling in Oregon Health Plan. CMS should allow states that can demonstrate quality standards and good Medicaid enrollment processes to revert to prior citizenship documentation requirements.

Threats of ERISA lawsuits: 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.

Inequitable federal income tax incentives for health insurance: 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.

Shortages in Oregon's health care provider workforce:

- 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 examine the financing structure for Graduate Medical Education residencies and either raise the federal limitations on Medicare funding or create a more stable and equitable method of federal funding.

Under-funded Indian Health Services programs: 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.

Strategy: 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.

Strategy: 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. For more on this, see the discussion of anti-trust in the Payment Reform section under Building Block 4 (page 73).

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. The Authority will designate resources for staff devoted to pursuing federal change.

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.

6. **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.

Appendix A:
Board, Committee & Workgroup Members and Staff

OREGON HEALTH FUND BOARD

The Health Fund Board met 17 times between October 2007 and December 2008.

Bill Thorndike, Chair
CEO, Medford Fabrication
Medford

Jonathan Ater, Vice Chairman
Chair & Senior Partner, Ater Wynne, LLP
Portland

Eileen Brady, Vice Chairwoman
Co-Owner, New Seasons Market
Portland

Tom Chamberlain
President, Oregon AFL-CIO
Portland/Salem

Charles Hofmann, MD
Physician
Baker City

Ray Miao
State President, AARP Oregon
Bend

Marcus Mundy
President, Urban League of Portland
Portland

BENEFITS COMMITTEE

The Benefits Committee met 9 times between October 2007 and June 2008

Susan King, RN, Chair
Executive Director, Oregon Nurses Association
Portland

Somnath Saha, MD, Vice-Chair
Staff Physician, Portland Veterans Affairs Medical Canter
Member, Health Services Commission
Portland

Nina Stratton, Vice-Chair
Insurance Agent and Owner, The Stratton Company
Portland

Gary Allen, DMD
Dentist, Willamette Dental
Director of Clinical Support for Training and Quality Improvement
Portland

Lisa Dodson, MD
Physician, Oregon Health and Sciences University
Member, Health Services Commission
Portland

Tom Eversole
Administrator, Benton County Health Department
Corvallis

Leda Garside, RN, BSN
Registered Nurse, Tuality Healthcare
Member, Health Services Commission
Lake Oswego/Hillsboro

Betty Johnson
Retired
Member, Archimedes Movement
Corvallis

Bob Joondeph
Executive Director, Oregon Advocacy Center
Portland

Jim Lussier
CEO, The Lussier Center
Member, Oregon Health Policy Commission
Bend

Susan Pozdena
Director of Product and Benefit Management, Kaiser Permanente
Portland

Hubert (Hugh) Sowers, Jr.
Retired
AARP Member
McMinnville

Kathryn Weit
Policy Analyst, Oregon Council on Developmental Disabilities
Member, Health Services Commission
Salem

Kevin C. Wilson, ND
Naturopathic Physician
Hillsboro

DELIVERY SYSTEMS COMMITTEE

The Delivery Systems Committee met 11 times between October 2007 and May 2008.

Dick Stenson, Chair
President and CEO, Tuality Health Care
Hillsboro

Maribeth Healey, Co-Vice Chair
Director, Oregonians for Health Security
Clackamas

Doug Walta, MD, Co-Vice Chair
Physician
Portland

Vanetta Abdellatif
Director of Integrated Clinical Services, Multnomah County Health Department
Portland

Mitch Anderson
Deputy Administrator, Benton County Health Department
Corvallis

Tina Castañares, MD
Government Relations Coordinator, La Clínica del Cariño
Hood River

Dave Ford
CEO, Care Oregon, Inc.
Portland

Vickie Gates
Health Care Consultant
Lake Oswego

William Humbert
Consumer/Retired Firefighter
Gresham

Dale Johnson, Jr.
Vice President, Corporate Human Resources, Blount International
Portland

Carolyn Kohn
Community Advocate
Grants Pass

Diane Lovell
Union Representative, Oregon AFSCME
Portland

Bart McMullan, Jr., MD
President, Regence BlueCross BlueShield of Oregon
Portland

Stefan Ostrach
Union Representative, Teamsters Local 206
Springfield

Ken Provencher
President and CEO, PacificSource Health Plans
Springfield

Lillian Shirley, BSN
Director, Multnomah County Health Department
Portland

Mike Shirtcliff, DMD
Dentist and CEO, Advantage Dental Plan
Redmond

Charlie Tragesser
President and CEO, Polar Systems, Inc.
Portland OR

Richard Wopat, MD
Vice-President & Chief Quality Officer, Samaritan Health Services
Lebanon

QUALITY INSTITUTE WORKGROUP
Of the Delivery System Committee

The Quality Institute Workgroup met 8 times between October 2007 and April 2008.

Vickie Gates, Chair
Health Care Consultant
Member, Oregon Health Policy Commission
Lake Oswego

Maribeth Healey, Vice-Chair
Director, Oregonians for Health Security
Clackamas

Nancy Clarke
Executive Director, Oregon Health Care Quality Corporation
Portland

Richard Cohen, MD
Physician
Grants Pass

Jim Dameron
Administrator, Oregon Patient Safety Commission
Portland

Gwen Dayton
Executive Vice President and Chief Counsel,
Oregon Assn. of Hospitals & Health Systems
Lake Oswego

Robert Johnson
Chair, Department of Community Dentistry
OHSU School of Dentistry
Portland

Gil Muñoz
Executive Director, Virginia García Medical Center
Portland

Ralph Prows, MD
Chief Medical Officer, Regence of Oregon
Portland

Glenn Rodríguez, MD
Chief Medical Officer, Oregon Region
Providence Health System
Portland

Kathy Savicki
Clinical Director, Mid-Valley Behavioral Care Network
Salem

Brett C. Sheppard, MD
Professor and Vice-Chairman of Surgery,
Oregon Health & Science University
The Digestive Health Center
Pancreatic/Hepato Biliary and Foregut Units
Department of General Surgery
Portland

Maureen Wright, MD
Assistant Regional Medical Director of Quality,
Kaiser Permanente Northwest Region
Portland

Mike Williams
Attorney, Williams Love O'Leary & Powers, P.C.
Portland

ELIGIBILITY & ENROLLMENT COMMITTEE

The Eligibility & Enrollment Committee met 11 times between October 2007 and April 2008.

Ellen Lowe, Chair
Advocate and Public Policy Consultant
Past Member, Health Services Commission
Portland

Jim Russell, Vice Chair
Executive Manager, Mid-Valley Behavioral Care Network
Co-Chair, Medicaid Advisory Committee
Salem

Robert Bach
Lattice Semiconductor Corporation
Member, Medicaid Advisory Committee
Portland

Jane Baumgarten
Retired
Coos Bay

Felisa Hagins
SEIU Local 49
Portland

Dean Kortge
Senior Insurance Specialist, Pacific Benefits Consultants
Eugene

Noelle Lyda
Ed Clark Insurance Inc.
Salem

CJ McLeod
Senior Vice President and Chief Marketing Officer, The ODS Companies
Portland

Eric Metcalf
Director of Health Services, Confederated Tribes of the Coos, Lower Umpqua & Siuslaw Indians
Coos Bay

John Mullin
Oregon Law Center
Portland

Bill Murray
CEO, Doctors of the Oregon Coast South
Coos Bay

Ellen Pinney
Health Policy Advocate, Oregon Health Action Campaign
Corbett/Salem Eligibility & Enrollment Committee
Salem

Susan Rasmussen
Manager - Special Populations
Kaiser Permanente Northwest
Portland

Carole Romm
Director of Community Partnerships and Strategic Development, Central City Concern
Co-chair, Medicaid Advisory Committee
Portland

Ann Turner, MD
Physician and Co-Medical Director, Virginia Garcia Memorial Health Center
Portland/Cornelius

FEDERAL LAWS COMMITTEE

The Federal Laws Committee met 10 times between November 2007 and November 2008.

Frank J. Baumeister, Jr., MD, Chair
Physician, Northwest Gastroenterology Clinic
Portland

Ellen Gradison, Vice Chair
Attorney, Oregon Law Center
Corvallis

Michael J. Bonetto, Ph.D., MPH, MS
Director, Community Benefit & Government Affairs
Cascade Healthcare Community, Inc.
Bend

Chris Bouneff
Director of Marketing and Development, DePaul Treatment Centers
Portland

Michael Huntington, MD
Retired Physician, Radiation Oncology
Member, Archimedes Movement
Corvallis

Julia James
Consultant
Bend

Mallen Kear, RN
Retired, Member, Archimedes Movement
Leader, Eastside Portland Archimedes Chapter
Portland

Cheryle Kennedy
Council Chairwoman, The Confederated Tribes of the Grand Ronde Community of Oregon
Grand Ronde

Sharon Morris, MPH
Health Care Administrator (ret.)
Grants Pass

Larry A. Mullins, DHA
President and CEO, Samaritan Health Services
Corvallis

Nicola Pinson
Health Law Attorney
Portland

Thomas Reardon, MD
Retired Physician
Gresham

FINANCE COMMITTEE

The Finance Committee met 13 times between October 2007 and May 2008.

Kerry Barnett, Chair
Executive Vice President, The Regence Group
Portland

John Worcester, Vice Chair
Manager, Benefits and Compensation, Evraz Oregon Steel Mills
Portland

Andy Anderson
Senior Vice President & CFO, Cascade Corporation
Fairview

Peter Bernardo, MD
Physician, General Surgery
Salem

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Dentist
Milwaukie

Aelea Christofferson
President, ATL Communications, Inc
Sunriver

Terry Coplin
CEO, Lane Individual Practice Assn., Inc.
Eugene

Lynn-Marie Crider
Public Policy Director, SEIU Local 49
Portland

Jim Diegel
President and CEO, Cascade Healthcare Community, Inc.
Bend

Steve Doty
President and Owner, Northwest Employee Benefits, Inc.
Portland

Laura Etherton
Advocate, Oregon State Public Interest Research Group
Portland

Cherry Harris
Union Representative, International Union of Operating Engineers
Gladstone

Denise Honzel
Healthcare Consultant
Camas

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John Lee
Consultant, Providence Health & Services
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Scott Sadler
Owner, The Arbor Café
Salem

Steve Sharp
Chairman of the Board, TriQuint Semiconductor, Inc.
Portland

EXCHANGE WORKGROUP
Of the Finance Committee

The Exchange Work Group met 10 times between October 2007 and April 2008.

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Healthcare Consultant
Camas

Laura Etherton, Vice-Chair
Advocate, Oregon State Public Interest Research Group
Portland

Kerry Barnett
Executive Vice President, The Regence Group
Portland

Damian Brayko
Director, Small Group and Individual, Kaiser Permanente NW
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Terry Coplin
CEO, Lane Individual Practice Assn., Inc.
Eugene

Lynn-Marie Crider
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President and Owner, Northwest Employee Benefits, Inc.
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Chris Ellertson
Regional Health Plan Officer, Health Net Health Plan of Oregon
Tigard

Jack Friedman
CEO, Providence Health Plans
Beaverton

Jon Jurevic
Senior Vice President, Chief Financial Officer, ODS
Portland

Ken Provencher
President and CEO, Pacific Source Health Plans
Springfield

Nina Stratton
Owner, Stratton Company
Portland

Kelsey Wood
Gordon Wood Insurance Agency
Roseburg

HEALTH EQUITIES COMMITTEE

The Health Equities Committee met 10 times between November 2007 and April 2008.

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Health Equity Initiative Manager, Multnomah County Health Department
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HEALTH INFORMATION INFRASTRUCTURE ADVISORY COMMITTEE (HIIAC)

HIIAC met 9 times between April and October 2008.

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Chief Information Officer, Legacy Health System
Portland

Ree Sailors, Co-Chair
Governor's Office
Salem

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President, Apgar & Associates
Portland

Ken Carlson
Pediatrician
Portland

Homer Chin
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Portland

Nancy Clarke
Executive Director, Oregon Health Care Quality Corporation
Portland

Andy Davidson
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Portland

Joyce DeMonnin
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Salem

Laura Etherton
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Portland

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CEO, The Corvallis Clinic
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Brandon Repp
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Delivery Systems Committee and Quality Institute Workgroup
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Jeanene Smith
Ilana Weinbaum

Eligibility & Enrollment Committee
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The Board wishes to thank the following people for their assistance in the development of the Committee and Board recommendations.

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Appendix B:
Key Links to Additional Information

Senate Bill 329
http://www.leg.state.or.us/07reg/measures/sb0300.dir/sb0329.en.html

Oregon Health Fund Board Committee and Work Group Executive Summaries
http://www.oregon.gov/OHPPR/HFB/Committee_Recommendations.shtml

Proceedings, Reports and Other Information from the Oregon Health Fund Board, Committees and Workgroups
http://www.oregon.gov/OHPPR/HFB

Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century* (2001)
http://books.nap.edu/openbook.php?record_id=10027&page=R1

Institute for Healthcare Improvement, *Best Health Care Results for Populations: The "Triple Aim"* (2007)
http://www.ihi.org/NR/rdonlyres/5FFFC58F-3236-4FB7-8C38-2F07CC332AE3/0/IHITripleAimTechnicalBriefJune2007.pdf

PriceWaterhouseCoopers Health Research Institute, *The Price of Excess: Identifying Waste in Health Care Spending* (2008)

http://www.pwc.com/extweb/pwcpublications.nsf/docid/73272CB152086C6385257425006BA2FC

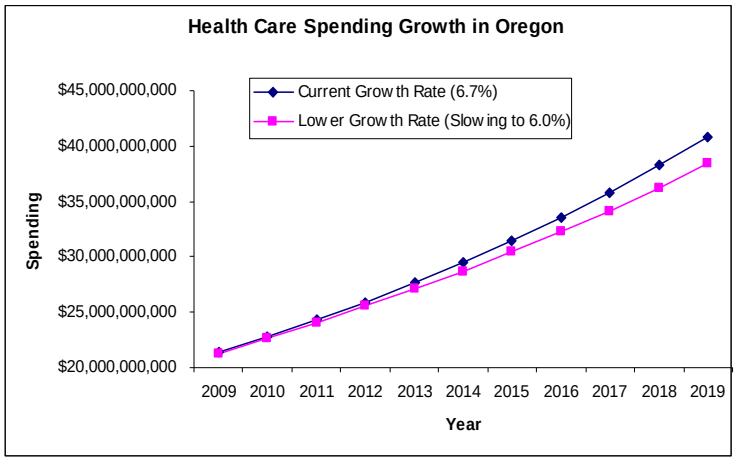
Governor Kulongoski's Wellness Initiative, Press Release, October 31, 2008
http://governor.oregon.gov/Gov/pdf/letters/wellness_initiative_103108.pdf

Appendix C:
Bending the Cost Curve in Oregon
Estimated Cost Savings and Suggested Investments for Cost Containment Strategies

The estimates included in this Appendix should be seen as ballpark targets that could be achieved from full implementation of the Board's recommendations. They are based on the best available research from state and national sources, but many significant assumptions were made in applying these estimates to Oregon's population. The point of these estimates is not to attach specific dollar amounts to each strategy, but to illustrate the significant magnitude of savings that could be achieved through a strategic, coordinated effort to contain costs, while improving health care access and quality.

The investment estimates attached to each strategy represent only the investment the Board believes the state would need to make to get these strategies started in the 09-11 biennium. The Board recognizes that future investments will be needed to expand these efforts and the cooperation of private sector partners will be required in many cases for full savings to be realized.

Overall Savings



The Board believes that it would be realistic to set a goal for Oregon to save up to $10 billion over 10 years.

To calculate these savings, we began by assuming that health care expenditures in Oregon are $20 billion in 2008.[75] Using data from the Centers for Medicaid and Medicare Services, we inflated spending at 6.7% from 2009 through 2019.[76] We assumed that the program would not be fully implemented until 2010, which is when savings would begin to accrue. Our ten-year (2010-2019) baseline spending projection was $310.2 billion.

Since it will take some time for the policies to affect the rate of spending, we assumed that the rate will drop to 6.3% in 2010-2012 and then to 6.0% from 2013-2019. The aggregate spending over this period with the lower growth rates will be $299.4 billion.

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[75] Office for Oregon Health Policy and Research. *Health Care Reform Reference: 2008 Oregon Health Care Spending Estimates*. Available: http://www.oregon.gov/OHPPR/OHREC/Docs/OregonHealthCareSpendingEstimates06thru08.pdf

[76] CMS National Health Expenditures Projections 2007-2017. Available: http://www.cms.hhs.gov/NationalHealthExpendData/Downloads/proj2007.pdf

Appendix C: Bending the Cost Curve – Estimated Cost Savings and Suggested Investments for Cost Containment Strategies

The total savings for the ten year period is $10.8 billion, which is 3.6% of aggregate spending at the current growth rate.

Direct Cost Containment Actions

Table 1: Summary of Potential Savings Resulting from Direct Cost Containment Actions ***NOTE: The savings estimates should not be summed due to interactive and synergistic effects of the various strategies. These are optimal estimates subject to change.***		
	Savings Accrued in First 3 Years Post-Implementation	**Savings Accrued in First 10 Years Post-Implementation**
Continue to Develop and Implement Evidence-Based Guidelines and Best Practice Clinical Standards	Up to $650,000,000	Up to $4,200,000,000
Reduce Growth in Administrative Spending by Health Insurance Plans	Up to $110,000,000	Up to $1,400,000,000
Reduce Spending on Health Care Administrative Transactions	Up to $42,000,000	Up to $350,000,000
Primary Care, Prevention, and Chronic Disease Management	Up to $44,000,000	Up to $190,000,000
Reduce Pharmaceutical Spending	Up to $8,600,000	Up to $39,000,000
Long-Term Prevention and Population Health	Up to $36,000,000	Up to $450,000,000
Institute Common Contracting	Unable to estimate	Unable to estimate
Facilitate Statewide Use of Health Information Technology	Up-front investments likely to be greater than savings in short-term	Up to $990,000,000

Table 2: Summary of Suggested 2009-2011 Investments for Direct Cost Containment Actions	
Delivery System Infrastructure	**Suggested Investment for 09-11**
Continue to Develop and Implement Evidence-Based Guidelines and Best Practice Clinical Standards	$400,000 State Funds; $200,000 - Federal Funds
Reduce Growth in Administrative Spending by Health Insurance Plans	Within Existing Cost Structure
Reduce Spending on Health Care Administrative Transactions	Within Existing Cost Structure
Primary Care, Prevention, and Chronic Disease Management	$9,7000,000 State Funds; $17,300,000 Federal Funds
Reduce Pharmaceutical Spending	Within Existing Cost Structure
Long-Term Prevention and Population Health	$26,000,000 State Funds
Institute Common Contracting	Within Existing Cost Structure
Facilitate Statewide Use of Health Information Technology	$5,520,000 State Funds; $2,480,000 Federal Funds

Continue to Develop and Implement Evidence-Based Guidelines and Best Practice Clinical Standards: Give providers the information they need to use the best available evidence to care for their patients. Based on accepted research on clinical effectiveness, the state, through the use of expert organizations, should expand its role in developing and endorsing evidence-based guidelines for the use of new and existing technologies and treatments. Where the evidence does not yet exist, the state should expand its role in identifying best clinical practices widely accepted and followed in the field, while encouraging and supporting further research to confirm these standards. Uniform implementation of these guidelines and clinical standards will reduce variation in utilization among providers, reduce the provision of unnecessary care, and improve the quality and value of care delivered. Guidelines will be used to design evidence-based benefit packages. An added benefit of establishing these guidelines is the potential reduction in defensive medicine.

- Policy Action: The Legislature empowers the Authority to develop clinical quality measures, health outcomes targets, clinical guidelines where evidence-exists and best practice clinical standards where evidence is still being developed. With oversight and direction from the Health Authority, the Health Resources Commission (HRC) and the Health Services Commission (HSC) expand their capacity to develop evidence-based guidelines based on the best available evidence for the use of medical technology and pharmaceuticals and best practice clinical standards. The Legislature increases the budgets of the HRC and HSC to meet these needs. The Authority creates a database of all claims paid across the state. This will allow the Authority to monitor and providers, purchasers, and policymakers to determine if evidence-based guidelines and best practice clinical standards are being followed and if they are affecting cost and quality.
- Implementation Strategy: The Authority approves, publishes, and disseminates evidence-based guidelines and best practice clinical standards. The Authority requires health plans contracting with the state to utilize guidelines and best practices and to adhere to uniform contracting standards, with processes and procedures for justifying care that does not meet evidence-based guidelines or best practice clinical standards. This policy will have the most power to improve quality of care and reduce costs if all purchasers and health plans, both private and public, utilize uniform evidence-based guidelines and best practice clinical standards.
- Estimated Investment for 09-11: $400,000 State Funds; $200,000 Federal Funds
- Estimated 3-Year Savings Post-Implementation: Up to $650 million
- Estimated 10-Year Savings Post-Implementation: Up to $4.2 billion
- See pages 44-48 for more details

Methodology: These savings were estimated based on the Commonwealth Fund's "Bending the Curve" report, which estimates that creating a center for medical effectiveness could save the nation $18 billion in one year and over $368 billion over ten years.[77] Since 1.13% of U.S. health care spending can be attributed to Oregon, we

[77] Schoen, C., Guterman, S., Shih, A., Lau, J., Kasimow, S., Gauthier, A., & Davis, K. (2007, December). Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending. The Commonwealth Fund. Available: http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=620087

assumed that this same percentage of the total savings would accrue to Oregon over one and ten years if all providers in the state implement evidence-based practice standards.[78] In order to calculate three year savings, we inflated the projected one year savings for Oregon using CMS's projected annual growth rate for national health expenditures (6.7%).[79] We estimated savings for Oregon from implementing this policy would be up to $650,000 for the first three years post-implementation (2010-2012) and up to $4.2 billion after ten years of implementation (2010-2019).

Reduce Growth in Administrative Spending by Health Insurance Plans

- Policy Action: The Insurance Division must report to the Authority on an annual basis the average administrative per-member-per-month rate for the individual and small-group health insurance markets. In addition, the Insurance Division will report total premiums earned, average per-member-per-month administrative rates, and percent growth in administration as a percent of premiums by company for the dominant insurers in Oregon.
- Implementation Strategy: The Authority sets benchmarks for the maximum allowed increase in administrative spending on a per-member-per-month basis for health insurers. The Legislature authorizes the Insurance Division to review the administrative expenses of health insurers for individual and small group lines of business and reject increases in administrative expenses that are determined by the Insurance Division to be unjustified or excessive. After two years, the Authority evaluates whether new regulation is needed to hold administrative spending to targets.
- Estimated Investment in 09-11: Within existing cost structure
- Estimated 3-Year Savings Post-Implementation: Up to $110 million
- Estimated 10-Year Savings Post-Implementation: Up to $1.4 billion
- See pages 62-63 for more details

Methodology: We first calculated the projected spending on private health insurance premiums in Oregon through 2019. Knowing that spending on premiums was $4.463 billion in 2006,[80] we inflated spending at 6.1% to 2007 and 5.0% to 2008 using the national rate of growth in health care premiums for these years, as reported in the Kaiser Family Foundation/Health Research and Educational Trust Employer Health Benefits Surveys.[81] In order to project the growth in spending on premiums from 2008 to 2019,

[78] Kaiser Family State Health Facts, Oregon: Health Costs and Budgets. Available: http://www.statehealthfacts.org/profileind.jsp?cat=5&sub=143&rgn=39

[79] CMS National Health Expenditures Projections 2007-2017. Available: http://www.cms.hhs.gov/NationalHealthExpendData/Downloads/proj2007.pdf

[80] Oregon Department of Consumer and Business Services. (2008, May). *Health Insurance in Oregon*. Available: http://www.cbs.state.or.us/external/ins/health_report/3458-health_report-2008.pdf

[81] Kaiser Family Foundation/Health Research and Educational Trust. *Employer Health Benefits Surveys* (http://www.kff.org/insurance/ehbs-archives.cfm), compiled by the Commonwealth Fund in Davis, K. (2008, September 23). Shifting Health Care Financial Risk to Families Is Not a Sound Strategy: The Changes Needed to Ensure Americans' Health Security. Invited Testimony, House Committee on Ways and Means, Subcommittee on Health, Hearing on "Health of the Private Health Insurance Market." Washington D.C. Available: http://www.commonwealthfund.org/usr_doc/Davis_shifting_financial_risk_families.pdf?section=4039

we inflated spending at the average annual increase since the KFF/HRET Employer Surveys were first published in 1988. The average rate of increase is 8.65%.

The Department of Consumer and Business Services reports that 7% of total spending on premiums goes toward plan administration and reports that this rate has stayed relatively consistent in the past few years.[82] We calculated the total projected spending on administration for 2010-2019 if this portion of premiums continued to rise at the same rate as overall premiums (8.65%). We then calculated aggregate spending on administration if the rate of increase in the administrative portion of premiums was held to CPI (estimated at 4%). This allowed us to estimate that savings from holding the growth in the portion of premiums used for administration to 4% could save up to $110 million for the first three years post-implementation (2010-2012) and up to $1.4 billion in ten years (2010-2019).

Reduce Spending on Health Care Administrative Transactions

- Policy Action: The Legislature requires the Insurance Division to convene a work group to develop uniform forms and processes for administrative transactions. The Insurance Division is authorized to require licensed health plans to utilize such forms and processes.
- Implementation Strategy: Applies broadly to Oregon's insured market.
- Estimated Investment in 09-11: Within existing cost structure
- Estimated 3-Year Savings Post-Implementation: Up to $42 million
- Estimated 10-Year Savings Post-Implementation: Up to $350 million
- See pages 49-50 for more details

Methodology: In 2007, the Minnesota Legislature passed amendments to the state's Administrative Simplification Act, which required that all health care providers and group purchasers conduct health care administrative transactions electronically, using standard data content and format by 2009. To calculate potential savings in Oregon if a similar policy were implemented, we used the same methodology as the Minnesota Department of Health (MDH).

According to work carried out by MDH staff, costs related to eligibility inquiries and responses, claims, and payment and remittance advice accounts for approximately 2% of total health care spending in the state.[83] To get a baseline figure for the cost of administrative transactions in Oregon without having the new policy in place, we applied the same percentage to total health care spending in Oregon, inflated by CMS's projected annual growth rate for national health expenditures (6.7%) through 2019.[84] From this data, we estimated the total cost of administrative transactions in Oregon without the new policy.

The MDH methodology assumes that a policy that requires standard electronic transactions could save 1% in the first year, 3% in the second year, 5% in the third year,

[82] Op. cit. Oregon Department of Consumer and Business Services.
[83] Calculations based on findings from: Minnesota Department of Health Staff. (2007, November 13). Administrative Efficiency Background Information Prepared for the Health Care Transformation Task Force.
[84] Op. cit. CMS National Health Expenditures Projections 2007-2017.

and 7% in years four through 10. Thus, using the administrative spending figures calculated above, we were able to determine the potential savings from 2010 to 2019 from implementing a similar policy in Oregon. Based on these calculations, the three-year (2010-2012) savings would be up to $42 million, with ten-year savings of up to $350 million for 2010-2019.

Primary Care, Prevention, and Chronic Disease Management: Enroll Oregon Health Plan beneficiaries with chronic and/or comorbid conditions in designated integrated health homes and require case management payments. Integrated health homes improve care coordination and service integration, which can reduce duplicative tests and services and avoid costly hospitalizations through better disease management.

- Policy Action: The Legislature authorizes the Health Authority to direct the Department of Human Services to modify its contracts with managed care organizations and providers to ensure that all OHP beneficiaries with chronic and/or comorbid conditions have integrated health homes. The Legislature appropriates sufficient funds to DHS to allow for case management payments to integrated health homes.
- Implementation Strategy: Health Authority directs state programs (PEBB, OEBB) and other public employers to implement integrated health homes in their contracting and benefit design. The Authority will encourage private purchasers to implement integrated health homes.
- Estimated Investment in 09-11: $9,7000,000 State Funds; $17,300,000 Federal Funds
- Estimated 3-Year Savings Post-Implementation: Up to $44 million
- Estimated 10-Year Savings Post-Implementation: Up to $190 million
- See pages 66-69 for more details

Methodology: Cost savings for this policy were calculated based on cost savings seen in a similar policy implemented in the Illinois Medicaid program. Launched in 2006, Illinois Connect is a primary care case management program of the Illinois Department of Healthcare and Family Services (HFS). Most people who receive their care through HFS, including Medicaid and All Kids enrollees, are required to select an "enrolled" primary care physician to serve as their medical home. Enrolled primary care providers are paid, on a monthly basis, $2 per child, $3 per parent, and $4 per senior or adult with a disability who is on their panel. Disabled adult Medicaid beneficiaries, children with asthma, and frequent emergency room users are also enrolled in the statewide Disease Management program called Your Healthcare Plus. Your Healthcare Plus provides additional comprehensive disease management support to the patient and the medical home.

Using data from the Illinois Health Connect program, we calculated a per-member-per-year (PMPY) savings from the first year of the program. The program reported a $34 million savings for 1.7 million enrollees, leading to a $20 PMPY savings.[85] We assumed enrollment would be consistent with the planned phase 1 enrollment expansion currently proposed by the Oregon Health Fund Board, leading to a total enrollment of 650,000 by

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

2010. We assumed that savings would remain at $20 PMPY, adjusted for inflation, since there is no follow-up data to demonstrate whether savings in Illinois will increase over time. The three-year (2010-2012) savings were estimated to be up to $44 million, with 10-year savings of up to $190 million for 2010-2019.

In the future, if the state was to expand its integrated health home policies for OHP enrollees, further savings could be realized. One possibility would be to model policies after the Community Care of North Carolina, which provides care coordination payments to integrated health homes for all OHP and SCHIP enrollees to provide primary care case management, disease management, and care coordination services *and* establishes and funds community health networks to support integrated health homes by hiring case managers and medical management staff to managing care for a group of enrollees. This is not meant to suggest the Board would necessarily recommend an expansion of integrated health home policies based on this model, but to illustrate possible cost savings from a similar initiative.

The North Carolina Department of Health and Human Services has built community health networks to: link enrollees to medical homes; provide care managers to support medical homes in carrying out population management activities in case and disease management; and develop and disseminate processes and information that supports care that meets the needs of the population, such as clinical guidelines and best practices. The state pays networks a $3 per-member-per-month (PMPM) fee to manage care for a group of enrollees and hire case managers and medical management staff to support primary care physicians in the networks. Primary care physicians in the networks are paid an additional $2.50 PMPM payment to provide medical home services, including quality improvement and disease management efforts.

Analysis of the first four years of the Community Care of North Carolina (CCNC) initiative demonstrates increasing savings. In the first year of implementation, the program saved North Carolina $10 PMPM. In years two, three and four, the program saved the state $27, $31 and $37 PMPM respectively.[86] In order to calculate possible savings from implementing a similar program in Oregon, we assumed enrollment would be consistent with the planned phase 1 enrollment expansion currently proposed by the Oregon Health Fund Board, leading to a total enrollment of 650,000. We assumed savings in years 1-4 would be the same as those experienced through the CCNC program and assumed that savings for years 5-10 would remain at $37 PMPM. We inflated the savings at CMS's projected annual growth rate for medical expenditures.[87] The three-year (2010-2012) savings for this program would be up to $620 million, with ten-year savings of up to $3.3 billion for 2010-2019.

Reduce Pharmaceutical Spending: Expand the use of the Oregon Prescription Drug Program in state-sponsored health programs to take advantage of group purchasing discounts.

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[86] Mercer financial analyses of the Community Care of North Carolina/Access Programs. Available:
SFY 03: http://www.communitycarenc.com/PDFDocs/Mercer%20SFY03.pdf
SFY 04: http://www.communitycarenc.com/PDFDocs/Mercer%20SFY04.pdf
SFY 05 & 06: http://www.communitycarenc.com/PDFDocs/Mercer%20SFY05_06.pdf

[87] CMS National Health Expenditures Projections 2007-2017. Available:
http://www.cms.hhs.gov/NationalHealthExpendData/Downloads/proj2007.pdf

- Policy Action: The Legislature authorizes the Health Authority to direct state-sponsored health programs (PEBB, OEBB, and OHP) to use their contracting authority to require health plans to provide pharmacy benefits through the Oregon Prescription Drug Program (OPDP), unless they can demonstrate greater savings through an alternate arrangement.
- Implementation Strategy: Based upon legislative action, other public employers could be required to use OPDP as the benchmark pharmacy benefits program unless alternative arrangements demonstrate greater savings. The Authority will encourage private sector purchasers to evaluate OPDP as an alternative pharmacy benefit program.
- Estimated Investment in 09-11: Within existing cost structure
- Estimated 3-Year Savings Post-Implementation: Up to $8.6 million
- Estimated 10-Year Savings Post-Implementation: Up to $39 million
- See pages 53-56 for more details

Methodology: In July 2006, the Oregon Prescription Drug Program (OPDP) joined the Washington Prescription Drug Program (WPDP) to form the Northwest Prescription Drug Consortium in order to share rates and contracts. To calculate the potential savings from expanding utilization of OPDP, we assumed that savings for Oregon through expanded utilization of OPDP would be similar to those realized in Washington through the expanded use of WPDP. In January 2006, Uniform Medical Plan (UMP), which is a preferred provider organization administered by the Washington State Health Care Authority and designed by the Public Employees Benefits Board for Washington state employees began to use the WPDP to provide prescription drugs. In the first two quarters, savings realized by UMP were about 8.0%.[88] However, a significant portion of this savings has been attributed to a large number of branded drugs going off patent during this time. The pharmacy director at the UMP estimates that long term savings are more likely to be in the 3-5% range.[89]

In an effort to estimate how much a large group (115,000) in Oregon could save by joining OPDP, we used the total pharmaceutical spending for PEBB, as presented by the Heinz Foundation in 2006,[90] and used estimates from the Office for Health Policy and Research to project spending on pharmaceuticals under current policies from 2010-2019.[91] We then calculated 3% savings, using the most conservative estimate provided by the Health Care Authority. The potential savings for a group of 115,000 were up to $8.6 million for 2010-2012, with ten-year savings estimated to be up to $39 million for 2010-2019.

[88] Washington State Prescription Services and ODS. (2008, August 12). Semi-Annual Meeting Presentation.
[89] Sullivan, D. Pharmacy Director, UMP. (2008, October 23). Personal Communication.
[90] Lewis, J. (2006, July). The Oregon Blueprint: Coordinated Contracting of Prescription Drugs – A Fiscal and Policy Strategy for the State of Oregon. The Heinz Family Foundation. Available: http://www.heinzfamily.org/pdfs/Oregon_Blueprint.pdf
[91] Office for Oregon Health Policy and Research. (2007, February). Trends in Oregon's Healthcare Market and the Oregon Health Plan: A Report to the 74th Legislative Assembly.Available: http://www.oregon.gov/OHPPR/RSCH/docs/LegRpt2007_Final.pdf

Long-Term Prevention and Population Health: Reduce the burden of chronic disease and improve individual and community health. This will reduce the need for expensive, invasive treatment in the future. Support community stakeholder collaboratives to develop and implement evidence-driven prevention initiatives that improve the quality and cost of delivery. The goal is to support community innovation for controlling costs and increasing the quality and outcome of care throughout the community. This can be achieved by enabling health care providers, consumers and payers to work collaboratively to continuously improve the delivery system, patient experience and public health. This action can also help reduce inequities resulting from health disparities.

- Policy Action: Pursuant to legislative action, the Health Authority provides grants to communities for evidence-based public health initiatives and invests in tobacco cessation, obesity prevention, and wellness.
- Implementation Strategy: The Authority directs the Public Health Division in the development, award, and monitoring of community grants.
- Estimated Investment in 09-11: $26,000,000 State Funds
- Estimated 3-Year Savings Post-Implementation: Up to$36 million
- Estimated 10-Year Savings Post-Implementation: Up to $450 million (would be greater savings with greater investment, see footnote)[92]
- See pages 82-86 for more details

Methodology: Estimates for this policy are were based on work performed by the Trust for America's Health.[93] The report provided estimates for annual savings that could be realized in 1-2 years, 5 years, and 10-20 years. In order to provide a conservative estimate for this policy, we assumed that Oregon would experience the 1-2 year rate of savings in the first five years following implementation and the 5-year rate of savings for the second five years of implementation. Savings were inflated using CMS's projected annual growth rate for national health expenditures (6.7%). The report estimated possible savings that could be realized from dedicating $10 per person per year of state funds to proven community-based disease prevention programs to reduce smoking, improve nutrition, and increase exercise. The potential savings if a full $10 per person was invested per year were $103 million for 2010-2012 and $1.3 billion for 2010-2019.

To reflect the 09-11 proposed spending on population health programs of $26 million, we adjusted the savings estimates down. This assumes spending $13 million per year and covering 35% of all Oregonians. The potential savings for this reduced estimate were $36 million for 2010-2012 and $450 million for 2010-2019.

Institute Common Contracts: Combine the purchasing powers of state-sponsored health plans to drive down rates, reduce waste, and improve quality. These contracts would include elements such as discounted group purchasing, integrated health homes, the use of evidence-based clinical guidelines and comparative effectiveness research to

[92] This represents the return on investing $26 million over the biennium on proven community-based disease prevention programs to reduce smoking, improve nutrition, and increase exercise. If $37 million (representing $10 per person) were invested annually, the three-year savings would be approximately $103 million, and the ten-year savings would be $1.3 billion.

[93] For the Trust's methodology, see: Trust for America's Health, *Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities*, July 2008. Available: http://healthyamericans.org/reports/prevention08/Prevention08.pdf. .

design benefit packages, utilization of health information technology, and the use of OPDP. A Public Employers Health Cooperative, including state agencies, counties, cities, and other local governments will facilitate the creation and utilization of common contract standards.

- Policy Action: Pursuant to legislative action, the Authority develops and directs agencies to adopt policies for state-sponsored health programs (PEBB, OEBB, OHP) relating to uniform contracting standards. In addition, the Authority is authorized to organize a Public Employers Health Cooperative to encourage local and county governments to adopt similar uniform contracting standards in their health benefits contracts.
- Implementation Strategy: The Authority establishes benchmarks for uniform contracting standards initially within state-sponsored health programs and works with other public employers through the Cooperative to adopt such standards on a voluntary basis. The Authority also collaborates with private purchasers through the Oregon Coalition of Health Care Purchasers to encourage adoption by the private sector.
- Estimated Investment in 09-11: Included in Health Authority Budget
- Estimated Savings: It is difficult to estimate the exact savings from this action, although common contracts will create probable savings to the health care system in the long run. Portions of the savings reflected in other strategies in this report, such as evidence-based clinical standards and integrated health homes, will result from common contracting that requires use of these strategies.
- See pages 53-56 for more details

Facilitate Statewide Use of Health Information Technology: Reduce errors and duplication, save time, and increase the use of evidence-based medicine by helping providers and patients utilize health information technology. This will ensure that patient information is available at the right time and the right place to reduce medical errors, improve the quality of care and reduce costs.

- Policy Action: The Legislature authorizes the Authority to accelerate the adoption and use of fully deployed electronic health records by endorsing a set of high quality electronic health record vendors and service vendors and leveraging group purchasing power to negotiate reduced prices for these products. The Authority provides subsidies for the purchase and maintenance of these products to small, primary care, and rural providers. The Authority also develops and implements a strategic plan for creating a statewide system of health information exchange. Payment policies are updated to encourage providers to adopt and utilize health information technologies.
- Implementation Strategy: The Authority utilizes the Governor's Health Information Infrastructure Advisory Committee (HIIAC) or another technical advisory group for developing policy recommendations that are implemented and monitored by the Authority and its staff.
- Estimated Investment in 09-11: $5,520,000 State Funds; $2,480,000 Federal Funds[94]

[94] These funds are to provide grants to small practices to enable them to implement electronic health records in their offices in 09-11. Further investments will be needed to begin to address other policy actions.

- Estimated 3-Year Savings Post-Implementation: Up-front investment likely to be greater than savings in the short-term
- Estimated 10-Year Savings Post-Implementation: Up to $990 million
- See pages 90-98 for more details

Methodology: These savings were estimated based on the Commonwealth Fund's "Bending the Curve" report, which estimates that the widespread adoption of interoperable health information technology would require an investment of $8 billion in the first year, and $14 billion in the first five years, but would save $88 billion over ten years.[95] Since 1.13% of U.S. health care spending can be attributed to Oregon[96] we assumed that this same percentage of the total spending savings would apply to Oregon over the long term. Therefore, we acknowledged that this policy would require an upfront investment, but estimated ten year savings (2010-2019) of up to $990 million.

An Oregon-specific analysis found that the there is a net potential annual savings of $1.0-1.3 billion from the widespread adoption of advanced health information technology. The report found these savings could be realized within 12 years.[97]

[95] Op. cit. Schoen, C., Guterman, S., Shih, A., Lau, J., Kasimow, S., Gauthier, A., & Davis, K. (2007, December).
[96] Kaiser Family State Health Facts, Oregon: Health Costs and Budgets. Available: http://www.statehealthfacts.org/profileind.jsp?cat=5&sub=143&rgn=39
[97] Witter, Jr., D., & Ricciardi, T. (2007, September). *Potential Impact of Widespread Adoption of Advanced Health Information Technologies on Oregon Health Expenditures.* Office for Oregon Health Policy and Research. Available: http://www.oregon.gov/OHPPR/docs/OR_HIT_Impact_Final.pdf.

Appendix C: Bending the Cost Curve - Estimated Cost Savings and Suggested Investments for Cost Containment Strategies

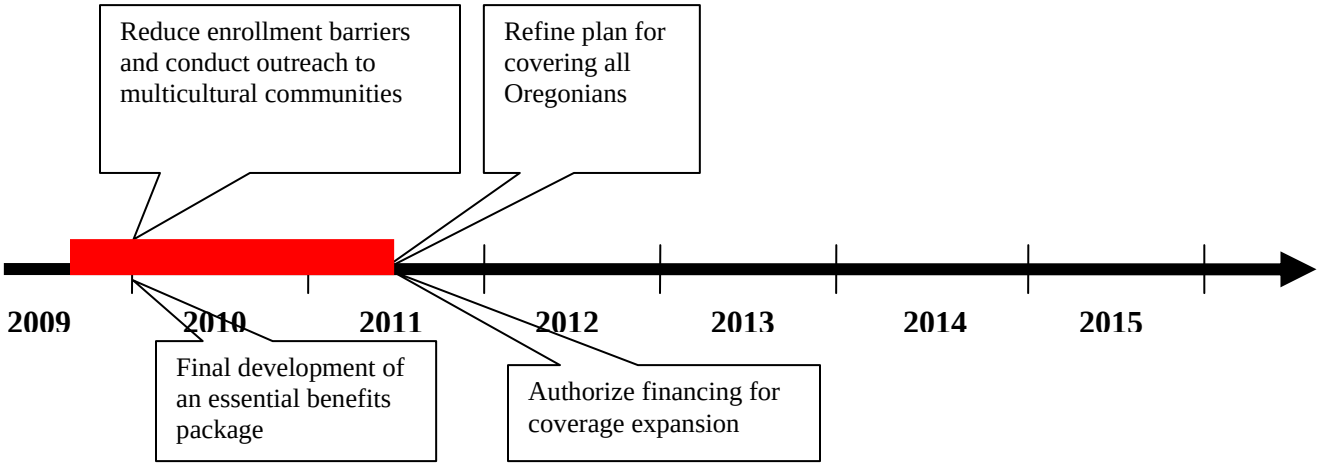
Infrastructure Necessary for Strategic, Coordinated Cost Containment Effort

Table 3: Summary of Suggested 09-11 Investments for Infrastructure Necessary for Strategic, Coordinated Cost Containment Effort	
Delivery System Infrastructure	**Suggested Investment for 09-11**
Health Authority	$400,000 - $3,000,000 State Funds; $200,000 - $2,000,000 Federal Funds
All-Payer, All-Claims Database	$400,000 State Funds; 300,000 Federal Funds
Quality Institute	$400,000-$2,500,000 State Funds; $400,000-$1,100,000 Federal Funds
Integrated Health Home Collaborative	Included in Health Authority Budget
Community-Based Collaboratives – Challenge Grants	$1,000,000 - $5,000,000 State Funds
Public Health Community Collaboration – Community Grants	$10,000,000 - Included in Estimated Investment for Long-Term Prevention and Population Health Strategy Above
Health Insurance Exchange – Further Research and Planning	Included in Health Authority Budget
Public Plan – Further Research and Planning	Included in Health Authority Budget
Financial Reporting	Included in Health Authority Budget
Payment Reform	Included in Health Authority Budget
Workforce Strategy	$300,000 State Funds; $200,000 Federal Funds
Medical Liability Reform	Included in Health Authority Budget
Expanding Coverage	$635,000,000 State Funds; $949,000,000 Federal Funds

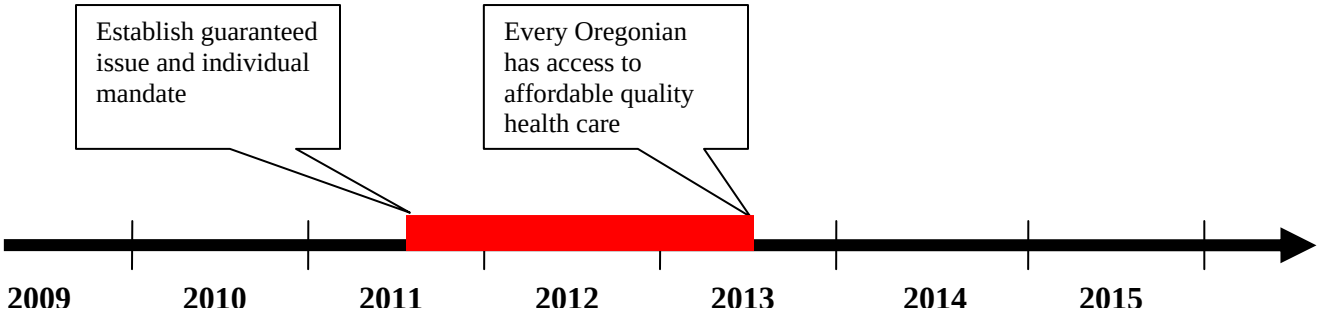
Appendix D:
Timelines for Each Building Block

Building Block 1. Bring everyone under the tent.

Expand coverage for all children and low income adults.

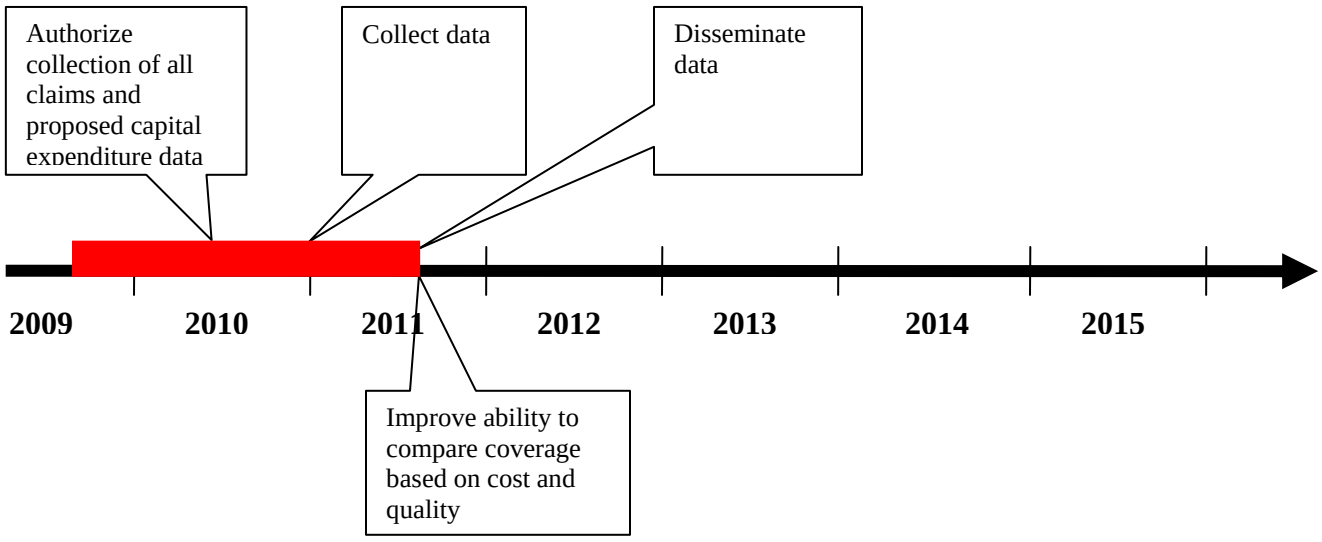


Expand coverage for all Oregonians.

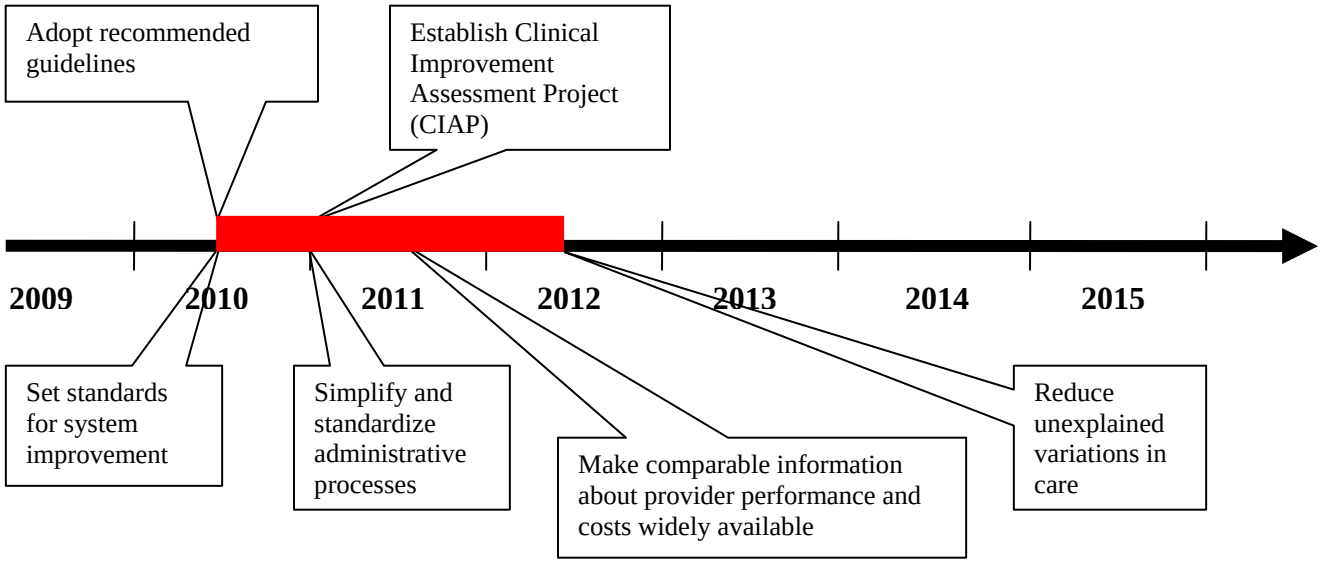


Building Block 2. Set High Standards, measure and report.

Establish an all payer, all claims data collection program

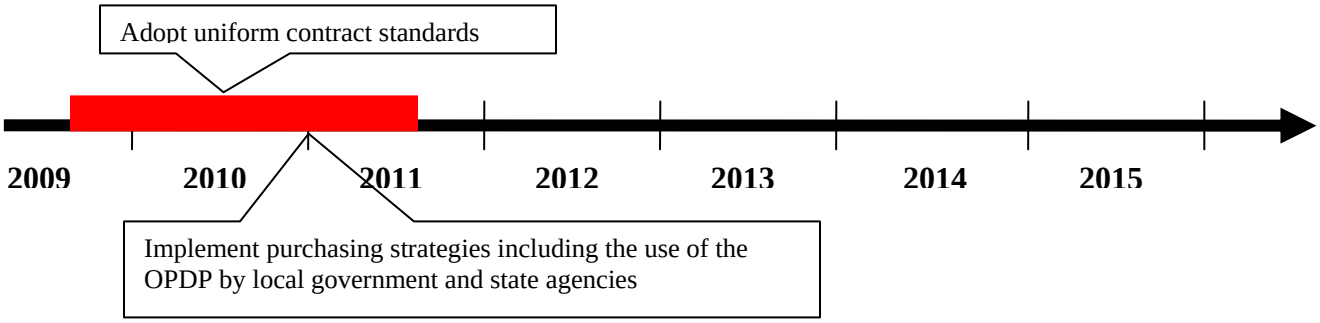


Establish an Oregon Quality Institute.

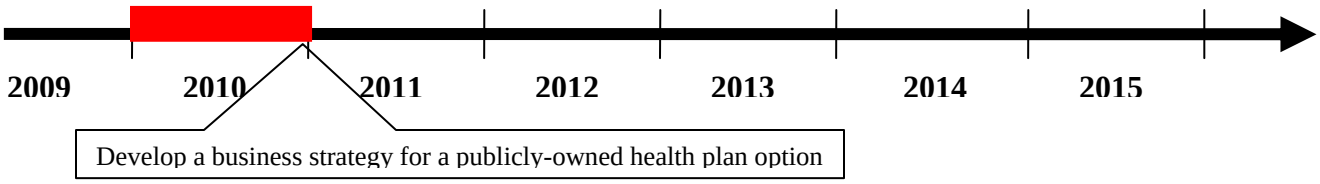


Building Block 3: Unify purchasing power

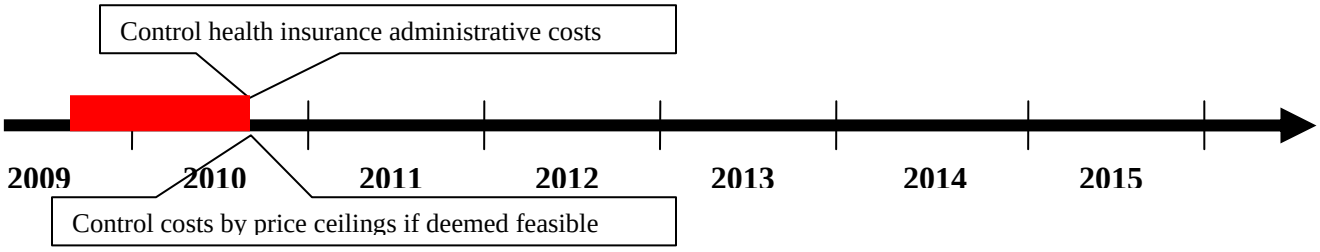
Create a Public Employees Health Cooperative



Establish an Oregon Health Insurance Exchange



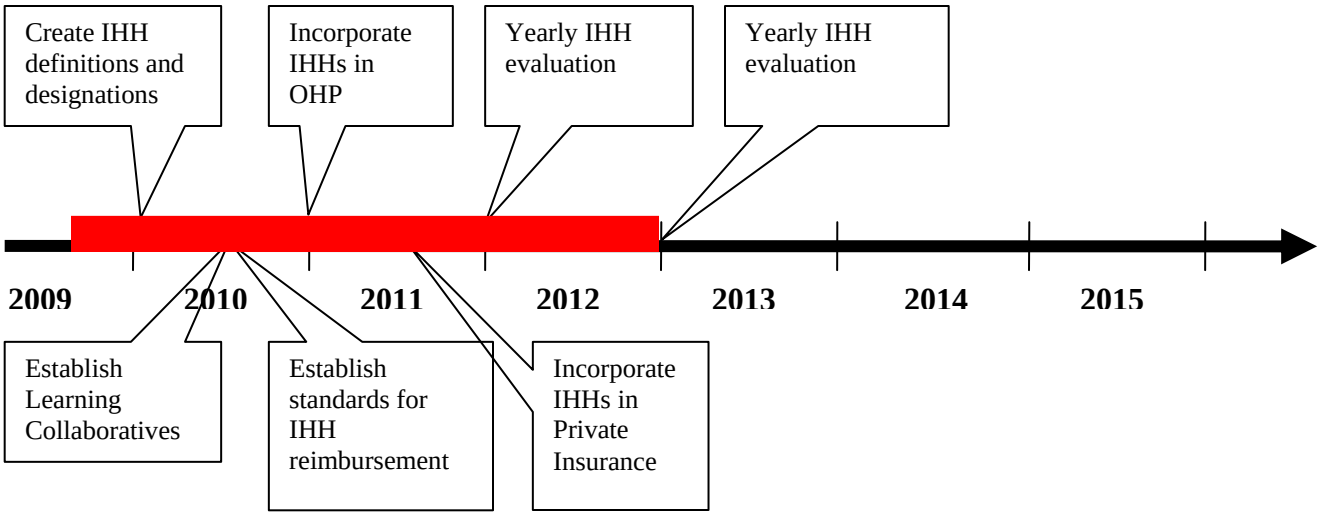
Implement regulatory options to control health care costs



Building Block 4. Stimulate system innovation and improvement.

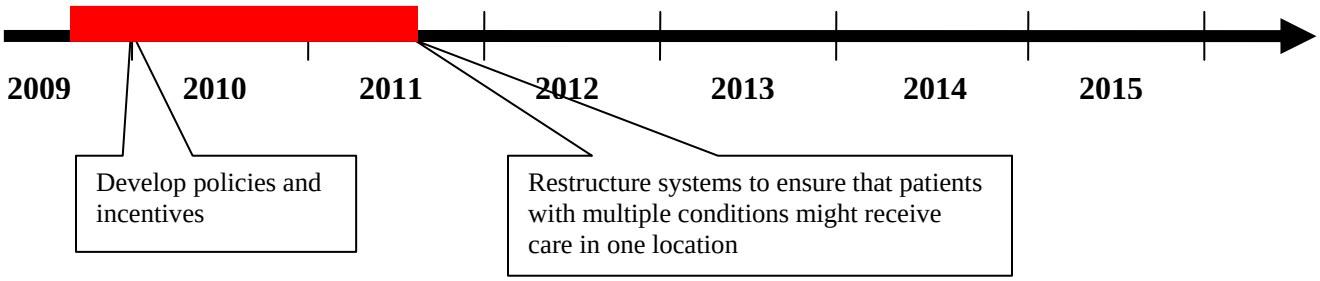
New Models of Care

Implement Integrated Health Homes



New Models of Care (cont)

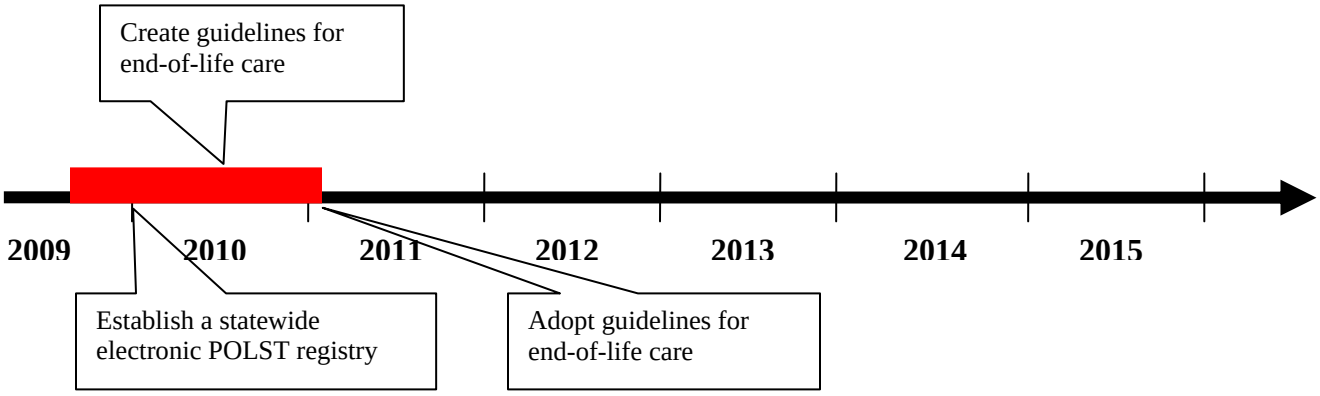
Integrate behavioral health services with physical health services



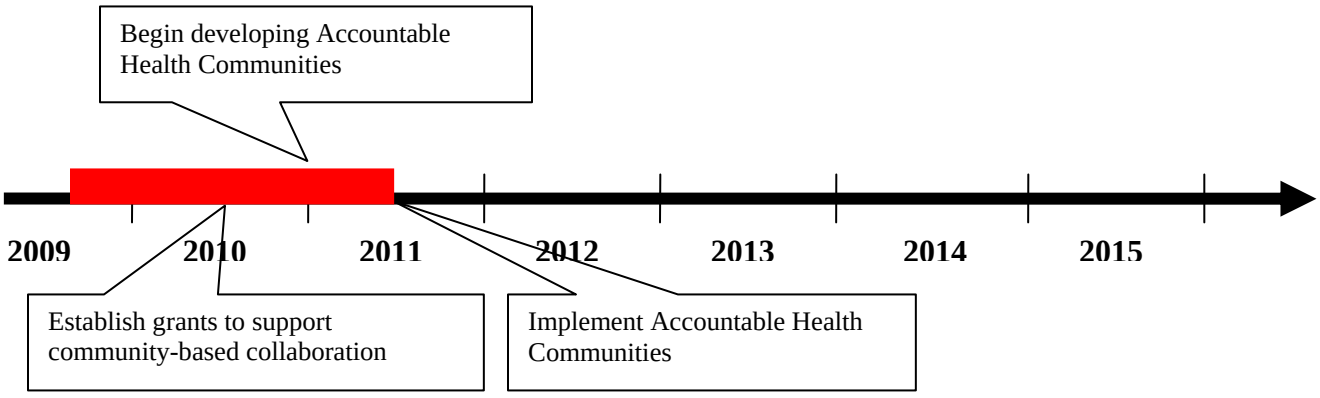
Building Block 4. Stimulate system innovation and improvement.

Establish a payment reform council

Provide high quality, dignified end-of-life care to all Oregonians

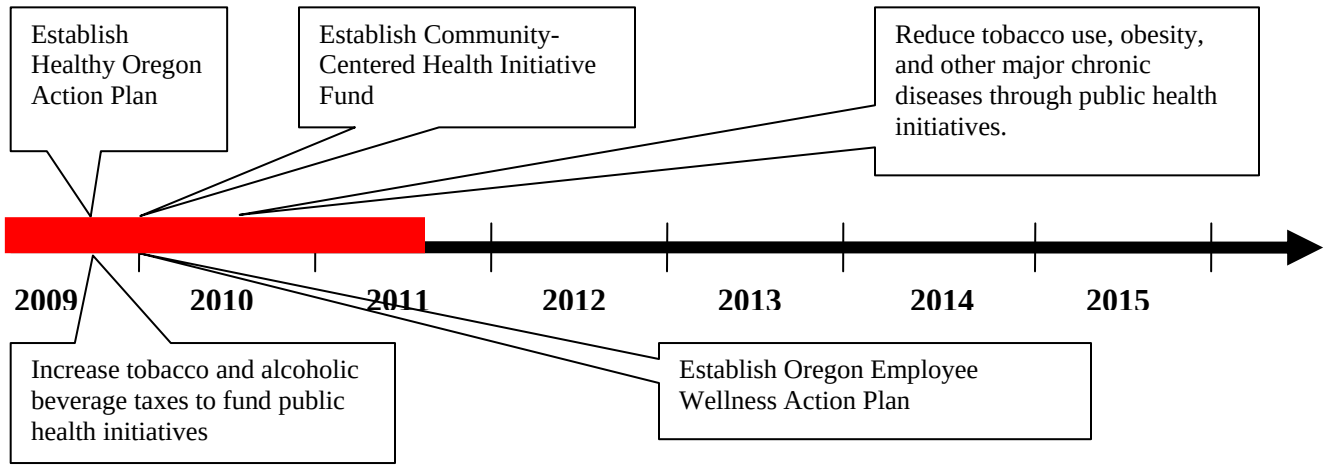


Establish programs to promote Community-Based Innovation

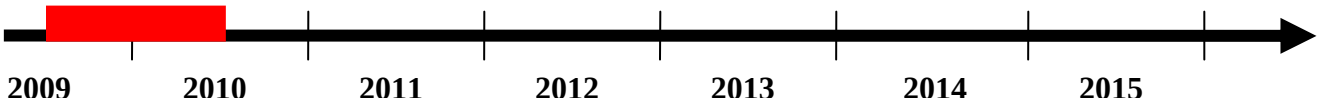


Building Block 4. Stimulate system innovation and improvement.

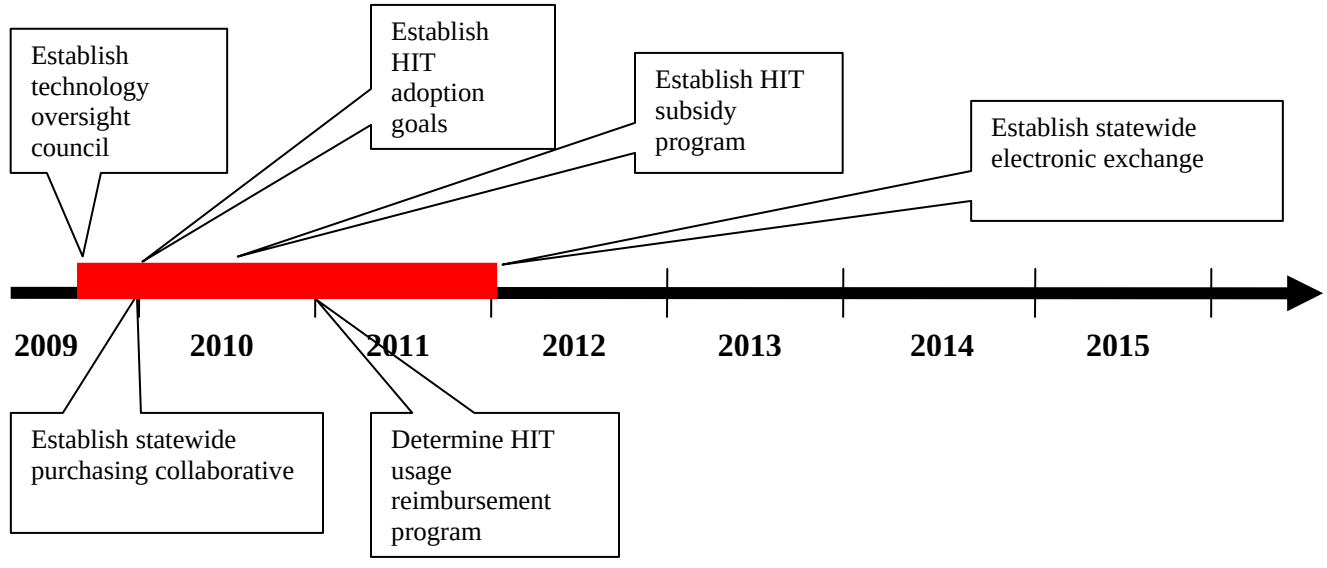
Expand Public Health throughout Oregon



Establish a medical liability reform council

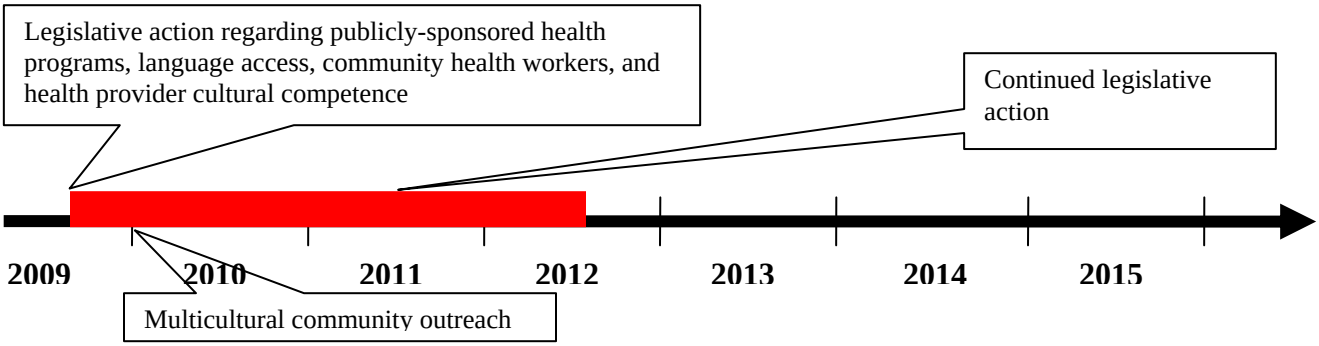


Promote the adoption of Health Information Technology throughout Oregon



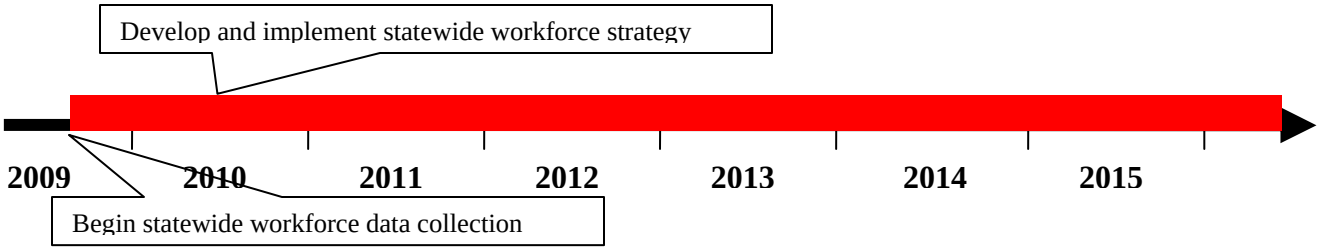
Building Block 5: Ensure health equity for all

Prevent health disparities before they occur, reduce barriers to health care, and improve quality of care



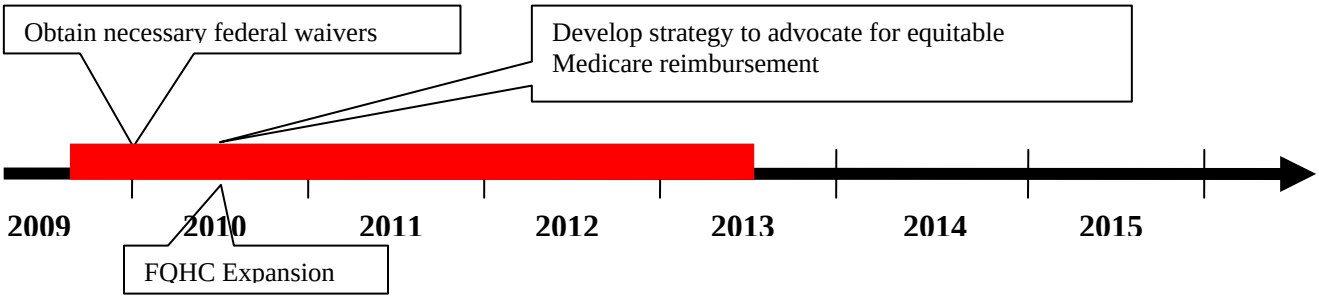
Building Block 6: Train a new healthcare workforce

Ensure Oregon's healthcare workforce is sufficient



Building Block 7: Advocate for federal changes

Align federal policy with Oregon's reform efforts



Appendix E:
Overview of Comments on the OHFB October 2008 Draft Action Plan

Introduction

In September 2008, the Health Fund Board solicited public comment on its Draft Action Plan. Over 1,500 comments were collected through four venues (see table below):

- An online survey was posted on the Board's website,
- 10 Town Hall Meetings were held around the state,
- A meeting of the full Board was devoted to public comment, and
- Written comments were submitted via emails and letters.

Count of comments received as of October 2, 2008	
Survey respondents (online)	431
Town Hall Meetings (approximately 1,000 attendees)	
Individuals offering verbal comments	256
Comment cards from meetings	95
Written comments submitted at meetings	16
Board meeting, Sept. 30	
Individuals offering verbal/written comments	47
Other written comments	
OSPIRG citizen emails	319
Other emails	180
OSPIRG small business petition signers	101
Letters	63
TOTAL	**1,508**

Online Survey: The online survey asked respondents to rate their agreement with specific strategies proposed by the Board. Respondents were also able to submit additional comments on these strategies through the survey. The survey data have a few limitations: respondents were not asked to provide any demographic information, so responses may over-represent particular constituencies. Respondents were able to complete the survey more than once; however, analysis of IP addresses from survey respondents indicates that few did so.

Town Hall Meetings: Between September 8 and 19, Board members and staff convened 10 meetings involving approximately 1,000 attendees in all five congressional districts in Oregon. Meetings were held from 6:30-9:00 p.m. in: Portland, Hillsboro, Bend, Medford, Gresham, Eugene, Salem, La Grande, Corvallis, and Newport.

Each meeting was attended by at least one Board member, with each Board member attending at least one meeting. The meetings were conducted in a town hall format: after a brief video and presentation of the draft Action Plan, attendees were invited to provide comments and pose questions which were answered by staff and/or the Board member attending. Meetings were facilitated by Oregon Health Forum and American Leadership Forum staff, who carried microphones around the room. Comment cards were distributed at the meeting for attendees to make a comment or ask a question, and provide contact information.

September Town Hall Meetings	**Individuals offering verbal comments**	**Estimated attendance**
Portland	39	330
Hillsboro	22	60
Bend	23	60
Medford	22	120
Gresham	18	55
Eugene	33	85
Salem	27	90
La Grande	27	56
Corvallis	31	130
Newport	14	30
Total	***256***	***1,016***

Board meeting, September 30, 2008: A full meeting of the Board was convened with the sole purpose of gathering public comment on the draft plan. The Board heard testimony from 47 groups and individuals. Some submitted written versions of their comments. All comments were incorporated into the summary that follows.

Other written comments: The Board received numerous emails and letters with comments on the draft Plan. The Oregon State Public Interest Research Group (OSPIRG) coordinated two efforts to provide comments on the Board's draft: an online petition and a citizen email campaign. The email campaign included a form letter that could be edited, signed, and sent to the Board.

Summary of Comments to the OHFB's Draft Action Plan

Building Block 1: "Bring Everyone under the Tent"

Online Survey Results: Building Block 1

Strategy or Objective	Responses	Support	Oppose	Neutral or No Opinion
Expand access to affordable coverage through new and existing programs	422	77.0%	18.5%	4.7%
Implement an Essential Benefit Package	408	59.5%	31.1%	9.6%
Expand access to all Oregon children and low-income adults in 2009	411	71.7%	21.4%	7.0%
Finance coverage expansions in 2009 with provider (hospital and health insurance carrier) taxes	380	38.1%	47.3%	14.5%
Tie additional coverage expansions (2011-2015) to cost containment successes and available funding	375	57.4%	22.4%	20.3%

Online Survey Additional Comments:

- *Existing programs* – Forty-seven respondents stated that this plan is not necessary because there are already programs in place that provide health care to those who do not have access. They feel the state should continue funding, and even increase funding, for these programs that are already in place.
- *Costs* – Twenty-three respondents are concerned about the costs of this program. Some feel that this is not affordable and are concerned about increasing taxes. Some are unclear of how the plan will actually decrease costs. Some mentioned that costs will be high if the insurance companies are included, as they believe insurance companies always increase costs.
- *Realistic* – Ten respondents do not believe this plan is realistic. Some support and see the importance of providing health care to all, and feel that this plan is a good idea but completely out of reach.
- *Free Market* – Ten respondents stated that government does not belong in health care, and it should rely on free market principles. They believe competition in the free market will increase quality and prices will go down.

Expand access

- Coverage for all (58):
  - 48 support
  - 3 oppose
  - 7 had a concern
- Phase 1: Cover children and/or low-income adults (32):
  - 22 support,
  - 1 oppose (in favor of covering all);
  - 3 support expanding full OHP Plus benefits to OHP Standard population
  - 4 encourage outreach, 1 expand school based health centers

- Access for working uninsured (13)
- Rethink timeline – expand coverage sooner
- Residency (12): most opposed/concerned about non-residents/illegal aliens
- Other populations (12): 3 parents, 3 veterans, 3 mentally ill/developmentally disabled, 2 prison population, 1 rural

Online Survey Additional Comments:

- *Defining Low-Income* - Eight respondents had concerns about how "low-income" is defined. One respondent stated that income should not be a qualifying factor. Some voiced concern that people who are struggling financially and unable to afford health insurance, may not be considered poor enough to receive assistance.

Essential Benefit Package

- Essential Benefit Package concept (33):
  - 23 support
  - 10 had a concern (balancing coverage and costs, EBP might limit benefit package options for businesses, 4 concerns about "meet or exceed" definition)
- Package design (23):
  - 11 concerned about out-of-pocket costs,
  - 2 opposed to pre-existing conditions,
  - 2 support rationing care,
  - 2 support medical expense accounts
- Covered services
  - Prevention/primary care focus (130*)
  - Complementary and alternative medicine (98): nearly all mention acupuncture
  - Should cover: Dental care (8), mental health care (7), home birth, hospice (2), nursing home, home health, vision (2), STDs, reproductive care, psoriasis
  - Shouldn't cover: abortion, autism, colonoscopy, limit end-of-life care spending, pregnancy
- Other: comments about current OHP covered services (5)

Online Survey Additional Comments:

- Eleven respondents expressed concern about the Essential Benefits Package, particularly how it will take into account people having different needs, financial resources, and risk tolerance. In addition, some were concerned about how "essential" will be defined and that Oregonians will have to accept limitations in coverage.

Financing (102)

- Provider tax (31):
  - 3 opposed,
  - 2 support
  - 16 concerned about tax being passed on to consumers
  - 10 questions about how this would work, other concerns
- Tobacco/alcohol tax, other sin taxes (22):
  - 11 opposed,
  - 4 support

  - Opposed mention favoring broad based, equitable tax instead; increase property tax; premium taxes; tobacco tax has failed in the past; sin taxes send wrong message
  - 6 support other sin taxes (soda)
- Payroll tax (13):
  - 4 opposed,
  - 1 support
  - 8 questions or concerns about how this would work, including concerns that employers would drop coverage
- No new taxes (6) – reallocate current funds
- Concerns about expense of reform (7)
- Concerns about relying on federal match (3)
- Other financing options: 7 income tax, 3 bonds, 2 check-off contribution on tax return, tax pharmaceutical companies

Online Survey Additional Comments:

- *Increase Costs to Consumer* - Fifty-one respondents stated that increasing provider taxes will only increase consumer costs in the form of higher premiums.
- *Providers* - Five respondents expressed concern over the chance that providers will disagree with this system and leave the state.

Building Block 2: Set High Standards – Measure and Report

Online Survey Results: Building Block 2

Strategy or Objective	Responses	Support	Oppose	Neutral or No Opinion
Expand the collection of data on race, ethnicity, and primary language	367	36.3%	37.0%	26.7%
Ensure comprehensive reporting by insurers and health facilities	364	72.0%	15.1%	12.9%
Develop a common set of measures, standards, and targets for Oregon to improve quality in the health care system	347	78.3%	13.0%	8.7%
Increase the use of evidence-based practice in the Oregon health care system	341	73.9%	10.5%	15.5%
Establish an Oregon Quality Institute	340	45.3%	30.6%	24.1%
Develop standard formats and processes for eligibility, claims, payment and remittance transactions	339	71.1%	16.8%	12.1%
institute public reporting that gives the Legislature, consumers, providers, purchasers and carriers information across payers and providers	340	69.7%	15.9%	14.5%

Set High Standards (130*)

- Data/information collection (20):
  - 12 support transparency in costs/quality data
  - Important to measure programs, quality and outcomes (4)
- Concerns:
  - Consumer finds Explanation of Benefit forms confusing, consumer would like hospital claims itemized
  - Insurance industry concern about non-aggregated data and connection of per capita/CPI cost increases with improving quality
- Hold insurers, providers accountable for quality and value (103*)
- Clinical standards (5)
- Support Quality Institute (1)
- Other: Disagree that quality must be linked to cost

Online Survey Additional Comments:

- **Standard formats and processes for eligibility, claims, payments and remittance transactions:** Eleven respondents stated that there are standard formats and processes that are already being followed, and it is not necessary to recreate. Respondents mentioned UB 92 and HDFA 1500 as examples of standards already in place.

- **Oregon Quality Institute**
  - *Excessive* - Thirty-five respondents stated that the Oregon Quality Institute is excessive. Several said that there were already organizations monitoring hospital quality. Others felt that a Quality Institute would not increase access to care - which is where resources should go.
  - *Defining Quality*- Four respondents questioned how quality will be defined, because different institutes or agencies use different measures and standards.

- **Develop Measures, Standards, and Targets**
  - *Standards/Measures* - Eleven respondents were concerned about the standards and measures that are to be created. Some were concerned that standards developed by the government tend to not be evidence-based and often miss the intended mark. Some were concerned about how measures will adjust for the providers who care for patients in poor health.
  - *Already Exists* - Five respondents stated that these standards are already in place (at Kaiser, Providence, and Regence). Some felt that Providence and Kaiser's model should be followed as opposed to standards developed by the government.

- **Evidence-Based Practice**
  - *Providers* - Six respondents were concerned that using evidence-based practice would force providers to change the way they practice medicine. Some were concerned that putting too much regulation on providers will lead to providers leaving the state.
  - *Public Outreach* - Four people mention that the use of evidence-based practice needs to be communicated clearly to the public; particularly that people will no

* OSPIRG form letter or petition included this topic.

longer get services "based on emotion" and they need to understand "rational rationing".

- *Evidence* - Eight respondents questioned the sources of evidence used. Some were concerned that new practices would not have sufficient evidence or that patients will be denied care. There is also a concern that the term "evidence-based" has become meaningless because an invalid, biased study could be labeled "evidence-based" with the right lobbying efforts. There are also concerns about evidence provided by pharmaceutical companies.

- **Public Reporting**
  - *Confidentiality* - Five respondents were worried about the confidentiality of their personal health information under public reporting.
  - *Is the data important?* - Four respondents questioned whether the data will be useful. Some were concerned that the public will not be able to understand the data. Some questioned why this information is important to consumers because there are not many "shoppers" and this may give a false sense of choice.

Building Block 3: Unifying Purchasing Power

Online Survey Results: Building Block 3

Strategy or Objective	Responses	Support	Oppose	Neutral or No Opinion
Develop model contract standards and policies that can be adopted by the State of Oregon (Oregon Health Plan, PEBB, OEBB)	294	54.1%	26.2%	19.7%
Create a Public Employers Health Cooperative	295	36.9%	39.7%	23.4%
Create an Insurance Exchange to consolidate the individual health insurance market	300	37.0%	47.0%	16.0%
Authorize the Department of Consumer & Business Services, Insurance Division, to regulate the annual growth rate in administrative expenses charged by health insurers	299	51.5%	37.1%	11.3%
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)	299	54.5%	35.8%	9.7%

Unifying purchasing power (115[*])

- Support (109*)
- Recommendations on how to pool different groups (4)
- Concerns (2): PEBB hasn't demonstrated that it can curb costs, low physician payments would affect access (like Medicare)

[*] OSPIRG form letter or petition included this topic.

Online Survey Additional Comments:

- *Cost* – Seven respondents expressed hesitation about OHP, PEBB, and OEBB's abilities to lower health care costs, and instead feel that these entities increase cost.
- *Choice* – Six respondents were concerned about the lack of choice that the feel this plan includes. They felt that there should not be a "one size fits all" policy because needs differ and people should be able to choose accordingly. One respondent noted that this plan would be acceptable as a model standard but not required, with the flexibility as to which provisions to adopt.
- Seven respondents were not supportive of the Public Employers Health Cooperative specifically because they did not believe that public employees should get preferential treatment. Respondents who support providing health care for all do not think that public employees deserve better care just because they serve the public, and feel that private employees, public employees, and the uninsured should all get the same. Others did not support this because they are already displeased with public employees use of tax dollars.

Insurance Market Reform: Exchange (36)

- Support (10)
- Oppose (14): won't lower costs, won't work, brokers already provide this service
- Concern (10): should encourage competition, should be voluntary, need more information on how this will work

Online Survey Additional Comments:

- *System Already Exits* – Eleven respondents see the insurance exchange as unnecessary because a working system is already in place. They felt an exchange would be a great threat to insurance companies. Some felt that insurance companies and brokers are capable of providing to consumers at a lower cost that the state could. They felt an exchange will result in higher costs and would put insurance companies and brokers out of work.
- *Options/Choices* – Twelve respondents expressed concerns about options and choices under the insurance exchange. Some respondents support the insurance exchange if it provides many options to choose from. Others are opposed to this idea because they believe that an exchange will limit choice and flexibility, which will harm consumers and the health care market. Some did not trust the government to provide an exchange.

Insurance Market Reform: Guaranteed Issue (26)

- Support Guaranteed Issue (19)
- Oppose Guaranteed Issue (3): will ruin market, drive costs up for young/healthy
- Concerns (4): allow differential premiums based on lifestyle choices, OMIP works, medical underwriting excludes many for minor issues

Insurance Market Reform: Mandate (29)

- Support (1)
- Opposed (23): want freedom of choice (4), member of cost-sharing organization (some faith-based) instead of insurance (10), too expensive (1), not yet proven (1), would stifle competition/innovation (1)
- Concerns: enforcement (3), won't work (2)

Insurance Market Reform: Public Plan Option (64)

- Support (52): should happen faster (7), allow PEBB buy-in (2), allow small business to purchase public plan (1), see SAIF and Medicare as models
- Oppose (4): would block private insurance; wouldn't be cheaper overhead
- Concern (9): end up w/two-tiered system (5); crowd-out (1), result in poor access to providers like Medicare, should only be used as last resort

Insurance Market Reform: Single Payer (72)

- Support Single Payer system (68): some comments wondered why Single Payer not represented or addressed in report when it had such broad support in the community
- Oppose Single Payer system (3)
- Other: Argument that ERISA blocks Single Payer system: explain in federal barriers section; not true

Insurance Market Reform: Other

- Insurance Industry (78): Need oversight, oppose oversight, profit-motive problematic (33), need small carriers in some communities, eliminate insurance companies
- Agents/Brokers: keep brokers in the system (30)
- Portability needed (6)
- Use existing public programs (17): OHP (12), FHIAP (15), OMIP (5)
- Guaranteed Renewability (2)
- Opposed to regulation of insurance industry (2)

Addressing Costs

- Health care costs (482[*])
    - Support cost containment strategies (442*)
        - Common claim forms, administrative processes
        - Cut waste in system
        - Contain annual increases
    - Concerns (39)
        - Link to CPI (3)
        - Institute price controls (3)
        - Better understanding of admin costs, admin costs are too high, admin costs are already low (7)
        - Rising premiums are unsustainable (6)
        - Want more specificity on cost containment measures (5)
        - General comments about expensiveness of health care (6)
        - Other: look at other countries, concern about overutilization rather than price, concern that clinical judgment protected
- High insurance costs (120[*])
    - Support for oversight of insurers (103*)
    - Support for cutting excessive administrative costs (3)
    - General comment about expensiveness of insurance (7)
    - Question whether insurers will drop premiums after reform (2)
    - Concern that state mandates drive up insurance rates (2)

[*] OSPIRG form letter or petition included this topic.
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  - Concern about regulating the annual growth rate (1)
- Concerned about costs to small businesses (10)
- Promote research as a way to curb costs later (2)

Online Survey Additional Comments:

- *Regulate Annual Growth Rate:* Seven respondents stated that the annual growth rate is already being regulated by the Department of Consumer & Business Services – Insurance Division. Some wondered if the reason behind this recommendation was that DCBS was ineffective.
- Annual Maximum Limits on Price Increases:
  - *Free Market* – Twelve respondents support the free market in being able to keep costs low.
  - *Providers* – Six respondents expressed concern that cost limits would drive doctors out of the state. Some did not support limits because prices are based on factors outside of their control.
  - *Transparency* – Eight respondents felt that cost transparency is required. Some felt that cost transparency is needed for the free market to succeed. Some felt that the state should analyze the true cost of care because of a large difference between actual and charged costs of care.

Building Block 4: Stimulate System Innovation & Improvement

Online Survey Results: Building Block 4

Strategy or Objective	Responses	Support	Oppose	Neutral or No Opinion
Pursue development of integrated health homes	324	51.0%	19.1%	29.9%
Develop learning collaboratives to improve and further the widespread use of new models of care	319	65.6%	16.7%	17.9%
Integrate behavioral health services	317	64.6%	18.7%	16.7%
Restructure payment systems to encourage high-quality health care delivery	322	69.3%	16.8%	14.0%
Create a statewide voluntary, electronic Physician Orders for Life Sustaining Treatment (POLST) Registry	317	64.9%	12.3%	22.7%
Ensure payment systems adequately reimburse providers for services necessary to provide dignified end-of-life care	318	74.9%	11.3%	13.8%
Support community-based collaboratives	312	59.3%	15.3%	25.4%
Strengthening the role of the safety net in providing health care services to Oregon's vulnerable populations	308	68.5%	17.2%	14.3%
Creating community-level accountability for quality and cost across the continuum of care by creating a performance measurement tool	306	61.4%	18.0%	20.6%

Ensuring effective investment in Oregonians to prevent and reduce tobacco use, obesity and other major chronic diseases	309	76.0%	17.2%	6.7%
Set quality, performance and service standards that all health information technology vendors in Oregon are required to meet	303	71.6%	12.3%	16.1%
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	300	54.0%	28.0%	18.0%
Subsidize small practices' use of state-selected Electronic Medical Record (EMR) vendors and service companies	294	46.3%	31.0%	22.8%
Encourage and support the use of technology that supports clinical decision making (CDM) and evidence-based medicine (EBM)	293	67.9%	14.0%	18.1%
Have a statewide Health Information Exchange system in place by 2012	296	57.5%	27.7%	14.8%
Provide patient control over when, what and with whom personal health information is shared	301	80.4%	10.9%	8.6%

Integrated health homes (30)

- IHH support (14)
    - Need immediate implementation of IHH
- Appreciate prevention/primary care focus (4), patient education important (2)
- Concerns/questions:
    - Concept of IHH unclear
    - How will IHH be paid? How will people get into an IHH?
    - Not sure IHH best for those routinely needing specialist care

Online Survey Additional Comments:

- Six respondents stated that IHHs limit consumer choice and sound very similar to HMOs - which have failed. Five respondents also want to know what type of care will be covered, such as; mental, dental, naturopathic, hospital visits, and pharmaceuticals.

Integrate behavioral health services (28)

- Support integration of mental/physical health care (16)
- Concerns about integration (8):
    - Coordinated care better than integrated care, carve out model works
    - Preserve MH provider innovation
    - Other concerns: Integrate MH and substance abuse care, MH reforms need to address housing, criminal settings, better funding, and availability
- Consumer role in policy making, peer counseling, etc (3)

Online Survey Additional Comments:

- Five respondents say that behavioral health is so specialized and unique that is should not be integrated with physical care; that behavioral health cannot follow the "basic medical model." Five respondents see this form of care as getting out of control in terms of cost.
- Four respondents are hesitant to support integration because some behavioral health problems are self-inflicted and are the fault of the individual.

Community-based innovation (3)

- Support Accountable Health Communities
- Concern that local system innovation will drive up costs and about financing mechanism

Online Survey Additional Comments:

- *Rural communities* – Three respondents mention the need for this in rural communities. However, they expressed concern that there are not enough providers and hardly any medical coverage in rural communities, let alone collaboratives.
- *Already in place?* – Three respondents question whether this is necessary because this is already in place through community-based clinics and a large system of safety net providers. One respondent wonders whether the board has done any work with or has gotten any input from the Oregon Community Health Information Network.
- *Quality Measurement* – Eight respondents expressed concern about measuring quality. They felt the report is unclear about measurement tools and whether the plan would take into account the already poorer health of the target population. Some were concerned about the additional cost of implementing and the impact on providers, in particular, hampering providers' ability to provide care that they see appropriate.
- *Preventing Chronic Disease* – Respondents stated that it is an individual's responsibility for their own lifestyle choices and should pay for their care accordingly, and not have their poor choices funded by tax dollars.

Safety net (17)

- Support strengthening the safety net and school based health centers (12)
- Concern about the need for safety net clinics, coordination of safety net clinics, and unrealistic timeframes for expanding access (4)
- Opposed to separate clinics for uninsured (1)

High-quality health care delivery (19)

- Support quality initiatives and payment reform (10)
- Concern about quality metrics, improving disease management, utilizing existing programs and length of time to realize changes (7)
- Oppose uniform rates – removes incentives (1)
- Oppose Quality Institute (1)

Public health investment (49)

- Support community involvement, public health and prevention recommendations (6)
- Concerns/questions (43)
    - Personal responsibility for lifestyle choices (17)
    - Population health important
    - Wellness model
    - End grass seed burning

- Exercise, nutrition, education

Electronic Medical Records (EMR) (20)

- Support EMR (13)
- Concerns/questions (7):
  - Help small practices afford EMR
  - Ensure patient privacy
  - May burden providers and detract from care
  - Important to allow adequate transition time for implementing and testing

End-of-Life Care

End-of-Life Care (2):

- Need to fund counseling about end of life care options to avoid expensive ER care

Online Survey Additional Comments:

- Seven respondents did not understand what POLST is and what it has to do with health care reform.
- Nine respondents support life-sustaining practices, but are confused about whether these practices are already in place
- Ten respondents stated that physicians should be compensated for all care provided – including end of life care.

Other issues:

- Legal reform Support malpractice/tort reform (20)
- Prescription drugs (6): Use OPDP as benchmark, need to limit drug costs, ban advertising
- Payment reform (13): Reform provider payment system

Building Block 5: Ensure Health Equity for All

Online Survey Results: Building Block 5

Strategy or Objective	Responses	Support	Oppose	Neutral or No Opinion
Prevent health disparities before they occur through health promotion and chronic disease prevention and management	298	80.2%	9.0%	10.7%

Health Equity (7)

- Consider disparities: race, people with mental/physical disability, rural areas, income

Online Survey Additional Comments:

- *Health promotion/disease management prevention already exists* – Six respondents felt that this is not necessary because this system already exists. Some mentioned that every carrier in Oregon already has programs that deal with these issues.
- *Personal Responsibility* – Six respondents emphasized the importance of personal responsibility. They felt that health equity is not realistic and cannot be enforced because people will continue to make poor decisions regarding their lifestyle and when seeking care.

Building Block 6: Train a New Health Care Workforce

Online Survey Results: Building Block 6

Strategy or Objective	Responses	Support	Oppose	Neutral or No Opinion
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	294	71.5%	15.7%	12.9%

Workforce (60)

- Concern about shortage (28), need for more primary care providers in particular
- Use allied health care workers (nurse practitioners, alternative medicine providers, etc.) (11)
- Incentives for increasing workforce (12): Loan forgiveness, higher reimbursement for primary care
- Data needed on workforce shortages (1)
- Concern about funding of workforce efforts

Online Survey Additional Comments:

- *How will this work?* – Ten respondents were concerned about how this will work. Some feel that providers have no incentive to come to Oregon because of high provider taxes and lower payments. Some were concerned that Oregon's loan repayment program was less desirable than other states' programs, which may keep providers out of the state. Some questioned how the state can afford new providers.
- *Education* – Eight respondents stated that education plays a part in building Oregon's health care workforce. They felt that promoting education should start early and reach out to both urban and rural schools. Some felt that Oregon should have additional educational facilities and provide incentives for health care workforce students to stay in the state. Some mentioned specific areas of training and incentives for students to focus in needed areas such as primary care, internal medicine, and geriatric medicine.

Building Block 7: Federal Advocacy

Online Survey Results: Building Block 7

Strategy or Objective	Responses	Support	Oppose	Neutral or No Opinion
Advocate for change at the federal level to remove barriers to Oregon's health reform strategies	299	63.5%	20.4%	16.0%

Federal Issues (33)

- Medicare (13): Low provider rate, concerns about Medicare Advantage
- Impact of national health care reform
- Role of Oregon's US congressional delegates
- Questions about whether Board's plan takes on federal barriers

- ERISA
- EMTALA
- Tax codes
- Indian health
- Medicaid: Citizenship documentation, SCHIP expansion limits, payment reform
- Rural Health Clinic designation
- Nurse practitioner practice limited under Medicare, permitted under state

Online Survey Additional Comments:

- *Need Federal Advocacy* – Seven respondents stated that Oregon needs advocates at the federal level to remove barriers. Some felt that to solve our health care crisis, Oregon must work with the federal government, and that changes with current Medicare/Medicaid/Social Security laws would be key to change happening in Oregon. Some expressed distrust in the federal government because it may counter state actions.
- *No Federal Advocacy* - Seven respondents feel that there should not be any advocacy at the state level. Some felt that Oregon should take the lead in health care reform, that the federal government is unlikely to reform health care, and that going to the federal government will just slow the process.

Keystone for Reform: Oregon Health Authority

Online Survey Results: Building Block 8

Strategy or Objective	Responses	Support	Oppose	Neutral or No Opinion
Create an Oregon Health Authority	300	43.7%	40.0%	16.3%

Oregon Health Authority (28)

- Support (19): Many support if Authority has true authority to act ("needs teeth")
- Concerns (9):
    - 5 concerned about make-up of Authority members, especially excluding members who might profit from Authority's actions (providers, insurance companies) and including consumers
    - 1 concerned OHA would be duplicative and should be limited to reform efforts
    - 1 concerned that Authority would be cost-neutral
    - 1 wanted info on costs associated with implementing Authority

Online Survey Additional Comments:

- *Too much government/bureaucracy* – Fifteen respondents do not support the Oregon Health Authority because they felt it represents too much government involvement and too much bureaucracy. Some felt that the free market would lead to a more efficient and lower cost health care industry, which would not happen under government control. Some were concerned that an Authority would overstep the authority of the DCBS. One respondent noted that the government would end up stifling innovation and efficiency with mandates that are not based in reality.
- *OHA needs real authority* – Among the supporters of the OHA, eight respondents stated that in order to work, the OHA needs to be granted real authority. They felt that OHA should not just study current topics and make recommendations, but should have the

ability to implement change. Some were unclear about how the OHA would relate to the legislature.

- *Cost* – Six respondents did not support the OHA because they felt it would be too costly, inefficient, and ineffective.

Other

- Accountability/Fraud
  - Support strong enforcement provisions (2) and prosecution of fraud (1)
  - Continue to make reform processes transparent to public
- Media (5):
  - Need more media attention to make public aware – concerned that many doctors not aware of SB329, put meetings on cable access
- OHP (7):
  - Low provider rates under OHP (3), need to expand access to providers (2),
- Response to Proposal as a Whole
  - Support (13): for overall plan, thanks to Board, appreciate transparency of process
  - Clarify implementation (9), make it specific to show how legislators can translate into legislation (2)
  - Call to action (9): emphasize urgency, don't worry about political feasibility, continue to engage public
  - Edits about presentation of report (12): some comments to simplify presentation, make less confusing
  - Concern about costs of reform (8): Want clear costs of reform in report, too expensive overall (2), too much bureaucracy
  - Be bolder (5): Feel that plan outlines small changes, keeps status quo
- Timing of Implementation (25):
  - Needs to happen faster (20) – many urge 2011 timeline for coverage for all, some want change immediately
  - Clarify timeline in report and for legislature (5)
- Other
  - Concern about pollutants in environment, clean food and water (3)
  - Other States/Countries/Systems: can learn from California, Cuba, Veterans' Administration, failures in Canada/Australia
  - Where is "fund" mentioned in SB329?
  - Need medical ombudsman program (2)
  - Mistrust of state ability to be good manager/overseer of programs (1)
  - Be a leader for the nation (5)