
Handout 1
January 13, 2015

OREGON EDUCATORS BENEFIT BOARD BUDGET UPDATE JANUARY 2015



Oregon
Health
Authority

The logo for the Oregon Health Authority is centered at the bottom of the slide. It features the word "Oregon" in a smaller, orange, sans-serif font above the word "Health" in a large, blue, serif font. Below "Health" is the word "Authority" in a smaller, orange, sans-serif font. The entire logo is set against a light blue, curved background that spans the width of the slide.

PRESENTATION OVERVIEW

2011-2013 Biennium

2013-2015 Biennium

2015-2017 Biennium

Overview “Three Year Operating Budget”

Overview “Three Year Revolving Budget”

Revolving Cash Balance

How is the yearly Administrative Fee Developed?

2011-13 BIENNIUM

- **OEBB Operating:**

Budget: OEBB Operations concluded the 2011-13 Biennium expending \$9.3 million of the total \$10.6 million budget (**88% Expended**).

Debt Service obligation for MyOEBB System is complete.
Last payment made in April 2013.

2013-15 BIENNIUM

- OEBS Operating:

Budget: OEBS Operations is projected to conclude the 2013-15 Biennium expending \$9.7 million of the total \$10.7 million budget (**91% Expended**).

2013-15 ACTUALS AND PROJECTIONS BY CATEGORY

2013-2015 Budget Category	Actuals (July13 to November14) + Projections	2013-2015 LAB Budget	(Over)/Under Budget	Pct. Of Budget (Projected to be) Expended
Personal Services	4,250,755	4,210,151	(40,604)	101%
Consultant Charges	2,506,494	2,630,549	124,055	95%
IT Professional Services	2,105,512	2,292,643	187,131	92%
Attorney General Charges	254,736	706,143	451,407	36%
Other Supplies and Services	660,886	892,027	231,141	74%
Total	9,778,382	10,731,513	953,131	91%

2015-17 BIENNIUM GOVERNOR'S BUDGET

- **OEBB Operating:**

Budget: OEBB Operations budget is \$12.2 million for the 2015-17 biennium.

2015-17 GOVERNOR'S BUDGET BY CATEGORY

2015-2017 Budget Category	2015-2017 GBB
Personal Services	4,968,360
Consultant Charges	3,167,357
IT Professional Services	2,368,300
Attorney General Charges	802,266
Other Supplies and Services	945,999
Total	12,252,282

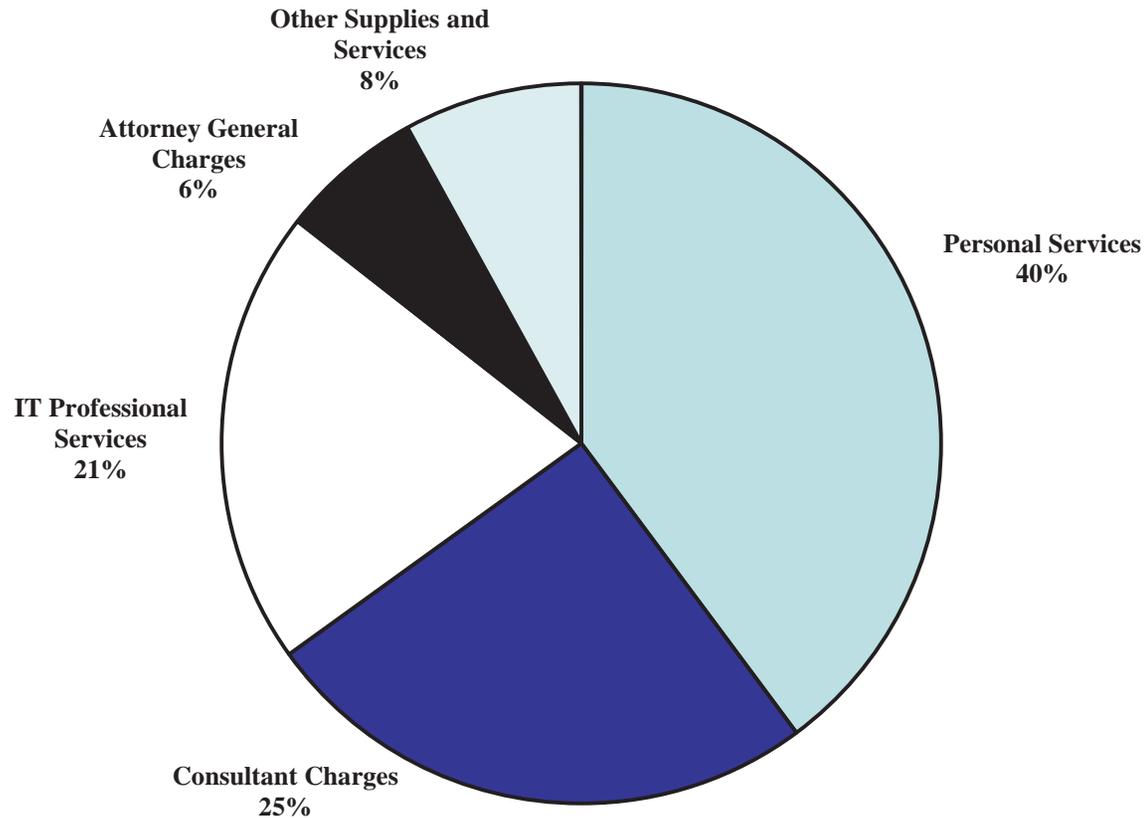
THREE BIENNIUM OPERATING BUDGET COMPARISON

Budget Category	2011-2013 LAB	2013-2015 LAB	Difference 2011-13 & 2013-15	2015-2017 GBB	Difference 2013-15 & 2015-17
Personal Services	4,212,867	4,210,151	-0.06%	4,968,360	15.26%
Consultant Charges	2,683,900	2,630,549	-2.03%	3,167,357	16.95%
IT Professional Services	2,237,849	2,292,643	2.39%	2,368,300	3.19%
Attorney General Charges	645,491	706,143	8.59%	802,266	11.98%
Other Supplies and Services	859,404	892,027	3.66%	945,999	5.71%

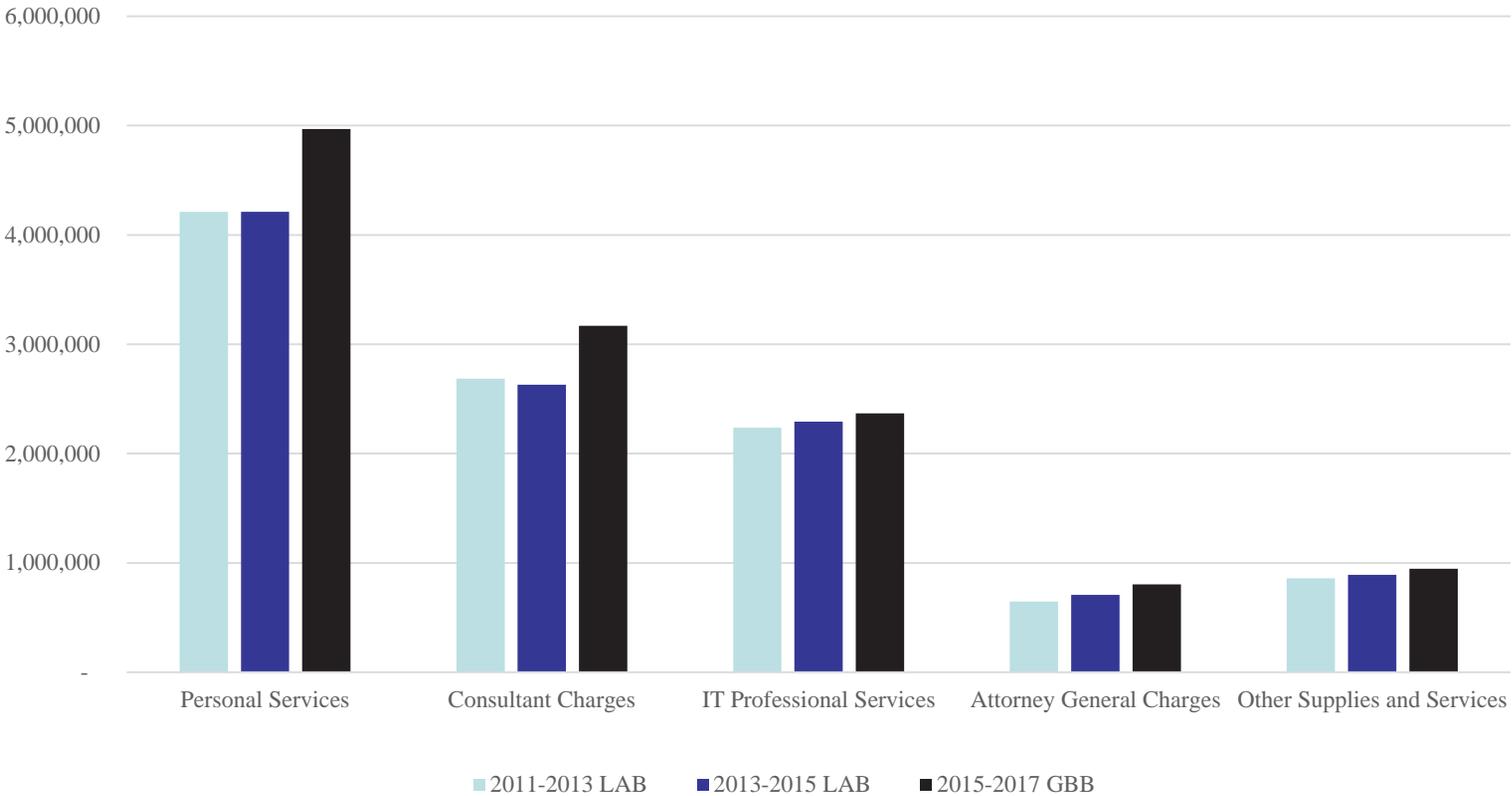
NOTES:

- **Personal Services 2011-13 and 2013-15**
Negative percentage increase due to: Reduction of (5.5%) to personal services and PEBB/OEBB Administrator position biennium was moved from OEBB to PEBB for 2013-15
- **Consultant Charges 2011-13 and 2013-15**
MyOEBB Feasibility Study increase in 2011-13 was removed for 2013-15
- **Personal Services 2013-15 and 2015-17**
PEBB/OEBB administrator position was moved from PEBB to OEBB and employee salary increases included for 2015-17
- **Consultant charges 2013-15 and 2015-17**
Policy Option Package (POP) for Truven Tool Enhancement included for the upcoming biennium

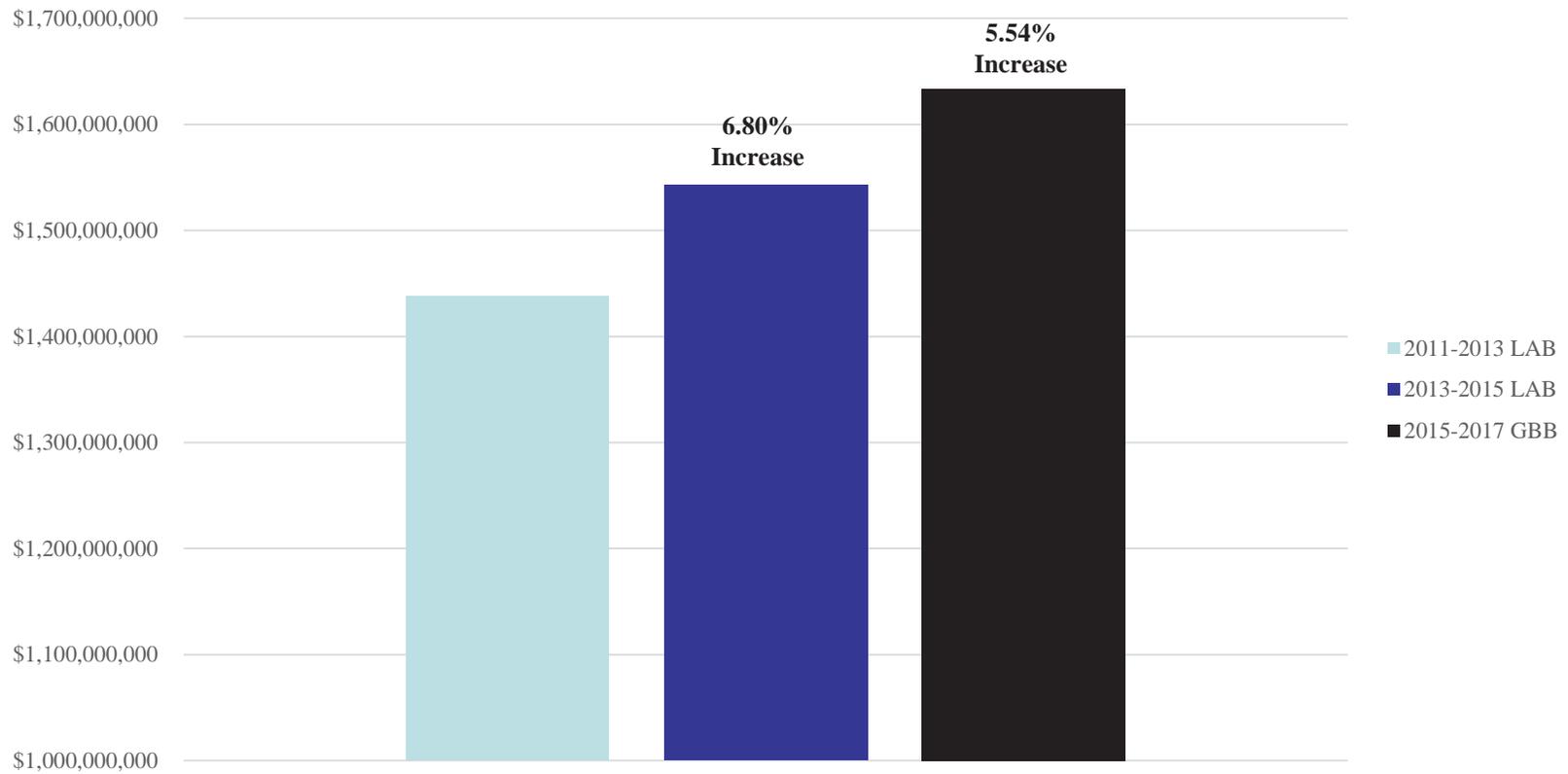
THREE BIENNIUM OPERATING BUDGET AVERAGE



“AT A GLANCE” OPERATING BUDGET



“AT A GLANCE” REVOLVING BUDGET



REVOLVING ACCOUNT CASH BALANCE

As of December 31, 2014 Cash balance \$6,071,000

Revenue:

- All insurance premiums (pass through)
- Monthly Administrative Fee
- Carrier Penalty Payments
- Monthly Interest earnings
- Carry forward

Expenditures:

- All insurance premiums/claims
- Monthly Operating account transfer
- COBRA Subsidy payments
- Health and Wellness Programs

ADMINISTRATIVE FEE DEVELOPMENT

Items taken into account when developing the yearly administrative fee:

- Monthly cash requirements for Operating expenses
- Monthly cash requirements for Health and Wellness programs (revolving account)
- Current member count
- Current composite rate
- Potential percentage rate increases

Oregon Health Authority

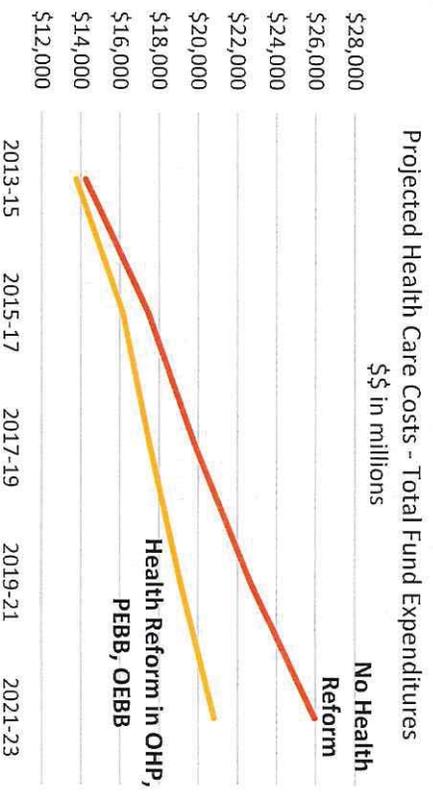
	2011-13 Actuals	2013-15 Leg Approved Budget	2015-17 Governor's Budget
General Fund	1,692,058,113	1,959,909,729	2,209,589,887
Lottery Funds	10,098,261	10,592,532	10,353,121
Other Funds	2,271,074,220	3,893,808,710	5,601,257,540
Federal Funds	5,062,816,693	8,632,707,613	10,720,015,757
Other Funds (Nonlimited)	2,910,050,130	1,904,711,565	143,500,000
Federal Funds (Nonlimited)	108,360,598	106,880,067	106,653,023
Total Funds	\$12,054,458,015	\$16,508,610,216	\$18,791,369,328
Positions	4,226	4,521	4,414
FTE	4,109.69	4,139.97	4,347.21

OVERVIEW

The Governor's Budget for the Oregon Health Authority shows in stark relief how Oregon's approach towards better health and better care brings lower costs. The Oregon Health Authority purchases care services for approximately 1,360,000 people through the Oregon Health Plan, Public Employees Benefits Board and the Oregon Educators Benefit Board. It provides direct mental health care through the Oregon State Hospital and funds local behavioral health services in every county in the state. Through its Public Health Division it provides disease prevention and wellness services to every Oregonian. This budget saves money and makes people's lives better by investing in what works, supports improved health, leverages the state's power as a health care purchaser, reduces waste and inefficiency and sets clear standards for quality.

Highlights of the 2015-17 Governor's Budget include:

- Applying the coordinated care model to all health purchasing. This caps health care spending for the Oregon Health Plan, PEBB and OEGB members to below the national trends while setting standards for improved health services and reduced waste and inefficiency. This funds spending at a fixed, predictable rate, putting Oregon on a path to save billions against future projections while improving health over the next decade.



Every dollar saved on unnecessary health expenses is a dollar that can be invested in health care services for the Oregon Health Plan, education, or state workers and their families.

- Continuing support for access to health care coverage for low-income Oregonians. Today 95 percent of Oregonians have health insurance – this is a 63 percent reduction to the number of Oregonians without health coverage from 2013.
- Increasing investment by \$53.2 million in community mental health and addiction services.
- Investing in the future of public health and improving our ability to prepare and plan for public health emergencies.
- Prioritizing health care workforce development with the intention of increased Other Funds investments leveraging Federal Funds in partnership with Oregon Health Sciences University. This will expand programs targeted to address Oregon’s healthcare workforce needs, especially those aimed at enhancing access to primary care and emphasizing rural and underserved communities.
- Investing in the Healthiest State challenge to work in partnership with Oregon businesses to create and sustain healthy environments to support healthy lifestyles.

GOVERNOR’S BUDGET

The Oregon Health Authority (OHA) includes the state’s publicly funded health care programs: Oregon Health Plan (OHP), the Public Employees’ Benefit Board (PEBB), the Oregon Educator’s Benefit Board (OEBB), and Addiction and Mental Health programs. In addition to the health care programs, Public Health, the Office of Health Licensing, and the Oregon State Hospital are also included in OHA’s mission to help people and communities achieve the optimum physical, mental and social well-being through partnerships, prevention and access to quality, affordable health care. A nine-member Oregon Health Policy Board serves as the policy-making and oversight body for OHA. The Board is committed to provide access to quality, affordable health care for all Oregonians and to improving population health.

The 2015-17 Governor’s Budget for OHA is \$18,791.3 million total funds. This is a 13.8 percent increase from the 2013-15 Legislatively Approved Budget. Key elements of the Governor’s Budget include:

- Ensuring access to health care coverage - The Governor’s Budget continues investment in health care coverage for low-income Oregonians and their families. With the state’s successful implementation of the Affordable Care Act and Medicaid expansion, more than 395,000 Oregonians have received coverage since January 2014. The overall state insurance rate is 95 percent.
- Transforming care for better health at lower costs – The Governor’s Budget continues investment in the Medicaid coordinated care model, capped at 3.4 percent per member per year growth. Coordinated Care Organizations (CCO) have shown results to stay within their budget while improving the health and quality of care for members.
- Ensuring access to a transformed health care system.
 - OHP members have access to a transformed health care system where reimbursement for Medicaid services includes performance payments measured on how well CCOs perform on key health care measures. OHP has seen improvements as CCOs have



decreased emergency department visits, decreased hospitalization for chronic conditions and increased primary care. Examples of two specific measures are displayed above.

- Larger hospitals are eligible to receive payments out of the hospital transformation performance pool based on performance on designated metrics, including re-admission rates and medication safety. Additionally, the Governor’s Budget earmarks \$10 million within OHP to establish an incentive pool for small, rural hospitals transitioning from cost based reimbursement to alternative payment models that reward performance.
- Funding the PEBB at 3.4 percent per member per year growth and paying for outcomes. In the 2013-15 biennial budget, PEBB’s annual growth rate per member was limited from projected rates, saving employees in premium costs, and saving state agencies and other participating employers in compensation costs. Current medical trend rates are 7.3 percent per year. PEBB has been achieving these capped cost growth targets and the Governor’s Budget continues this limited growth, continuing savings for PEBB members.
- Funding the OEBC at health system transformation growth levels, stepping down to 3.4 percent per member per year growth from projected rates of 6.9 percent. The Governor’s Budget limits OEBC cost growth starting in the 2015-16 plan year, holding per member cost increases to 4.4 percent and 3.4 percent going forward, aligning with health system transformation efforts. This allows for an estimated \$82.3 million to be reinvested in the education system in the 2015-17 biennium.
- Investing in the Patient Safety Commission for the Early Disclosure and Resolution Program to transform patient and provider interactions. An additional investment of \$0.5 million is included in the Governor’s Budget to increase support for the essential work of the Patient Safety Commission. The Commission operates Oregon’s confidential and voluntary Patient Safety Reporting Program, which gathers information on adverse events that occur in Oregon health care facilities. Allowing health care providers an opportunity to share lessons learned, leads to more understanding of why and how adverse events occur, improving patient safety.
- Increasing investment by \$53.2 million in community mental health and addiction services
 - The Governor’s Budget continues the commitment to improving access to community behavioral health through integrating behavioral health services in OHP as well as increased support of community mental health programs. This includes sustaining and building on key investments made in the 2013-15 biennium and adding needed capacity to provide services in local communities. These investments are intended to allow communities to work together and

Leverage opportunities to ensure Oregonians get the right care, at the right time, and in the right place.

- Investing in the future of public health while improving our ability to respond through preparedness and planning efforts – Within the Oregon Public Health system, prevention and control of acute and communicable diseases is essential. The Governor’s Budget maintains support of local public health departments and makes an additional \$1.0 million investment in planning and operational readiness for communicable disease preparedness and response, and mitigation of other disasters. The budget also includes a \$0.5 million investment to support the recent recommendation from the Task Force on the Future of Public Health Services.

REVENUE SUMMARY

OHA programs are largely funded with Federal Funds, primarily Medicaid funds matched with state funds. State funds in the 2015-17 Governor’s Budget, most which are used for matching, include the General Fund, hospital provider tax, tobacco tax, drug rebate revenues, and tobacco master settlement agreement funding. Federal Medicaid reimbursement is based on the Federal Medical Assistance Percentage which varies for each state based on per capita income. The Federal Medical Assistance Percentage is adjusted annually for economic changes in the state. Other federal sources of revenue include the Children’s Health Insurance Program, Mental Health Services Block Grant, the Substance Abuse Prevention Treatment grant, as well as a number of smaller specific federal grants primarily in the Public Health Division and Health Policy Programs.

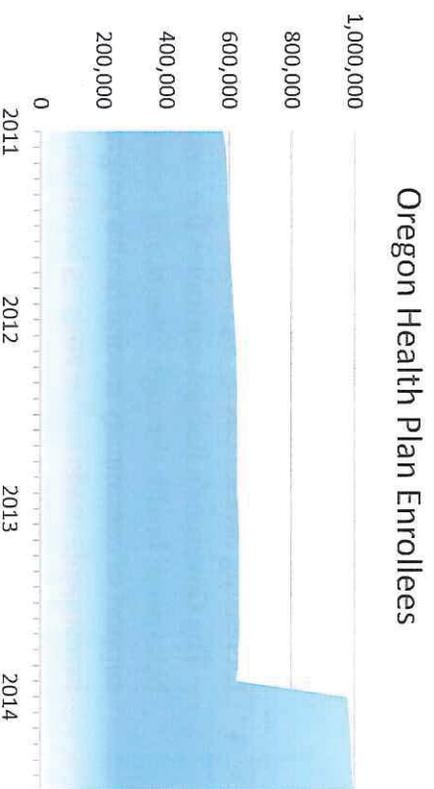
With the implementation of the Affordable Care Act and Medicaid expansion, over 57 percent of the OHA budget is funded through our federal partners. Approximately 12 percent of the OHA budget is supported by General Fund and 31 percent by Other Funds and Lottery Funds.

AGENCY PROGRAMS

Medical Assistance Programs

The Medical Assistance Programs (MAP) within OHA administer a number of programs to provide comprehensive health coverage to low-income and disabled Oregonians, primarily through the Oregon Health Plan (OHP). With health system transformation, the innovations happening in the OHP delivery system are at the center of the Healthy People 10-Year Plan for Oregon. The implementation of the

Coordinated Care Organizations (CCO) aligns directly with the goals for expanding health coverage and improving Medicaid population health while reducing cost of care. With Medicaid expansion through the successful implementation of the Affordable Care Act, the Governor’s Budget continues investment in the coordinated care model of the OHP. Nearly 90 percent of people on the OHP are covered through CCOs, emphasizing prevention and



helping people manage chronic conditions, reducing unnecessary and expensive medical services, and supporting healthy living.

In 2012, Oregon committed to containing cost growth in the OHP in return for additional flexibility in the use of Medicaid dollars, allowing increased federal fund availability to support the OHP and health system transformation. Also supporting the OHP, the Governor's Budget continues the hospital provider tax through the 2015-17 biennium, with the assumption that the hospital transformation performance pool continues; however, half of the funding funds the OHP transformation efforts. Within the OHP budget, the Governor earmarks \$10 million to establish an incentive pool for small, rural hospitals transitioning from cost based reimbursement to alternative payment models that reward performance. Additionally, the budget makes a small investment to support establishing a psychiatric emergency department based on the Alameda Model and enforces mental health preferred drug list, identifying the most effective and safe drugs for OHP members.

The 2015-17 Governor's Budget for MAP is \$13,177.7 million total funds. State funds consist of \$1,217.1 million General Fund, \$289.1 million Other Funds tobacco tax revenues, and \$1,667.8 million in remaining Other Funds.

MAP is primarily funded with federal Medicaid funding, where Federal Funds account for 76 percent of the revenue. State funds supporting the MAP account for the remaining revenue coming from General Fund, Tobacco Tax, continuation the current hospital provider tax, the final two years of the Designated State Health Programs funding through the federal waiver and, Tobacco Master Settlement Agreement funding. General Fund and Tobacco Tax revenues account for 11.4 percent of the revenues and Other Funds account for 12.7 percent.

Public Employees Benefit Board

The Public Employees Benefit Board (PEBB) designs, contracts for and administers health plans, group insurance policies and flexible spending accounts for state employees and their dependents, representing over 130,000 Oregonians. PEBB is funded with Other Funds through premiums collected for all insured individuals. Premiums are collected from agencies, universities, and self-pay members to directly cover the costs of the plans. Agencies, as the employer, pay the majority of the premiums from the available revenue source for employees, which is comprised of General Fund, Other Funds, and Federal Funds.

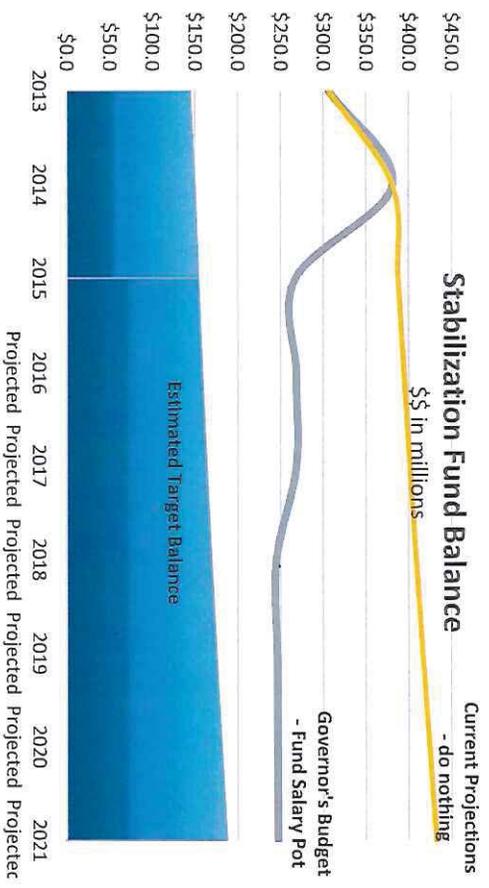
Instead of responding to increasing cost trends with one of the conventional approaches to controlling health care spending—reducing provider payments, changing covered benefits or shifting costs to members—PEBB is moving down a new pathway with its new health care partners: transform the delivery system for better efficiency, value and health outcomes. The health care system needs to deliver care with state employees and their families at the center.

By eliminating waste and controlling costs, PEBB wants to ensure members have the care they need today and in the future. In addition, PEBB wants to ensure that members' care is coordinated across the continuum and that quality and financial incentives are more aligned throughout the delivery system.

Since moving to self-insurance, PEBB has experienced lower costs each year compared to premiums collected. As costs were effectively managed with health care transformation efforts, there has been a steady increase in the ending balance in the PEBB Stabilization Fund, well above the target level

outlined by the Board's actuary.

Excess funding of \$120 million from the PEBB Stabilization Fund is transferred to the General Fund to support the overall cost of compensation for state employees, offsetting the projected cost of compensation changes in the Special Purpose Appropriation to the Emergency Fund. Even with this transfer the account maintains a sustainable fund balance to support the projected target ending balance.



The Governor's Budget continues to limit cost growth for PEBB, ultimately saving agencies and universities in employee compensation costs. PEBB's budget is limited to the same health care transformation per employee cost growth as in the 2013-15 biennial budget, savings estimated to be over \$275 million in health care costs for agencies and PEBB members in the 2015-17 biennium.

The 2015-17 Governor's Budget for PEBB is \$1,645.7 million. This is an increase of 6.8 percent from the 2013-15 Legislatively Approved Budget, primarily from the capped annual per employee inflation. PEBB links to the 10-Year Plan by designing plans that focus on coordinated care and preventing chronic disease while containing costs.

Oregon Educators Benefit Board

The Oregon Educators Benefit Board (OEBB) administers medical, dental, vision and other benefits for Oregon's school districts, community colleges, education service districts and, recently eligible, cities, counties and special districts. OEBB designs and maintains a full range of benefit plans for eligible and participating entities to offer their employees and early retirees. OEBB's goal is to provide high-quality benefits at the lowest possible cost, and to work collaboratively with members, entities and insurance carriers to further advance the triple aim of health care, in alignment with the Healthy People Outcome Area within the 10-Year Plan for Oregon. OEBB is funded through premium payments from school districts, community colleges, other government entities, and members. The Governor's Budget limits cost growth for OEBB premiums by stepping down to the same annual per member health system transformation capped growth, saving approximately \$82.3 million in health care costs for the education system, primarily in compensation costs for schools.

The Governor's Budget for OEBB is limited to \$1,645.7 million Other Funds based on the capped growth rate starting in the 2015-16 plan year. This is an increase of less than 0.5 percent from the 2013-15 Legislatively Approved Budget. This essentially flat funding is primarily because OEBB's budget removed expenditures related to the Oregon Health Insurance Program for Home Care Workers as the group no longer uses OEBB.

Addictions and Mental Health

The Addictions and Mental Health (AMH) budget provides funding to behavioral health care for Oregonians at risk of developing or who have been diagnosed with any behavioral health disorder, including problem gambling and severe and persistent mental illness. Services are delivered in the least restrictive and most integrated setting possible through counties, community mental health partners, addiction providers and the Oregon State Hospital. While there has been a significant increase in the number of Oregonians with health coverage with the implementation of the Affordable Care Act and Medicaid expansion, mental health services continue to be a critical component in Oregon's health care system.

Community Mental Health (CMH) services are local treatment and intervention services delivered through counties and community mental health partners to provide services in outpatient, residential, acute hospitals and criminal justice settings. CMH has experienced several major changes in the past year, including significant program investments in the 2013-15 Legislatively Approved Budget and impact of the implementation of the Affordable Care Act. Many AMH clients now have health care coverage, largely through the Oregon Health Plan and coordinated through Coordinated Care Organizations. CMH and the Medical Assistance Program are working closely together to coordinate the system of care and integrate physical and behavioral health services, aligning with the strategies and outcomes of the Healthy People Outcome Area within the 10-Year Plan for Oregon.

The Governor's Budget continues the commitment to prioritize community mental health programs by investing an additional \$53.2 million in community mental health and addiction services. The budget:

- Makes additional investments in the expanded programs in 2013-15; this includes supported housing, crisis services, parent-child interactive therapy, and assertive community treatments among other programs.
- Increases funding to support rental assistance programs.
- Continues support of the newly established Older Adult Mental Health Coordinators located in communities across the state to strengthen the Aging and Physically Disabled and AMH systems that serve older adults and people with disabilities.
- Invests in community mental health programs to provide evaluation and treatment services to people who have been charged with a crime and unable to participate in legal proceedings.
- Supports additional capacity in communities to provide services across the continuum, from residential treatment facilities to adult mental health initiative capacity.
- Invests in access through provider rate increases.
- Additionally, with the passage of Measure 91, \$2.3 million Other Funds is increased in support of addiction prevention and treatment efforts.

The state hospital system and state-delivered secured residential treatment facilities are an important part in the continuum of care for people with severe and persistent mental illness. They provide the most intensive health services essential to restoring patients to a level of functioning that allows for successful community living. They work in partnership with the community mental health programs to deliver the right care at the right time. The Governor's Budget supports state hospital operations in both Salem and Junction City, continuing the closure of the one neuro-geriatrics ward in Salem and continuing to phase in operations of the Junction City campus.

The 2015-17 Governor's Budget for AMH is \$1,134.3 million total funds, an increase of 16.4 percent from the 2013-15 Legislatively Approved Budget. The budget is primarily supported by \$760.0 million General Fund. Other state funds supporting AMH include tobacco tax revenues as passed in the 2013 Special Legislative Session, beer and wine tax, and Lottery Funds for problem gambling treatment. Additionally, Federal Funds are utilized including Medicaid matching funds, the Substance Abuse Prevention grant, Access to Recovery grant, and the Strategic Prevention Framework-State Incentive grant.

Public Health Program

The Public Health (PH) division administers a variety of programs addressing behavioral and social determinants of health. PH works to ensure the physical and social environments promote health and make it easier for people to make healthy choices, contributing to the Healthy People Outcome of the 10-Year Plan. PH programs complement and amplify investments in health care transformation and by focusing on prevention, have the potential to reduce the need for costly health care services. Oregon's public health system includes federal, state, counties and local agencies, private organizations and other partners. PH operates some programs directly and funds and coordinates other programs through the 34 local health departments across the state.

Public Health has three Centers, overseen by the Office of the State Public Health Director:

- Center for Health Protection – Protects the health of individuals and communities through establishing, applying and ensuring compliance with regulatory and health based standards. This includes protection from environmental health hazards, developing patient safety efforts, and quality improvement activities for all health care providers.
- Center for Prevention and Health Promotion – Helps communities and residents achieve and sustain lifelong health, wellness and safety. This includes prevention of chronic disease, child developmental delays, injuries and unsafe relationships, and physical and behavioral problems.
- Center for Public Health Practice – Prevents and controls diseases, monitors population health information and ensures emergency public health services in natural and human-caused disasters.
- Office of the State Public Health Director – Provides scientific, fiscal, communications, and policy leadership to Public Health programs.

The 2015-17 Governor's Budget for Public Health is \$528.7 million total funds, an increase of 1.1 percent from the 2013-15 Legislatively Approved Budget. The budget adds \$0.5 million to build on the recommendations in the Future of Public Health task force while maintaining support of local public health departments. The budget makes an additional investment in planning and operational readiness for communicable disease preparedness and response. PH is primarily funded with \$355.1 million Federal Funds, including Medicaid revenues, and over 120 grants are categorically dedicated to specific PH programs. PH also collects Other Funds through fee based programs. General Fund supports approximately eight percent of the PH budget.

Health Policy Programs

Health Policy Programs includes offices providing policy support, technical assistance, and access to health information statistics and tools to organizations and providers. Together these offices provide services and support focused on achieving the triple aim of better health, better care, and lower costs, aligning with the Healthy People Outcome Area within the 10-Year Plan for Oregon.

The 2015-17 Governor's Budget for Health Policy Programs is \$138.6 million total funds, which is a decrease of 7.5 percent from the 2013-15 Legislatively Approved Budget. This budget structure was created during the 2013-15 biennium, making the biennial budget comparison difficult, however, a large portion of the decrease is related to the phase-out of the \$30 million Health System Transformation Fund. Health Policy Programs are supported by General Fund matched with Medicaid Administrative Federal Funds. The office also receives grant funding from federal and private partners. The federal Strategic Innovation Model grant, which has supported significant health transformation efforts, expires in September 2016. The Governor's Budget adds General Fund support to continue this work through the entire 2015-17 biennium.

Health Licensing Office

The Health Licensing Office (HLO) is a central licensing and regulatory office overseeing multiple health and related professions. This office was created when the Oregon Health Licensing Agency (OHLA) merged with OHA in July 2014. HLO is aligned to the Healthy People Outcome Area within the 10-Year Plan by protecting the health and safety of Oregon consumers, by ensuring only qualified applicants are authorized to practice. HLO reviews and approves applicant qualifications, conducts examinations, inspects thousands of licensed facilities and independent contractors, responds to and investigates consumer complaints, and disciplines licensees who are found in violation of state requirements. HLO regulates over 70,000 authorizations among 12 boards and councils, including over 4,800 facilities. The Governor's Budget for HLO is \$7.4 million Other Funds, funded with fee revenues from applications, examinations, authorizations, renewals, and fines and forfeitures. The budget is an increase of 86.4 percent from the OHA's 2013-15 Legislatively Approved Budget for HLO, because the 2013-15 Legislatively Approved Budget only included a partial biennium with the transfer to OHA from the Oregon Health Licensing Agency.

Private Health Partnerships

The Office of Private Health Partnerships administered six programs that closed in the 2013-15 biennium due to the implementation of the federal Affordable Care Act in January 2014. The one program which continues into the 2015-17 biennium is the Oregon Transitional Reinsurance Pool. This pays a portion of high claims costs to help stabilize the individual insurance market. This temporary program covers claims incurred through December 2016. The program is funded by an annual assessment on all insurers for calendar years 2014, 2015, and 2016. The 2015-17 Governor's Budget of \$104.2 million total funds supports this program based on projections to spend down assessments received through 2016 and close the program during the 2015-17 biennium.

Central Services

OHA Central Services provides the necessary leadership and business support to achieve the agency's mission aligning to the Improving Government Outcome Area within the 10-Year Plan for Oregon. This program includes the Office of the Director and Policy, which is responsible for the overall leadership, policy development and administrative oversight for the agency. The clear direction of the agency is to innovate, improve and transform the state health care system. Additionally, Central Services includes the Office of Communications, Human Resources, and Budget, Planning and Analysis. The Governor's Budget for Central Services is \$20.7 million total funds, funded primarily through General Fund matched with Federal Funds. This is a decrease of 39 percent from the 2013-15 Legislatively Approved Budget. This is deceiving as the decrease is due to the movement of Health Policy Programs from Central Services part way through the 2013-15 biennium.

Shared Services

Shared Services funding supports costs associated with business functions supporting both the Department of Human Services (DHS) and OHA under a joint governance agreement by providing consistent and coordinated administrative services to all programs within both departments. Funding for Shared Services, in both agencies, is based on cost allocation which determines the distribution of expenditures to OHA or DHS and the revenue distribution by General Fund, Other Funds, or Federal Funds.

OHA Shared Services contains the Office of Information Services and Information Security and Privacy Office. DHS Shared Services contains the Office of Forecasting, Office of Financial Services, Office of Human Resources, Facilities, Office of Imaging and Records Management, Office of Payment, Accuracy, and Recovery, Performance Excellence Office, and Internal Audits. Shared Services is linked to the Improving Government Outcome Area within the 10-Year Plan; it supports critical business functions necessary to achieve the mission of both departments. The 2015-17 Governor's Budget for Shared Services is \$136.7 million, funded entirely by Other Funds transferred from other programs through a federally approved cost allocation plan, and funded through the appropriate General Fund, Other Funds or Federal Funds. This is an increase of 0.3 percent from the 2013-15 Legislatively Approved Budget.

State Assessments and Enterprise-wide Costs

State Assessments and Enterprise-wide Costs funding supports payments to the Department of Administrative Services and third parties for goods and services that serve the whole agency, such as facility rents, state data center charges, risk assessment, state government services charges, unemployment assessments, mass transit taxes, computer replacement, and debt service. Other OHA programs transfer funding to State Assessment and Enterprise-wide Costs based on cost allocation statistics. This allocation method determines distribution of expenditures by program General Fund, Other Funds, and Federal Funds.

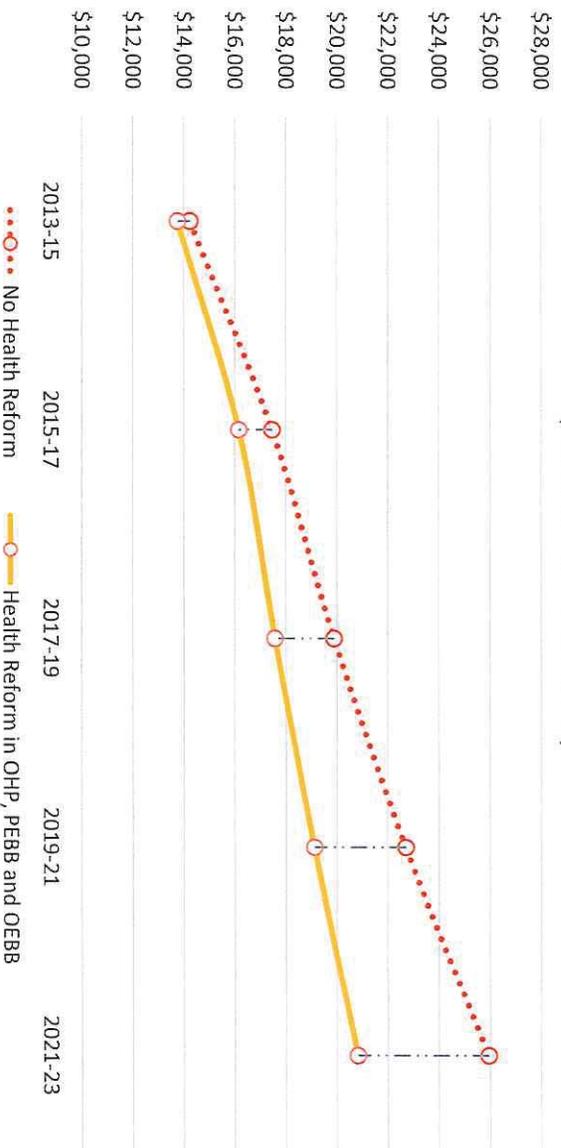
State Assessments and Enterprise-wide Costs is linked to the Improving Government 10-Year Outcome. It supports critical business functions necessary to achieve the mission of the agency. The 2015-17 Governor's Budget is \$250.2 million total funds, an increase of twelve percent from the 2013-15 Legislatively Approved Budget.

Capital Improvements

Capital Improvements funding supports capital expenditures essential to health and safety repairs for the two campuses of the Oregon State Hospital aligning with the Healthy People Outcome Area within the 10-Year Plan for Oregon. Since the two campuses are new and do not require significant improvements, the Governor's Budget transfers the funding to a dedicated account for the purpose of saving any unspent funds for future capital improvement projects. The Governor's Budget for Capital Improvements is \$1.4 million total funds. The \$0.7 million General Fund in this budget is a three percent increase from the 2013-17 Legislatively Approved Budget.

A SUSTAINABLE BUDGET

Projected Health Care Costs (total funds in millions)



For decades Oregon has lurched from budget crisis to budget crisis, largely for one reason: the cost of providing quality schools, health care and other social services, and keeping our communities safe has outpaced the state's economic growth and tax revenue.

However, because of reforms established over the last three years, Oregon is on track to have a structural budget surplus seven years from now.

While a severe economic recession or a large tax rebate under Oregon's unique kicker law could still unbalance the state budget, the fact that we are on the brink of erasing the structural budget deficit that has been with us since the passage of Ballot Measure 5 in 1990 puts Oregon on a solid

path toward the future. As a result the Governor's 2015-17 Budget includes significant investments in education and our economy.

HEALTH CARE SAVINGS

At the heart of this transformation is Oregon's new business model for health care, which prioritizes preventive care and reduces costly hospital admissions and emergency room visits. In 2011 Governor Kitzhaber and the Legislature passed a bipartisan bill establishing a statewide network of Coordinated Care Organizations (CCOs) charged with holding down the cost of the state Medicaid system, the Oregon Health Plan. Historically the cost of the Oregon Health Plan grew at 5.4 percent each year, outpacing state revenue,

which historically grows at 4 percent annually.

But CCOs work within a set budget that grows at 3.4 percent per member each year by focusing on improving patient health through innovation and avoiding catastrophic health crises that send patients to the emergency room and into the hospital.

In 2013, Oregon used coordinated care to step down to a 3.4 percent cap on health care costs for the Public Employees Benefits Board (PEBB), which provides health care to state workers.

Together, these reforms in Medicaid and PEBB are projected to save the state over \$3 billion in eight years.

HEALTHY PEOPLE

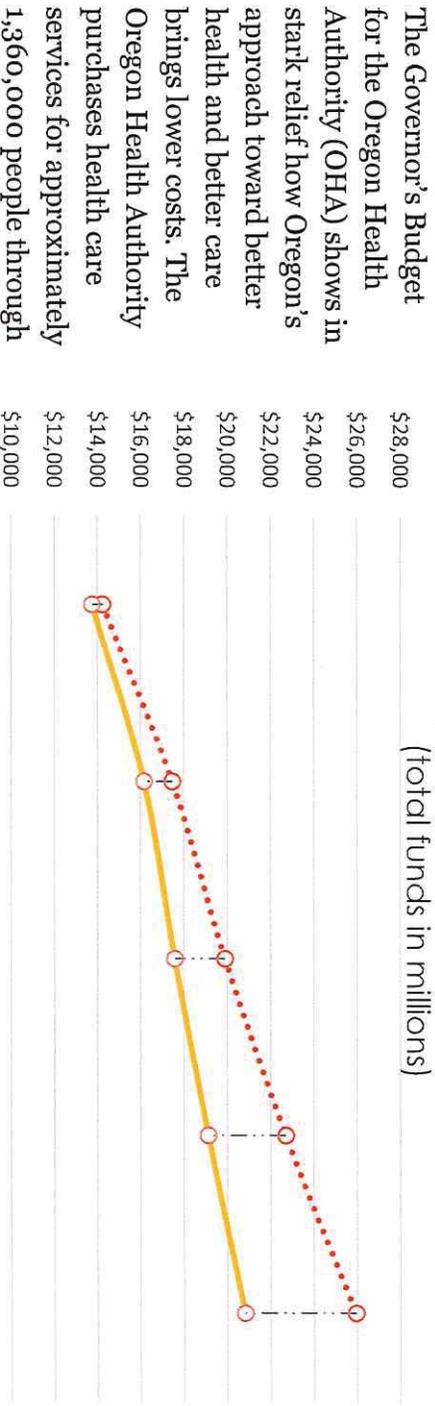
VISION: OREGONIANS ENJOY GOOD HEALTH AND THE BEST POSSIBLE QUALITY OF LIFE

Key Strategies:

- Fully implement Coordinated Care Models
- Focus on prevention of chronic diseases
- Strengthen long-term care service system
- Improve access to healthy housing and nutrition

HEALTH CARE

TRANSFORMATION



- Applying the coordinated care model to all health purchasing. This caps health care spending for the Oregon Health Plan, PEBS and OEBS members to below the national trends while setting standards for improved health services and reduced waste and inefficiency. Oregon is on track to save billions against future projections, avoiding shifting costs to members through holding health care providers accountable to better coordinate care. Every dollar saved on unnecessary health expenses is a dollar that can be invested in health care services for the Oregon Health Plan, education, or state workers and their families.
- Continuing support for access to health care coverage for low-income Oregonians. Today 95 percent of Oregonians have health insurance – this is a 63 percent reduction to the number of Oregonians without health coverage from 2013.

TRANSPORTATION INFRASTRUCTURE INVESTMENTS

The Governor's Budget reflects his continued dedication to supporting robust investment in transportation which strengthens regional economies and creates good-paying jobs now and in the future.

- ConnectOregon VI – The Governor's Budget invests \$58.7 million in ConnectOregon VI to continue Oregon's investment in non-highway projects aimed promoting economic development by improving port infrastructure, public transportation, the aviation system, bike and pedestrian facilities, and the rail network.
- Continues passenger rail in Oregon – The budget provides General Fund, Other and Federal Funds necessary to continue passenger rail service between Eugene and Portland.
- Facilities Capital for ODOT – The budget increases funding for capital improvement projects within the Department of Transportation, and also provides the funding necessary to complete two capital construction projects that will provide the Department of Transportation with new maintenance stations in Meacham and on the South Coast.
- DMV IT systems modernization – The budget enhances the Driver and Motor Vehicles Services (DMV) Division budget to begin modernization of its computer systems, which are over 40 years old.
- Aviation operations and improvements to state airports – The budget increases aviation related registration fees for aircraft, pilots, and public airports to provide sufficient revenue for the Department of Aviation's operational expenditures; and provides funding for two capital construction projects at the Condon State Airport and the McDermitt State Airport.
- Transit service for seniors – Continued funding for senior and disabled transit services.

Vision/Guiding Principles Oregon Educators Benefit Board

April 24, 2008

1. VISION

OEEBB will work collaboratively with districts, members, carriers and providers to offer value-added benefit plans that support improvement in members' health status, hold carriers and providers accountable for outcomes, and provide affordable benefits and services.

Key components of the OEEBB program are:

- Value-added plans that provide high-quality care and services at an affordable cost to members.
- Collaboration with districts, members, carriers and providers that ensures a synergistic approach to the design and delivery of benefit plans and services.
- Support improvement in members' health status through a variety of measurable programs and services.
- Measurable goals and programs that hold carriers and providers accountable for health outcomes.
- Encourage members to take responsibility for their own health outcomes.

2. GUIDING PRINCIPLES

SB 426 outlines specific criteria that OEEBB is to emphasize in considering whether to enter into a contract for a benefit plan. In September 2007, the Board further defined those criteria to serve as a guide in carrying out its charge.

- Employee choice among high quality plans
Board Definition — OEEBB will offer employees a range of affordable benefit plan designs that provide high-quality care and services.
- Encouragement of a competitive marketplace
Board Definition — OEEBB will encourage competition in the marketplace in the areas of quality, outcomes, service and cost.

- Plan performance and information
Board Definition — OEGB will consider plan performance in the areas of quality, administrative processes, costs and outcomes in making its decisions. It will promote system-wide transparency that provides members with comprehensive information on these issues.
- District flexibility in plan design and contracting
Board Definition — OEGB will offer a range of affordable benefit plan designs that provide districts and employee groups with the flexibility to choose options through collective bargaining agreements and documented district policies that meet their and their employees' financial and health needs.
- Quality customer service
Board Definition — OEGB will collaborate with districts and benefit plans to ensure that members receive efficient, effective and timely service in the areas of enrollment, benefit and service coverage, and claims administration.
- Creativity and innovation
Board Definition — OEGB will seek out plans and providers that use creative and innovative methods and practices that are evidence-based and/ or have measurable outcomes.
- Plan benefits as part of total compensation
Board Definition — OEGB will consider the impact of benefit costs on members' compensation when designing, selecting and renewing benefit plans and programs.
- Improvement of employee health
Board Definition — OEGB will promote employee health and wellness through a variety of means with a focus on those activities supported by evidence of improvement in health outcomes.

- Cost Affordable to the districts, employees and taxpayers

Board Definition — OEGB will take into account the present and future costs of benefit plans (premiums, deductibles, copayments, etc.) in offering a range of affordable, high-quality benefit plan designs.

3. GUIDING PRINCIPLES OF BOARD OPERATIONS

- The Board will operate as a cohesive unit that provides for open discussion on topics, and
- The Board will operate in a transparent manner that fosters public trust, input and understanding of OEGB decisions and policies.

4. BOARD DECISION-MAKING PROCESS

- The Board should strive to reach consensus on general direction, strategies, and final decisions, but the use of parliamentary process is acceptable for final decision-making,
- Board members should strive to raise concerns about specific issues or items prior to final decision-making,
- Board members disagreeing with a final decision are free to express their views to stakeholder groups, but should respect the final decision and not campaign to undermine it,
- Public explanation of Board decisions will be conducted by the Chair or designated staff,
- Requests for reconsideration or tabling of decisions will be directed to the Chair through parliamentary procedure, and
- Board members concerned with methods or processes of addressing issues should direct their concerns to the Chair.

5. ROLES OF BOARD, STAFF, AND CONSULTANTS

Board Roles

- Provide strategic direction and vision,
- Provide direction and context for the development of options,
- Prioritize and focus work of Board, workgroups, staff and consultants, and
- Make decisions that align with the intent and requirements of SB 426.

Workgroup Roles:

- Workgroups will undertake further analysis, discussion and development of options/recommendations for Board decision,
- Each workgroup will contain 1-2 Board members along with representatives from select stakeholder groups when it is deemed appropriate,
- Workgroups should provide periodic updates to the Board, and
- Administration, Communications, Plan Design and Quality Workgroups were formed by the Board.

Interaction with Staff and Consultants:

- Staff and consultants should feel free to suggest direction to the Board (at least as a starting point) rather than only waiting for the Board to determine its desired direction,
- Staff and consultants should feel free to identify implications for the Board if they believe that the Board may be going in a direction that may not be wise or may require more resources than anticipated to accomplish,
- Consultants should provide leadership in identifying issues, options, and timelines necessary to accomplish the work, and
- Requests for additional research or work by staff or consultants will be directed to the Chair or come through the workgroups.
- Staff will implement decisions of the Board.

SUMMARY OF BOARD DISCUSSION REGARDING ROLES AND PROCESSES

BACKGROUND

The Oregon Educators Benefit Board (OEEBB) met on September 14, 2007, in a facilitated session to discuss roles and processes for its work. Prior to the meeting, individual Board members completed a survey to determine their individual thoughts about the Board's roles and responsibilities, decision-making and public involvement. Two guiding principles emerged from the discussion of these issues:

- The Board will operate as a cohesive unit that provides for open discussion on topics, and
- The Board will operate in a transparent manner that fosters public trust, input and understanding of OEEBB decisions and policies.

STAKEHOLDER INPUT

- Solicitation of stakeholder input on specific issues will play a key role in the Board's decision-making process, and
- Input from organized stakeholder groups and the general public should be solicited continually.



Handout 3
January 13, 2015

Attachment 1
October 11, 2007

Oregon Educators Benefit Board Retreat September 14, 2007

The Oregon Educators Benefit Board held a retreat on September 14, 2007, at the DAS General Services Building, 1225 Ferry Street in Salem, Oregon. The retreat began at 9:30 a.m.

Attendees

Board Members:

Steve H. McNammy, Chair
Brett M. Yancey, Vice Chair
Mylia Christensen
Richard T. Clarke
Ron A. Gallinat
Thomas A. Husted
Alison S. Little, MD
Victor S. Musial
Peter M. Tarzian

Board Members Absent:

Michael Cannerella

OEBB Staff:

Jean Thorne, PEBB/OEBB Administrator
Denise Hall, OEBB Deputy Administrator
Carolyn Bader, Contracts Coordinator
Glenn Baly, Program/Policy Analyst
Ali Hassoun, Financial Coordinator
Scott Rupp, Communications Coordinator
Rose Mann, Executive Assistant

Consultants:

Geoff Brown, Watson Wyatt
Steve Carlson, Watson Wyatt
Anne Thompson, Watson Wyatt

Guests:

Diane Lovell, PEBB Chair

Facilitator:

Connie Green, Willis, Green and Associates



1. [Welcome \(info\)](#)

Steve McNannay welcomed everyone to the retreat.

[Overview of Meeting \(info\)](#)

Denise Hall provided an overview of the retreat.

[The PEBB Perspective \(info / discussion\)](#)

Diane Lovell, Chair of the Public Employees' Benefit Board (PEBB) presented information on PEBB. PEBB was created out of two existing benefit boards, the SEIU Local 503 Benefits Council and the State Employees Benefit Board. PEBB initially established several subcommittees -- Communications, Plan Design, Operations. As things progressed some of the subcommittees were eliminated.

Diane recommended that OEGB really think about the roles for the leadership of the Board. She also emphasized the importance of building trust within the Board. Have discussions about what the members see as their roles as board members while still keeping in mind that they represent various constituents. Be cognizant of staying on target and don't get bogged down in the minutia ("getting lost in the weeds"). The Chair is responsible for keeping everyone on track and the members should have a discussion about the way that should happen.

Based on the experiences of PEBB Diane suggested OEGB:

- Keep the stakeholders you represent as board members informed and engaged in a way that builds their trust with the Board. Help them understand the "why" and this will also help them help you to make the best decisions.
- Stay open to the next horizon as you move past the initial start-up phase.
- Partner with others for collaboration and learning opportunities (stakeholders, Oregon Health Fund, other state agencies, etc). This will help them understand and support OEGB's efforts.
- Engage stakeholders in subcommittees and workgroups.

Jean Thorne stated that PEBB sees their role as not only addressing the issues of the members, but also as a role model for other purchasers.

Richard Clarke asked how quickly the Board should communicate that this is about changing the way healthcare is delivered. Diane recommended that the Board begin communicating to the stakeholders immediately how the vision of OEGB will be beneficial to them.

Steve McNannay asked how difficult has it been for PEBB to address evidence-based medicine.

Diane Lovell stated it has been a challenge and there has been some push-back on some issues.

Jean Thorne explained the challenge has been when benefits are taken away or premiums have increased, based on evidence-based medicine. The challenge is in explaining the reasons why a member's benefits are changing based on evidence-based medicine.

2. Guiding Principles (Discussion)

Connie Green led a discussion on the guiding principles the Board would use as it designed and administered the OEBB benefits program consistent with requirements under Section 4(1) of SB 426. The Board agreed that the following should be used to develop definitions and guiding principles relating to the nine elements included in the Bill:

- Employee Choice Among High-quality Plans
 - Affordable
 - Bring down trends
 - Save Money
 - Employer/Employee Share costs
 - Rates comparable to today
 - Total cost of premium/plan
- Encouragement of a competitive market place
 - Costs
 - Quality
 - Performance
 - Service
- Plan performance and information
 - Useful metrics
 - ✓ Appeal
 - ✓ Financial performance
 - ✓ Customer service
 - ✓ Quality - build in quality measures up front
 - ✓ Costs
- District Flexibility in plan design and contracting
 - Range of plans/costs
 - May change/narrow over time
- Quality Customer Service
 - Plan
 - Providers
 - Employers
 - Meets customers' needs
 - Monitor and evaluate
- Creativity and Innovation
 - Evidence-based – milestones
 - Use creativity in all areas:
 - ✓ Purchasing
 - ✓ Contracting

- ✓ Communication
 - Plan benefits as part of total employee compensation
 - Be aware of impact on CBA
 - Communicate with employees on rising cost of healthcare
 - Improvement in employee health
 - Wellness – Disease management included in plan
 - Case management (if have measurable results)
 - Costs affordable to districts and employees
 - Difference between cost of plan and employee affordability
 - Range of plans – allow choice
 - Affordability – member out-of-pocket

At the conclusion of the discussion the Board agreed on the following long-term goals:

- continue to be innovative and creative;
- promote wellness programs; and
- recognize that some staging will need to occur.

3. Processes, roles and responsibilities (Discussion)

Connie Green facilitated a discussion regarding processes, roles and responsibilities of the Board based on the survey sent out prior to the retreat. The Board came to consensus regarding the following:

- The Board will operate as a cohesive unit that provides for open discussion on topics.
- The Board will operate in a transparent manner that fosters public trust, input and understanding of OEBB decisions and policies.

Specific roles of the Board are to:

- Provide strategic direction and vision.
- Provide direction and context for the development of options.
- Prioritize and focus work of Board, workgroups, staff and consultants.
- Make decisions that align with the intent and mandate of SB 426

Interaction with staff and consultants:

- Staff and consultants should feel free to suggest direction to the Board (at least as a starting point) rather than only waiting for the Board to determine its desired direction.
- Staff and consultants should feel free to identify implications for the Board if they believe that the Board may be going in a direction that may not be wise or may require more resources than anticipated to accomplish.
- Consultants should provide leadership in identifying issues, options, and timelines necessary to accomplish the work.
- Requests for additional research or work by staff or consultants will be directed to the Chair or come through the workgroups.

Workgroup roles:

- Workgroups will undertake further analysis, discussion and development of options/recommendations for Board decision.
- Each workgroup will contain one to two Board members along with representatives from select stakeholder groups.
- Workgroups should provide periodic updates to the Board.

Board decision-making processes:

- The Board should strive to reach consensus on general direction, strategies and final decisions, but the use of parliamentary process is acceptable for final decision-making.
- Board members should strive to raise concerns about specific issues or items prior to final decision-making.
- Board members disagreeing with a final decision are free to express their views to stakeholder groups, but should respect the final decision of the Board and not campaign to undermine it.
- Public explanation of Board decisions will be conducted by the Chair or designated OEBB staff.
- Requests for reconsideration or to table decisions will be directed to the Chair through parliamentary procedure.
- Board members concerned with methods or processes of addressing issues should direct their concerns to the Chair.

The retreat adjourned at 3:40 p.m.

EFFECTIVE: July 1, 2014

OEBB BYLAWS 2014

I. Statutory Authority

ORS 243.862 establishes the Oregon Educators Benefit Board in the Oregon Health Authority.

II. Purpose and Role

The Board was created to design, create, implement and administer a benefits program for Oregon’s educational employees. By statute, the Board is directed to study all matters connected with providing adequate benefit plan coverage for eligible employees on the best basis possible with relation to both to the welfare of the employees and affordability for the districts. The Board is further directed to design benefits, prepare specifications, and analyze carrier responses to advertisements for bids and award contracts.

In carrying out these duties, the goal of the Board is to provide high quality plans for health, dental and other benefits for eligible employees at a cost affordable to the districts, the employees and the taxpayers of Oregon.

III. Composition of the Board

Membership

The Board consists of 12 members appointed by the Governor and confirmed by the Senate, including:

- a. Two members representing district boards;
- b. Two members representing district management;
- c. Two members representing non-management district employees from the largest labor organization representing district employees;
- d. One member representing non-management district employees from the second largest labor organization representing district employees;
- e. One member representing non-management district employees who are not represented by labor organizations described in paragraphs (c) and (d) ;
- f. Two members with expertise in health policy or risk management;
- g. One member representing local government management; and
- h. One member representing local government non-management employees.

EFFECTIVE: July 1, 2014

IV. Terms of office

The term of office of each member is four years, but a member serves at the pleasure of the Governor. Before the expiration of the term of a member, the Governor will appoint a successor to take office upon the date of that expiration.

V. Vacancies

If there is a vacancy on the Board for any cause, the Governor will appoint a successor to serve the remainder of the former member's term.

VI. Reappointments

Board members are eligible for reappointment.

VII. Compensation

Members of the Board receive no compensation for their services, but will be paid for their necessary and actual expenses while on official business in accordance with ORS 292.495.

VIII. Role and Representation

Each Board member will contribute their individual expertise and may express the viewpoint of the stakeholder or constituent group they represent. However, individual Board members acknowledge his or her appointment requires he or she act in the best interest of all current and future participating entities and members and the public at large.

IX. Officers

a. Election of officers

The Board will elect one of its members as chair and another member as vice chair. The Board will elect or reaffirm the chair and vice chair each year at its July Board meeting. Terms of office will be structured such that after serving as vice chair, the vice chair will move into the office of chair.

b. Representation among officers

EFFECTIVE: July 1, 2014

Representation among officers of the Board will be structured such that the chair and vice chair offices are filled by representatives from different stakeholder constituencies. The Board will elect the chair and vice chair from a slate of eligible candidates.

c. Terms of office

An officer may be re-elected by Board members, but will generally serve no more than a total of four consecutive years, two years as vice chair and two years as chair.

d. Duties of officers

- i. Duties of the Chair
 - 1. Preside over regular Board meetings
 - 2. Sign contracts or delegate signing of contracts
 - 3. Make workgroup and committee assignments when necessary
 - 4. Serve as ex-officio member of all workgroups
- ii. Duties of the Vice Chair
 - 1. Preside over meetings in the absence of the Chair
 - 2. Assist the Chair; perform duties of the Chair in the Chair's absence

X. Meetings

a. Frequency

The Board will meet at times and places specified by the call of the Chair or a majority of the Board. Regular meetings will be scheduled as determined by a majority of the voting members of the Board. Special meetings may be held at the Chair or Board's discretion at a time and place to be determined by the Chair or Board.

b. Notice

Notice of all Board meetings will also be given to the public in accordance with Oregon Public Meetings Law.

EFFECTIVE: July 1, 2014

Notice of special meetings will be delivered to each Board member personally, by telephone or electronic mail not less than two days prior to the meeting unless emergency situation requires otherwise.

c. Records

The Board will maintain all records in accordance with Oregon Public Records Law.

d. Meetings by telecommunication

A regular or special meeting may be held by telephone or telecommunication in which all Board members may hear each other so long as it complies with Oregon Public Meetings Law. If a Board member is unable to attend any meeting in person, the Member may participate via telephone or internet conferencing provided that all participants can hear each other and members of the public attending the meeting can hear any board member who speaks during the meeting. Board members attending through such electronic means will be included in constituting a quorum.

e. Attendance

Regular attendance at meetings is expected of each Board member. A Member will notify the Chair or the deputy administrator at least 24 hours in advance of a meeting if the Member is unable to attend. In an emergency, the Member will contact the Chair or deputy administrator as soon as reasonably possible.

f. Transparency

Board members will refrain from private meetings or communication on official Board business (electronic, by telephone, or in person) that involves a quorum of Board members outside of public meetings or executive session. Board member will also refrain from disclosing matters discussed in executive session unless these matters are part of the public record.

XI. **Procedures**

The Board will operate in accordance with Roberts Rules of Order. All procedural conflicts will be resolved in accordance with these rules.

XII. **Quorum and Voting Rights**

EFFECTIVE: July 1, 2014

a. Quorum

A majority of the members of the Board constitutes a quorum for the transaction of business. The continued presence of a quorum is required for any official vote or action of the Board throughout an official meeting.

b. Voting

Any of the 12 voting members of the Board who are present at a meeting may vote on motions raised during the meeting, with the exception of the chair.

On all motions or other matters, “voice” vote may be used. At the discretion of the chair, or at the request of a Board member, a show of hands or “roll-call” vote may be conducted. Proxy votes are not permitted.

A majority vote of the members present is necessary to pass any motion raised during a meeting.

c. Chair’s Role in Voting

In accordance with Roberts Rules of Order, the chair may vote to produce a tie, and thus cause a motion to fail, or to break a tie when necessary.

d. Abstaining Votes

Abstaining votes will be recorded.

XIII. Conflict of Interest

Board members will declare any direct interest of potential financial gain for any issue to be discussed. Conduct of members will be consistent with ORS 244.010 to 244.400 and the Oregon Government Standards and Practices Laws.

When met with a potential conflict of interest, Board members will announce publicly the nature of the potential conflict prior to taking any action thereon.

Board members will refrain from participating in any discussion on the issue out of which an actual conflict of interest arises and refrain from voting on the matter in any circumstances.

EFFECTIVE: July 1, 2014

XIV. Committees

a. Administrative Review Committee

i. Selection or appointment of committee members and officers

The committee will be comprised of three Board members. The Board chair will seek voluntary members to serve on the committee or otherwise appoint Board members to the committee as necessary. The Board chair will appoint a chair. Members of the committee will be selected or reaffirmed at the discretion of the Board chair.

ii. Meeting Frequency

The committee will meet on an as needed basis, unless otherwise determined by the chair.

iii. Authority

The committee will have decision-making authority regarding specific issues brought before the committee.

XV. Workgroups

a. Business and Operations Workgroup

i. Selection or appointment of workgroup members and officers

The Workgroup will be comprised of three Board members. The Board chair will seek voluntary members to serve on the Workgroup or otherwise appoint members to the Workgroup as necessary. The Board chair will appoint a workgroup chair. Members of the Workgroup will be selected or reaffirmed at the discretion of the Board chair.

ii. Meeting Frequency

The Workgroup will meet on a day and frequency determined by the consensus of the Workgroup members, unless otherwise specified by the Workgroup chair.

iii. Authority

EFFECTIVE: July 1, 2014

The Workgroup will discuss, reach a consensus and make recommendations for Board decisions.

b. Strategies on Evidence and Outcomes Workgroup

i. Selection or appointment of workgroup members and officers

The Workgroup will be comprised of three or four Board members and other individuals as deemed necessary. The Board chair will seek voluntary members to serve on the Workgroup or otherwise appoint members to the Workgroup as necessary. The Board chair will appoint a Workgroup chair. Members of the Workgroup will be selected or reaffirmed at the discretion of the Board chair.

ii. Meeting Frequency

The Workgroup will meet on a day and frequency determined by consensus of the Workgroup members, unless otherwise specified by the Workgroup chair.

iii. Authority

The Workgroup will discuss, reach a consensus and develop recommendations for Board decisions.

c. Healthy Futures and Member Engagement Workgroup

i. Selection or appointment of workgroup members and officers

The Workgroup will be comprised of three Board members. The Board chair will seek voluntary members to serve on the Workgroup or otherwise appoint members to the Workgroup as necessary. The Board chair will appoint a Workgroup chair. Members of the Workgroup will be selected or reaffirmed at the discretion of the Board chair.

ii. Meeting Frequency

The Workgroup will meet on a day and frequency determined by consensus of the Workgroup members, unless otherwise specified by the Workgroup chair.

EFFECTIVE: July 1, 2014

iii. Authority

The Workgroup will discuss, reach a consensus and make recommendations for Board decisions.

d. Ad-hoc workgroups and committees

The Board or Board chair may elect to form additional workgroups or committees as needed to address issues as they arise. Selection, meeting frequency and authority of ad-hoc workgroups will be consistent with those of permanent workgroups or committees.

XVI. Authority

a. Legislative Authority

The Board recognizes the role of the state legislature in approving the biennial budget.

b. Actions Requiring Board authorization

The Board may authorize action in key administrative and operational areas, or may choose to delegate authority to authorize such action to a Board committee. Areas where Board authorization is required include, but are not limited to the following:

- i. Filing of administrative rules
- ii. Release of Requests For Proposals
- iii. Awarding of any and all contracts after a formal bid process
- iv. Any decisions to terminate active contracts with vendors
- v. Approval of all benefit plan designs
- vi. Approval of premium rates
- vii. Approval of administrative rates
- viii. Approval of consultant fees
- ix. Stabilization Fund expenditures
- x. Hiring of Board Administrator

c. Authority Delegated to Board Staff

EFFECTIVE: July 1, 2014

The Board may delegate authority to OEGB administrative staff. Areas where this authority is delegated to staff include, but are not limited to the following:

- i. Direct rate negotiations with vendors through OEGB's contracted consultant
- ii. Direct contract negotiations for implementation and renewal of OEGB programs and benefits once the Board has awarded contracts to successful vendors or has approved renewals of existing program and service contracts
- iii. Authority to initiate contracts for specific services that fall under the definition of a Small Procurement as established under OAR 111-005-0044 (Small Procurement Process)
- iv. Authority to initiate transfer of excess reserve funds held by contracted carriers or refunds from contracted vendors to OEGB Stabilization Fund
- v. Authority to pay all invoices, purchase orders and travel expenses
- vi. Operational and administrative actions required to administer services to members and implement benefits (e.g., system enhancement work orders, amendments to statements of work under Board-approved contracts)
- vii. Other activities as determined by the chair and vice chair

XVII. Requests for Staff Assistance

Board members will direct individual requests for staff or consultant assistance through the Board chair, the OEGB administrator, or the OEGB deputy administrator.

XVIII. Amendments to Bylaws

These bylaws may be amended or repealed, and new bylaws adopted, by the Board by a majority vote of members present, if a majority of the full membership of the Board is present.

Name	Position	Email	Phone	Cell Phone
BOARD				
Rick Shidaker	Chair	rick@sea.org	503-588-0121	541-912-2223
Nancy MacMorris-Adix	Vice Chair	Nancymac93@gmail.com	541-364-3787	541-999-6148
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Ron Gallinat	Bd. Mem.	coemployeefits@bendcable.com	541-617-9111	541-385-4755
VACANT -- Health policy	Bd. Mem.			
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Cherie Maas Anderson	Bd. Mem.	cmass@pcc.edu	971-722-4266	503-803-9403
VACANT -- Largest union	Bd. Mem.			
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Heather Cordie	Bd. Mem.	hcordie@sherwood.k12.or.us	503-825-5003	
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VACANT -- Local govt (mgmt)	Bd. Mem.			
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Heidi Williams	Admin.	heidi.williams@oregon.gov	503-378-4695	
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2015-16 Renewal Process Overview

Month	Day	Activity	Responsible Party
2015			
February	3	SEOW reviews two Kaiser pharmacy-related requests for consideration during 2015-16 renewals	Staff, SEOW and Consultants
February	3	Executive session of full Board for advisory on renewal for The Standard (life, disability and AD&D)	Staff, Board and Consultants
March	3	Board approves renewal rates for The Standard - three year	Board
March through April		Staff and Consultants meet with carriers to discuss options and negotiate rates for presentation to the Board for consideration	
April	7	Executive session of full Board for advisory on renewal for medical, dental and vision coverages	Staff, Board and Consultants
April	21	Executive session of full Board for advisory update on renewal for medical, dental and vision coverages	Staff, Board and Consultants
April	28	Executive session of full Board for advisory update on renewal for medical, dental and vision coverages	Staff, Board and Consultants
April	28	Board approves plan designs and renewal rates for medical, dental and vision - one year	Staff, Board and Consultants
May	All month	Staff travels throughout Oregon to present plans and rates to insurance committees and other interested parties	Staff

2008 RFP Process and Rules that Apply to the Selection Committee

<p>A. General Rules for Participation in the RFP Process:</p>	
<p>Accountability</p>	<p>The role of the Selection Committee is a <i>public</i> one. As a member of the committee you are accountable for everything you say, write and do regarding the RFP, each proposal and the entire selection process. Oregon Administrative Rules (OARs) require that:</p> <ol style="list-style-type: none"> a. Committee members be selected on the basis of their ability to provide an objective, impartial selection of the proposals; b. Proposals be evaluated by a Selection Committee consistent with the process described in the RFP; c. Selection Committee members with actual or potential conflicts of interest must declare the conflict and its nature in writing. Potential conflicts of interest will be reviewed by OEBC to determine if the committee member will be excluded from participating in the selection process; and, d. Each member of the Selection Committee read and score all responsive and responsible proposals according to the selection criteria set forth in the RFP and independent of all other Selection Committee members.
<p>Selection Committee may not:</p>	<p>In addition, as a Comprehensive Medical and Related Service Selection Committee members, you may not:</p> <ul style="list-style-type: none"> • Discuss any aspect or opinion of proposers, proposals or proposal ranking or share information from proposals outside the Selection Committee forum; • Discuss the project in any way with, or accept anything from, proposers. These actions may constitute grounds for rejection of the respective proposal and disqualification of the proposer; or • Evaluate proposals based on criteria other than as prescribed in the RFP or based on information not included in the proposals. <p>• <u>Write on any of the Proposal materials.</u></p>

2008 RFP Process and Rules that Apply to the Selection Committee

Conflict of Interest	<p>All members of the Selection Committee must sign a Conflict of Interest Certification prior to beginning to score proposals.</p> <p>In the event a conflict of interest does exist, you must declare the conflict and its nature and you will subsequently be excluded from participating in this selection process.</p>
B. Selection Committee Member's Roles and Responsibilities in the RFP Process:	
Evaluation of Proposals	<p>The Selection Committee is charged with evaluating the proposals per the RFP requirements and must defend the scores and ranking. Please be thorough and document any concerns you might have regarding a proposal. Selection Committee members will evaluate the following information:</p> <ul style="list-style-type: none">• Copies of each proposal determined responsible and responsive by Watson Wyatt;• Summarized responses to the HighRoads questionnaire prepared by Watson Wyatt;• Reference Check responses summarized by Watson Wyatt; and• Proposer responses to the Supplemental Question Supporting Senate Bill 426.
Proposer Interviews Subject to Public Meeting Laws	
Evaluation/Scoring of Proposals	<p>The Selection Committee will evaluate and score the Proposer Interviews, the Proposer Reference Checks and the Supplemental Questions Supporting Senate Bill 426. The scoring by the members of the Selection Committee may be based on any information gathered in the RFP process. The score will represent the Selection Committee member's judgment about the extent to which the Proposer will achieve OEBB's Vision and Guiding Principles. Scores will be awarded in the following manner:</p> <ul style="list-style-type: none">• Proposer Interviews can receive a total of ___ possible points;

2008 RFP Process and Rules that Apply to the Selection Committee

	<ul style="list-style-type: none">• Proposer Reference Checks can receive a total of ___ possible points; and• Proposer responses to the Supplemental Questions Supporting Senate Bill 426 can receive a total of ___ possible points. <p><u>Please note: final scoring does not begin until after the Presentation/Interviews are complete.</u></p>
<p>C. OEBC Board Announcement of Intent to Award a Contract</p>	<p>Announcement of Intent to Award a Contract</p> <p>In addition to the scoring and all other information that has been obtained through the RFP process, the Board may consider the system considerations including but not limited to the interrelationships of proposals, network coverage, comparison between Proposer's access and networks, natural breaks in scoring, number of qualified proposals, interrelationships among proposals, and regional considerations.</p>

TIMELINE FOR 2008 MEDICAL/RX AND VISION RFP

Selection Process	Dates
RFP Released	January 4, 2008
Scoring Committee Meeting	
<ul style="list-style-type: none"> ○ Selection Committee’s Roles and Responsibilities Reviewed ○ Conflict of Interest Statement collected from committee members. ○ Summary of Questionnaire ○ SB 426 Section 4.1 Questions Reviewed-TW ○ Determine Interview Questions (TW and Selection Committee will work together to prepare) 	Late January-early February, 2008
RFP Closing Date	February 22, 2008
<ul style="list-style-type: none"> ○ 5 Medical/RX & Vision Proposers and 2 separate Vision Proposers 	
Scoring Process by Selection Committee	
<ul style="list-style-type: none"> ○ Interviews conducted Selection Committee members (Public Meeting) ○ Selection Committee members will independently provide a separate score for each Proposer’s Interviews and SB 426 Section 4.1 questions to TW 	March 19-21, 2008
Documentation to Full Board	April 4, 2008
<ul style="list-style-type: none"> ○ Packet including TW and Selection Committee scores tabulated by TW (Proposers names will be blinded) ○ Packet containing results of OEGBs best and final offer negotiations summarized by OEGB staff (Proposers will be blinded) 	April 24, 2008
Selection and Award by Full Board	April 24, 2008
<ul style="list-style-type: none"> ○ Select of ASPs from Blinded information 	
Identification and Announcement of ASPs by OEGB	April 24, 2008
<ul style="list-style-type: none"> ○ Announce Intent to Award ASP ○ Notify Proposers of status of Proposal 	
Notice of Contract Award	
<ul style="list-style-type: none"> ○ After award protest deadline Announce Contract Awards 	May 2, 2008
Contract Negotiations	
<ul style="list-style-type: none"> ○ OEGB staff will negotiate final Statement of Work and cost proposals with ASPs. 	August 1, 2008

ATTACHMENT B
Supplemental Questions Supporting Senate Bill 426

Senate Bill 426 Section 4.1 laid forth several goals for OEGB to achieve in contracting for benefit plans. The following questions, 1-8 below, reflect several of those goals.

Please provide written responses to the following questions. Submit your responses in Hard copy and electronic submission (CD) see RFP Submission, Section 3.10.

1. Describe the data you regularly collect to monitor plan performance in terms of both financial and quality perspectives.
2. Provide an example of how the collected data is analyzed and then used to implement plan performance improvements. Describe how you see this being valuable to OEGB.
3. Describe the method(s) for collecting member and provider feedback, and the process you use to review that feedback and determine the need for customer service change. Provide an example of how feedback was used to make a service improvement in the last few years.
4. Describe the internal process for reviewing feedback and determining the need for customer service change.
5. Provide an example of how feedback was used to facilitate change within the organization. Please include the planned goals for impacting the members, providers and the impact on your own internal organization. Provide examples of any feedback received as result of the changes made within the last five years.
6. Describe how you enable your own employees to make decisions in order to facilitate client satisfaction.
7. Provide an example of a creative and/or innovative approach you have taken in your organization which has benefited your members.
 - a. How do you partner with providers to enhance the quality of member care delivery?
 - b. How is technology being used to improve the following:
 - Quality of care,
 - Promotion of wellness, and
 - Efficiencies of services.
8. What is the greatest opportunity for improving OEGB member health?
 - a. How will you work with OEGB to address this opportunity both in the short- and long-term?

**OEBB Medical, Pharmacy, and Vision RFP & Contract Process and Timeline
2016-17 Plan Year Effective Date**

Month	Day	Activity	Responsible Party
2015			
February		Board reviews and approves Medical, Pharmacy and Vision RFP offering and any changes to benefits/service areas etc. to be included in RFP	Staff, Board and Consultants
March	3	Board or delegates provide input on initial draft	Board or delegates
May	5	Board or delegates provides final input on RFP	Board or delegates
June	2	Board approves final RFP for release	Board
June	3	RFP Posted on ORPIN	Staff
July	7	RFP "Selection Committee" Meeting-review conflicts of interest, questions, scoring tables, etc.	Staff, Consultants, Selection Committee
August	5	Proposals Due	Proposers
Aug	8	Begin Scoring Evaluation	Selection Committee, Consultants, Staff
September	1	Update Board on status of RFP	Staff
Sept	9	Scoring of Proposer Responses Completed	Consultants, Board and Staff
Sept	22-24	Proposer interviews and presentations	Selection Committee, Consultants, Proposers, and Staff
Sept	29	Selection Committee Scoring Completed	Selection Committee
Mid October		Consultants present ASP(s) & scores to Board in Executive Session	Consultants, Board, Staff
Mid October		OEBB Board approves ASPs	Board
2016			
May	15	Contractors return signed contracts	Proposers

Coordinated Care Model Alignment Work Group

Operationalizing the Principles of Oregon's Coordinated Care Model: A High-Level Framework for Procurement and Contracting

This framework is designed to be used by self-insured purchasers, however similar language can be used for a fully-insured product. It is by design written at a relatively high level. The framework includes the critical elements of the model. For procurement purposes, additional detail would be required in most instances. Some concepts, such as value-based benefit design, fall in a number of the elements. For the purposes of this framework, we have included them in one place. These CCM elements may be phased in over time if an employer is not able to implement all pieces at once.

Other content that falls outside of this framework but would be important for effective purchasing activity, such as reporting requirements and value-based purchasing language re: contractual performance goals and contract management have not been included in this draft.

I. Use best practices to manage and coordinate care

Application of evidence-based best practices of care delivery produces better care, improved outcomes and lower costs, as well as a positive patient experience.

- 1. Primary care clinician.** Plan Participant shall be required to identify a primary care clinician. The Administrator shall make sure that each Plan Participant has an identified primary care clinician and that the clinician establishes a relationship with every attributed Plan Participant if one does not already exist at the time of enrollment.
- 2. PCPCH.** The Administrator shall encourage its contracted primary care practices to operate as a high-functioning Patient Centered Primary Care Home (PCPCH) or similar primary care transformation, hold PCPCHs accountable for performance, and shall support PCPCHs with needed payer-supplied data, not limited to high-risk patient lists, costs of referral providers, information regarding non-primary care utilization, and quality information, utilization and cost measures for attributed Plan Participants.
 - **Options for stronger language regarding PCPCH participation:**
 - The Administrator shall require 85% of contracted primary care practices to operate as high-functioning PCPCHs (aggressive)
 - The Administrator shall require 70% of contracted primary care practices to operate as high-functioning PCPCHs (moderate)

- The Administrator shall require 50% of contracted primary care practices to operate as high-functioning PCPCHs (easier)
- 3. Team-based care.** The Administrator's contracted providers shall be encouraged to provide patient-centered, team-based care across appropriate disciplines through the application of a common, shared care plan and clinical information exchange.
- **Options for stronger language regarding team-based care:**
 - The Administrator's contracted providers shall be required to provide patient-centered, team-based care. (very aggressive)
 - 75% of the Administrator's contracted providers shall be required to provide patient-centered, team-based care by Year 3 of the contract (aggressive)
 - 50% of the Administrator's contracted providers shall be required to provide patient-centered, team-based care by Year 3 of the contract (moderate)
 - 25% of the Administrator's contracted providers shall be required to provide patient-centered, team-based care by Year 3 of the contract (easier).
- 4. Care coordination.** The Administrator shall ensure the provision of care coordination for patients at high-risk of future intensive service use. Care coordination may be provided through a combination of PCPCHs, coordinated care entities (such as CCOs or ACOs), and the Administrator. Where care coordination is available to a consumer through more than one organization, the Administrator shall ensure that these efforts are coordinated. Care coordination shall include integration of long-term services and supports (LTSS) with needed health care services, and shall leverage community-based human services that address social determinants of health, including housing and employment and coordination of population health (LTSS; Medicaid only).
- 5. Behavioral/physical health integration.** Behavioral health and primary care services shall be integrated through the application of evidence-based best practice strategies, including but not limited to co-location (including reverse co-location, which is defined as placement of primary care resources in community mental health settings), use of an integrated medical record, use of a shared treatment plan, and integrated payment.
- 6. Clinical protocols.** Contracted providers shall be required to specify and implement clinical protocols that are reflective of evidence-based practice, designed to maximize patient health status, clinical outcomes and efficiency, and to eliminate overuse (waste). For example, a clinical protocol may include a treatment plan for treating an individual with COPD or stroke management.

- 7. Formulary development.** The Administrator shall develop a formulary design that includes prescription drug coverage for each therapeutic class, but is flexible enough to allow for access to products outside the formulary in special circumstance. The formulary should be reviewed and amended at a minimum on an annual basis.
- 8. Electronic Health Record (EHR).** Contracted physician providers shall be required to adopt and fully utilize certified Electronic Health Records (EHR) systems across care settings. Such providers shall implement systems to ensure data completeness and accuracy.

 - **Options for stronger language re: EHRs**
 - All contracted providers shall be required to adopt and fully utilize certified EHRs. (very aggressive)
 - Purchasers and providers shall ensure that patients have secure access to their clinical health records electronically, such as through a patient portal, as well as ensure patients have the capacity to share information electronically with their providers.
- 9. Health information exchange.** Contracted physician and hospital providers shall be encouraged to use real-time electronic clinical information exchange across all care settings.

 - **Options for stronger language re: HIE**
 - All contracted providers shall be required to use real-time electronic clinical information exchange across all care settings (very aggressive)
 - Contracted physician and hospital providers shall be required to use real-time electronic clinical information exchange across care settings. (aggressive)
- 10. Value-Based Network Design.** Value-Based Network Design is the explicit use of employee plan benefits to create consumer incentives for use of high performance providers who adhere to evidence-based treatment guidelines.

 - a. Tiered network.** The Administrator shall make available to the Purchaser a benefit design that varies cost-sharing by provider performance. For example, the highest performing providers and/or centers of excellence are placed in Tier 1 with the lowest cost-sharing, while the lowest performing providers on a set of quality metrics are placed in Tier 3 with the highest cost sharing.
 - b. High-performing network.** The Administrator shall make available to the Purchaser a high-performing network that is limited to providers who have distinguished themselves based on evidence-based, statistically meaningful

and risk-adjusted measures of quality as well as risk-adjusted measurement of cost and efficiency.

11. Use of telemedicine. The Administrator shall support provision of covered telemedicine services.

II. Share responsibility for health

When providers, payers and consumers work together, improving health becomes a team effort. Informed, engaged, and empowered providers and patients/consumers can share responsibility and decision-making for care, while coming to joint agreement on accountability for individual health behaviors.

- 1. Shared decision-making.** Contracted providers shall be expected to make shared decision-making a standard of care with patients and their family members (as appropriate), utilizing tools such as personal health self-assessments and technologies such as video and web-based decision aids to support the process.
- 2. Benefit design incentives for preventive care.** The Administrator shall make available to the Purchaser and its Plan Participants benefit design incentives for evidence-based screenings, well-child visits and other preventive care services. For example, incentives could include enriched benefit coverage, reduced cost-sharing and “extras” such as car seats and gym memberships
- 3. Benefit design incentives for health behaviors.** The Administrator shall make available to the Purchaser and its Plan Participants benefit design incentives for personal health behaviors and improved health status using evidence-based strategies relating to diet, exercise, smoking and medication adherence. For example, incentives could include enriched benefit coverage, reduced cost sharing and “extras” such as gym memberships.
- 4. Benefit design for evidence-based services.** The Administrator shall propose for Purchaser consideration a benefit design that varies cost-sharing for services that are nationally recognized as over-used or being driven by supply and/or physician preference rather than evidence-based practice. For example, this may include incentivizing the use of physical therapy without cost-sharing for back pain prior to receiving an MRI or reducing cost-sharing for prescription drugs related to chronic conditions such as diabetes.
- 5. Patient activation.** Contracted providers shall be expected to utilize strategies that activate patients to take charge of their health and any chronic condition needing management. Such strategies shall include provider training, use of standardized assessment instruments and differentiated patient activation strategies based on assessment results.
- 6. Health Risk Assessment.** The Administrators shall provide for a Health Risk Assessment and request its completion by each adult Plan Participant.

III. Measure performance

Comprehensive performance measurement, aligned across payers, supports identification of performance improvement opportunities and provider performance accountability purchasers while easing the burden of reporting for providers.

1. **Aligned measure set.** The Administrator shall adopt and utilize the set of provider performance measures developed by the Health Plan Quality Measures Workgroup (<https://www.coveroregon.com/docs/HB-2118-Recommendations.pdf>) or future consensus document, which aligns measures across major public and private payers, including commonly defined measures in each of the following domains and stratified by major subpopulations: a) access, b) quality, c) patient experience, d) patient activation, e) service utilization, and f) cost. These performance measures shall be reported to the appropriate state agency or entity, including where applicable to the All Payer All Claims (APAC) Reporting Program.
2. **Administrator health informatics.** The Administrator shall perform analysis of claims and clinical data to identify a) population characteristics, b) variations in care delivery, costs and avoidable complications, c) provider deviation from practice guidelines and/or clinical pathways, d) patients at risk for future high-intensity service use.
 - **Option for Stronger Language;**
 - **Provider health informatics.** The Administrator shall require contracted providers operating under population-based contracts to perform analysis of integrated claim and clinical data to identify a) population characteristics, b) variation in care delivery, costs and avoidable complications, c) provider deviation from practice guidelines and/or clinical pathways, d) patients in need of evidence-based services, e) patients at high risk of future high-intensity service use
3. **Administrator-level measurement.** The Administrator shall measure performance across all provider types and providers with meaningful volume for the Administrator's book of business.
4. **Provider-level measurement.** The Administrator shall require contracted providers to measure performance at the clinician, practice team and/or practice site, and organizational levels.
5. **Population measurement adjustment.** The Administrator shall apply clinical risk adjustment techniques when measuring provider performance and utilize socio-economic risk-adjustment techniques to the extent available.

IV. Pay for outcomes and health

Alternative payment methodologies (APMs) such as population-based payment, episode-based payment, and offering incentives for quality outcomes instead of volume-based fee methodologies all support better care and better lowered cost growth. Our intent is to increase use of these alternative payment methodologies over time.

- 1. Population-based contracting.** The Administrator shall take such actions as are necessary to annually increase the number of insured covered lives that are paid under a population-based contract with shared savings, and with risk sharing.
 - **Options for stronger language on population-based contracting:**
 - By the end of Contract Year 3, claims for at least 30 percent of insured covered lives shall be paid under a population-based contract with shared savings or with risk sharing.
 - By the end of Contract Year 3, claims for at least 45 percent of insured covered lives shall be paid under a population-based contract with shared savings, and claims for at least 10 percent of insured covered lives shall be paid under a population-based contract with risk sharing. (moderate)
 - By the end of Contract Year 3, claims for at least 60 percent of insured covered lives shall be paid under a population-based contract with shared savings, and claims for at least 20 percent of insured covered lives shall be paid under a population-based contract with risk sharing. (aggressive)
- 2. Pay providers, including both those operating under population-based contracts and those not, differentially according to performance.** The Administrator shall evaluate and implement successful programs to differentiate providers who meet or exceed state or national standards for quality and efficiency. Compensation paid to effective and efficient providers should reflect their performance and result in market efficiencies and savings to purchasers and payers. Examples include quality-based incentive payments, differential fee schedules, and fee increases at risk based on provider performance.
- 3. Design payment and coverage approaches that cut waste while not diminishing quality, including reducing unwarranted payment variation.** The Administrator shall evaluate and implement successful approaches to payment that are designed to cut waste while not diminishing quality. Examples include, but are not limited to, reference pricing, non-payment for avoidable complications and hospital-acquired infections, lower payment for non-indicated services and warranties on discharges for patients who undergo procedures.

4. Support primary care. The Administrator shall support Patient Centered Primary Care Home (PCPHs) or similar primary care transformation, ensuring that the level and method of compensation support an effective primary care infrastructure, through the use of enhanced fee schedules, supplemental payments and/or primary care capitation.

V. Provide information so that patients and providers know price and quality

Readily available, accurate, reliable and understandable cost and quality data can help patients understand health care plan choices, and share responsibility in treatment, care management, and other health care decisions. Increased transparency on price and quality can also lead to increased accountability for providers.

1. Fully disclose quality performance to facilitate comparisons of providers. The Administrator shall develop and implement a strategy to report the comparative performance of Providers, using the most current nationally-recognized or endorsed measures of hospital and physician performance. Information delivered through the Administrator's provider ranking programs should be meaningful to Plan Participants and reflect a diverse array of provider clinical attributes and activities. Information available to Plan Participants should include, but not be limited to, provider background, quality performance including specific to high-volume interventional services, patient experience, volume, and should be integrated into and accessible through one forum providing Plan Participants with a comprehensive view.

2. Fully disclose prices to facilitate price comparisons of providers. The Administrator shall, where permitted, make transparent and available for use by Company and its Plan Participants, including those in consumer-directed plans, Plan- and any Purchaser-specific price information for services that represent at least 80% of the Administrator's medical spend in all markets, including full disclosure of the prices it is paying to Providers. The disclosed information shall be based on the contracted price of specific procedures and services including, without limitation, reasonable and customary estimates, to facilitate Plan Participants' informed choice of treatment and care decisions.

3. Combine projected price information with Plan Participants' benefit design. The Administrator shall identify and engage third-party vendors, if any are necessary, to enable the Administrator to integrate tools providing information about the price of specific services with information about the benefit design, such as deductibles, coinsurance, and balance of account-based plans. The Administrator shall align with future transparency efforts led by the Oregon Insurance Division or other state entities.

VI. Establish a sustainable rate of growth

Bending the cost curve is a vital component of the coordinated care model that fortifies all other principles. Preventing a cost shift to employers, individuals, and families and reducing inappropriate utilization and costs through a fixed rate of growth approach is foundational to health care transformation in Oregon.

- 1. Population cost growth.** Population-based contracts shall include a provision that the risk-adjusted annual increase in the total cost of care for services reimbursed under the contract shall be informed by the efforts of the Sustainable Health Expenditure Work Group.
- 2. Provider price growth.** Provider contracts, including but not limited to hospital and physician contracts, shall include a provision that agrees on rates, and quality incentive payments for each contract year, informed by the work of the Sustainable Health Expenditure Work Group.

Defined Terms

Administrator – the entity responsible for providing third party Plan administration services on behalf of an employer purchaser and contracting with a provider organization(s) representing a defined network for purposes of providing benefits to Plan Participants.

Behavioral Health – services related to both mental health and addiction

Clinical Protocols – standardized tools designed for a particular chronic condition or procedure that provides clear care guidelines based on scientific evidence and organizational consensus regarding the best way to manage the condition or procedure.

Employer – sponsor of a group health plan with specified benefit coverage through the Administrator.

Patient Centered Primary Care Home (PCPCH) – a primary care practice that meets the State criteria for a PCPCH as defined at <http://www.oregon.gov/oha/pcpch/Pages/standards.aspx>.

Plan – the set of benefits offered by the Employer through the Administrator through an agreement.

Plan Participant – employees, dependents and retirees of the Employer who are eligible to receive their health benefits under the Plan.

Primary Care Clinician – a Provider that focuses his or her practice on the provision of primary care; a Primary Care Clinician may include pediatricians, family physicians, nurse practitioners, internists, and based on a Plan Participant’s diagnoses, may also include a specialty physician upon agreement by that physician and approval by the Administrator.

Provider - primary care and specialty physicians, hospitals, outpatient and ancillary facilities participating in the Administrator’s network for the purposes of this Plan.