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December 11, 2013

Dear Governor Kitzhaber:

Please accept the attached report from the Oregon Health Policy Board (OHPB) in response to your letter to the Board dated June 3, 2013. The report contains recommended actions and strategies to align implementation of the Affordable Care Act (ACA) with Oregon's health reforms and ensure that our triple aim goals of lower costs, better care and better health are achieved across all markets.

The Board recommends three principal strategies to best meet your charge. Additionally, the Board endorsed the recommendations made by our Coordinated Care Model Alignment Workgroup and made recommendations to the Oregon Insurance Division (OID). Those strategies and recommendations are:

1. To create system-wide transparency and accountability through a robust measurement framework, including a public-facing health system dashboard, to track the effect of ACA implementation and Oregon's health system reforms.
2. To measure the total cost of care and move the health care marketplace toward a fixed and sustainable rate of growth
3. To improve quality and contain costs by expanding an innovative and outcome-focused primary, preventive and chronic care infrastructure.
4. To spread the foundation of Oregon's health system transformation, the coordinated care model, to the broader market by aligning coordinated model principles across payers and implementing organization alignment around those principles.
5. To implement administrative simplification and improve consumer outreach strategies in OID's rate review process

In addition to supporting ACA implementation and alignment with Oregon's reforms these strategies and actions represent next steps for Oregon's health care transformation. We look forward to continuing your vision of better health, better care and lower costs.

Sincerely,

Eric Parsons  
Chair, Oregon Health Policy Board

# **Recommendations for aligning Affordable Care Act implementation with Oregon's health system reform**

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**16 December 2013**

**Prepared by  
Oregon Health Policy Board**

**Prepared for  
Governor John Kitzhaber, M.D.**



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## Executive Summary

### Introduction

In a June 2013 letter, Governor Kitzhaber asked the Oregon Health Policy Board (OHPB) for recommendations to better align Oregon's implementation of the Affordable Care Act (ACA) with Oregon's current health system reform efforts and to spread the triple aim goals – better health, better care and lower costs – across all markets. The letter charged OHPB with providing recommendations which:

- Move the marketplace toward one characterized by coordinated care and growth rates of total health care that are reasonable and predictable;
- Mitigate cost shift, decrease premiums, and increase transparency and accountability;
- Enhance the Oregon Insurance Division (OID) rate review process;
- Align care model attributes within the Public Employees' Benefit Board (PEBB), Oregon Educators Benefit Board (OEBB) and Cover Oregon Qualified Health Plans (QHPs).

OHPB convened on five occasions over five months during 2013 to develop a process, review policy options, and recommend actions that met the Governor's charge. Manatt Health Solutions and Georgetown University's Health Policy Institute, supported by the Robert Wood Johnson Foundation, provided technical and policy guidance. They also recommended strategies to align transparency, cost containment and quality improvement, and analyzed the evidence for the effectiveness and feasibility of key policy options. OHPB also chartered a Coordinated Care Model Alignment Workgroup consisting of board members from PEBB, OEBB and Cover Oregon to make recommendations for moving the marketplace toward one characterized by coordinated care. This document describes the board's recommended next strategies and actions to address the Governor's charge.

## **OHPB Process**

At its August 6th meeting, OHPB agreed on a timeline and process framework based on the coordinated care model principles and the triple aim goals. OHPB also adopted additional principles to guide its response to the Governor. These principles are:

- Leveraging the coordinated care model;
- Enhancing transparency;
- Promoting and ensuring shared accountability;
- Focusing on outcomes;
- Improving quality and access;
- Containing costs.

Manatt Health Solutions, in collaboration with Oregon Health Authority (OHA) and Oregon Insurance Division (OID) staff, provided OHPB with an overview of potential policy options and related levers, including policy options used by other states. OHPB discussed options through a facilitator, and reviewed and refined potential strategies through a public and transparent iterative process. The board examined potential policy recommendations through the lens of feasibility and effectiveness, and discussed specific actions, accountabilities, and timelines for each strategy.

## **Recommended Strategies**

OHPB recommends three principal strategies as first steps to satisfy the Governor's charge and provide next steps for Oregon's long-term vision for health system transformation:

1. Create system-wide transparency and accountability through a robust measurement framework, including a public-facing health system dashboard, which tracks the effect of ACA implementation and Oregon's health system reforms.
2. Move the health care marketplace toward a fixed and sustainable rate of growth.
3. Improve quality and contain costs by expanding an innovative and outcome-focused primary, preventive and chronic care infrastructure.

The Board also recommends actions to the Oregon Insurance Division (OID) regarding communication outreach strategies that work for health plans and consumers and administrative simplification.

Finally, the Board endorses specific actions to move the foundation of Oregon's health system transformation – the coordinated care model – forward by spreading the model to the broader marketplace.

The full report can be found at <http://www.oregon.gov/oha/OHPB/Pages/2013-OHPB-Meetings.aspx>

## Recommended Strategies and Actions

### Strategy 1:

#### **Measure the impact of Affordable Care Act implementation and Oregon's health system reforms**

The goal of this strategy is to enhance transparency and accountability, measure the performance of Oregon's health care system, and provide information so that patients, purchasers and providers have accurate information about price and quality. Oregon should use the All-Payer-All-Claims Database (APAC) and other tools to understand the evolving health care landscape and to produce accurate and actionable data to inform policies that enable consumers, providers, and purchasers to pursue the triple aim.

**Recommended actions: by March 1, 2014, a quarterly health system dashboard and measurement framework is in place.**

- OHA and OID use APAC and other data sources to create a measurement framework to enhance transparency and accountability. The framework includes multiple tiers of data, which will include a dashboard with measures of utilization, cost, coverage, quality, and health equity.
- The measurement framework and dashboard are publicly available and contain validated statewide, plan, and health care entity-level data by market segment, health care setting, demographics, geography, diagnosis, and other variables. For specific elements of the dashboard, refer to the draft dashboard elements on page 17.
- OHA and OID engage in rulemaking as necessary to enable future collection of health care entity- and clinical-level data for inclusion in the measurement framework.

The board further recommends that OHA and OID jointly create a technical advisory group (TAG) that will provide input on the use of APAC and other related data sources. The TAG will also identify additional data collection needs and redundant data collection activities, advise on measure specifications, and inform data validation processes that are accurate and reliable in support of an effective measurement framework and dashboard.

**Recommended actions: by April 1, 2014, an APAC technical advisory group (TAG) is appointed and its charter is endorsed.**

- TAG members are appointed by the Commissioner of OID and Director of OHA, and serve at the pleasure of those offices.
- OHA provides OHPB with regular reports regarding the TAG and the dashboard and measurement framework.
- OHA consults via written correspondence with stakeholders including the Oregon Health Leadership Council, the Oregon Business Association and Cover Oregon's Board of Directors regarding the TAG's work and the dashboard and measurement framework.
- The TAG consists of but is not limited to stakeholders and technical experts from individual health entities, health plans, Cover Oregon, PEBB and OEBC.

Finally, this first strategy includes a recommendation to use a small set of focused dashboard metrics in rate filings in order to provide enhanced transparency in the OID rate review process.

**Recommended actions: by January 21, 2014, OID, in consultation with OHA and stakeholders, identifies and has in place a small set of focused metrics from the dashboard and measurement framework for informal inclusion in 2015 rate filings.**

- The metrics included represent key drivers of health care costs.
- These metrics are used for informational purposes to inform a broader narrative and promote market-wide transparency and alignment; they are not tied to rate decisions.

## **Strategy 2: Move the marketplace toward a sustainable and fixed rate of growth**

The goal of this strategy is to contain health care costs, to improve the affordability and sustainability of health care coverage, and improve Oregon's economic climate by measuring the true cost of the health care system. Oregon should formulate or endorse a sustainable rate of growth methodology aimed at containing and lowering the total cost of health care that includes, but is not limited to, costs for health care entities, individuals and health plans.

OHA and OID should create a sustainable rate of growth workgroup that will develop an accurate and stakeholder-driven sustainable rate of growth methodology for the total cost of care and advise on related processes and timelines.

### **Recommended actions: by January 31, 2014, a sustainable rate of growth workgroup is appointed and its charter is endorsed.**

- OHA and OID establish a sustainable rate of growth workgroup to advise a methodology development process.
- The workgroup members are appointed by and serve at the pleasure of the Commissioner of OID and Director of OHA.
- OHA reports quarterly to OHPB regarding progress toward developing a sustainable rate of growth methodology.
- The workgroup consults with stakeholders regarding the methodology and related components of this strategy. Stakeholders include but are not limited to the Oregon Health Leadership Council, the Oregon Student Public Interest Research Group and the Oregon Business Association, PEBB and OEBC

### **Recommended actions: by December 31, 2014, a sustainable rate of growth methodology is endorsed, measurement begins and potential accountability mechanisms are recommended.**

- Sustainable rate of growth measurement includes but is not limited to measurements of health entities and health plan premiums year over year.
- OHA and OID ensure financial modeling is conducted, and that it shows the potential effect of a sustainable rate of growth benchmark on different market segments, the delivery system and overall financial implications.
- Because there is shared responsibility for the total cost of care, OHA and OID explore the benefit of and make recommendations to the Governor's office and 2015 Legislature about potential mechanisms to hold health plans and health entities accountable for cost increases beyond the sustainable rate of growth benchmark.

### **Strategy 3: Expand and improve primary, preventive and chronic care infrastructure**

In order to improve quality and further spread the triple aim, Oregon should assess the infrastructure supporting the use of primary, preventive and chronic care. Potential measures could include tracking utilization and expenditures in preventive, chronic and basic health services as well as reporting on innovative models of care adoption (e.g., patient-centered primary care home), primary care workforce and payment methodologies providing incentives for coordinated care. These data can help Oregon better understand these care systems and recognize opportunities to increase care access points, improve care coordination, and support innovative payment mechanisms. Aligning payment incentives across the system and sharing best practices can generate cost savings statewide. Further, this work should be conducted in the context of a sustainable fixed rate of growth. Increasing resources directed toward primary, preventive and chronic care in Oregon should directly support a sustainable fixed rate of growth of the total cost of care and will help provide better health, better care.

**Recommended actions: by December 1, 2014, baseline data related to primary, preventive and chronic care infrastructure are collected.**

- OHA develops a timeline and process to develop baseline data related to primary, preventive and chronic care infrastructure using the measurement framework articulated in strategy No.1.
- An assessment of the primary care workforce in new models of care measurement may be included.

**Recommended actions: by December 31, 2014, OHA, in consultation with OID, makes recommendations to increase resources directed toward primary, preventive and chronic care.**

- OHA and OID explore the benefit of and make recommendations to the Governor's office and 2015 Legislature regarding mechanisms to increase the proportion of total resources directed toward primary, preventive and chronic care infrastructure.
- Recommendations are inclusive of innovative models of care delivery; e.g., patient-centered primary care homes and accountability mechanisms are based on outcomes and foster flexibility.

**Recommended actions: by December 1, 2015, OHA concludes "standardization initiative" to align metrics reporting requirements for all coverage entities at primary care provider level.**

- OHA develops a timeline and process to align metrics reporting requirements at the primary care provider level.
- Ensure metrics reporting alignment work is in consultation with and builds upon the health plan metrics workgroup required by HB 2118 (2013).

## **Recommended actions for implementing coordinated care model (CCM) principles in PEBB, OEBC, Cover Oregon and broader market**

PEBB, OEBC, and Cover Oregon are responsible for offering high-quality and affordable health insurance plans to a vast number of Oregonians in all regions of the state. Increasing alignment and collaboration among these organizations creates a significant opportunity to positively affect the delivery system statewide. Adopting principles of the coordinated care model within plans offered by PEBB, OEBC and Cover Oregon will help move the marketplace toward one characterized by coordinated care and move toward achieving the triple aim.

### **Recommended actions: by December 31, 2016, coordinated care model principles are embedded in PEBB and OEBC purchasing strategies and incorporated in individual and small group commercial plans sold in Oregon.**

- Purchasing strategies include, but are not limited to, the development of request for proposals (PEBB and OEBC), request for applications (Cover Oregon), contracts, renewals, and other means where appropriate.
- A shared timeline among PEBB, OEBC, and Cover Oregon provides a framework for alignment with key dates, opportunities for input and development periods.
- OHA and OID ensure that the same standards and principles adopted for plans sold inside the Oregon Health Insurance Exchange (Cover Oregon) are implemented consistently for those sold outside the exchange.

To identify potential opportunities for joint strategic planning, shared learning, and organizational alignment related to the adoption and implementation of coordinated care model principles and attributes in PEBB, OEBC, and Cover Oregon, OHA, in consultation with Cover Oregon and OID, should create a Coordinated Care Model Alignment Accountability Workgroup.

### **Recommended actions: Coordinated Care Model Alignment Accountability Workgroup appointed and charter endorsed before May 1, 2014.**

- The workgroup is appointed by and serves at the pleasure of the Director of OHA. The group reports bi-annually to OHPB and its authority is to make recommendations to OHPB, PEBB, OEBC, Cover Oregon, OID and OHA regarding:
  - Guiding implementation of CCM workgroup recommendations;
  - Assisting in implementation of CCM principles across multiple markets;
  - Providing a “coordinated care model tool-kit” for large group purchasers;
  - Assisting with metrics alignment.

## **Recommendations for administrative simplification and meaningful communication outreach strategies for the Oregon Insurance Division**

To meet the Governor's charge, OID should identify opportunities for administrative simplification and ensure there are meaningful and effective communication outreach tools in place that work for consumers and health plans.

### **Recommended OID actions for administrative simplification:**

- OID identifies opportunities and mechanisms for administrative simplification in the rate review process related to Oregon's reforms and ACA implementation. Potential mechanisms and opportunities include:
  - Clarifying filing requirements to reduce amount of additional correspondence with insurers during rate review;
  - Integration of ACA-related rate filing requirements in the rate filing standards;
  - Elimination of redundant and/or outdated filing requirements from the rate filing standards and adoption of associated administrative rules necessary to make these changes.
- OHA & OID identify opportunities to support administrative simplification for OID rate review through the measurement framework developed under Strategy #1.
- OID uses data available from the All Payer All Claims database.

### **Recommended OID actions for meaningful communication outreach strategies for consumers:**

- OID engages in a stakeholder-driven, public process to identify meaningful communication outreach strategies that work for consumers and health plans. Potential outreach strategies include:
  - Revision of consumer disclosure form used as part of the rate review process;
  - Media campaign to better inform consumers about the free assistance available from the OID's consumer advocates.
- OID implements meaningful and effective communications outreach strategies and process to measure success of new outreach strategies.
- OID reports the process and changes implemented to make outreach strategies more effective and meaningful for consumers to the 2014 and 2015 OHPB.

# **Manatt Health Solutions and Georgetown Health Policy Institute Memorandum: Aligning Strategies for Transparency, Cost Containment, and Quality Improvement**

**To: Oregon Health Policy Board**

**From: Joel Ario, Manatt Health Solutions  
David Cusano, Georgetown Health Policy Institute**

**Date: October 18, 2013**

**Re: Aligning Strategies for Transparency, Cost Containment, and Quality Improvement**

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## **1. GOVERNOR'S CHARGE**

The Governor has asked the Oregon Health Policy Board (Board) to make recommendations for how to better align Affordable Care Act (ACA) implementation with Oregon's current reform efforts and ensure Triple Aim goals are met across all markets. The Triple Aim requires simultaneous focus on three goals:

- (i) Better care for patients,
- (ii) Better health outcomes at the community level, and
- (iii) Lower costs or improved value.

In order to achieve the Triple Aim, the Governor asked the Board to consider strategies that would:

- (i) Move the marketplace toward models of coordinated care,
- (ii) Achieve reasonable and predictable growth rates in total health care spending,
- (iii) Mitigate cost shifting,
- (iv) Decrease health insurance premiums,
- (v) Increase transparency and accountability,
- (vi) Enhance the insurance rate review process, and
- (vii) Align care model attributes across public and private purchasers.

## **2. BOARD PROCESS**

The Board initiated consideration of the Governor's charge at its August 6, 2013 Board meeting, where a framework and four month timeline was presented and the Board began discussing potential recommendations and strategies for meeting the Governor's alignment goals. The Board discussion and input from stakeholder groups began to highlight some common themes, which became a list of ten potential strategies by early September.

At its September 10, 2013 meeting, the Board heard a presentation on the Rhode Island reform model and had a facilitated discussion of the ten potential strategies. The Board added an 11<sup>th</sup> strategy and requested an analysis of the feasibility and effectiveness of each strategy for its October meeting. The 11 strategies were divided into the following categories:

*Accountability and Measurement*

1. Strengthen and utilize All Payer All Claims database to set baselines for measurement and potential goals around outcomes (e.g. ER utilization, readmission rates) in individual and small group market;

*Cost Containment*

2. Incent or set goals with accountability for PCPCH and/or health home model expansion;
3. Promote increase in primary care spending;
4. Promote wellness incentives and expand to individual market;
5. Identify potentially unnecessary regulatory burdens and streamline and simplify rate review process;
6. Growth rates of total cost of care expenditures that are reasonable and predictable (identified by OHB during the September 10, 2013 meeting);

*Transparency*

7. Enhanced tools for consumers (rate comparison charts, pre-service pricing disclosure, etc.);
8. Enhanced bad debt/charity care analysis and timely reporting;
9. Enhanced disclosure of hospital and/or provider pricing;

*Quality Improvement*

10. Promote alternative payment methodologies (APMs) and collect relevant data to support APM development; and
11. Incent or set goals to promote value-based benefit designs

At its October 1, 2013 meeting, the Board considered a memorandum analyzing the feasibility and effectiveness of each strategy, and then had a facilitated discussion aimed at narrowing the list to a handful of top priorities. That discussion, combined with ongoing input from other stakeholders, made it clear that the Board was most interested in three broad strategies for meeting the Governor's charge:

1. Developing a broad measurement framework to better understand the evolving health care landscape and to establish clear metrics for measuring progress and achieving alignment across the marketplace for shared goals
2. Achieving reasonable and predictable growth rates in health care spending across market segments through a shared responsibility model that holds health plans and other health care entities accountable under a common framework
3. Focusing more resources on coordinated care models that promote primary care services and best evidence practices for preventive care and chronic care, with metrics that measure outcomes and allow flexibility in methods

The Board discussion also highlighted the value of alignment across purchasers and market segments, and embraced reforms in the insurance rate review process to streamline administrative requirements and enhance transparency through timely and effective communication tools.

With each reform priority, the Board also reviewed draft models for how to how best to pursue the priority in terms of responsible agencies, timelines, and specific work products. The Board provided additional direction in these areas and requested further analysis at its November meeting as to the public policy case for each strategy and a work plan for how to move forward.

This memorandum focuses on why it makes sense for Oregon to pursue major initiatives in the three areas noted above: building a common measurement framework, achieving reasonable and predictable growth rates in total health care costs, and promoting coordinated care models across market segments.

### **3. ANALYSIS**

Before analyzing each of the three key priorities on its own terms, it should be noted that the Board has taken a bold approach to the Governor's charge. Instead of selecting a list of narrow initiatives that would advance a handful of discrete reforms, the Board has chosen three broad strategies that go to the essence of what ails our health care system, even as they put the state in some uncharted waters.

With the first strategy, there is a starting point – Oregon's all payer all claims data base (APAC) – that is common across other states, but the Board's initiative pushes the concept of a common measurement framework further than other states have to date. This creates real challenges, but there also is no question that the balkanization of our health care system is a real impediment to improvement and that agreement on how to measure progress across market segments is critically important.

Similarly, there is broad consensus on the importance of bending the cost curve, but the Board's concept of developing a sustainable fixed rate of growth (SRG) and applying it across the entire health care system puts Oregon in a precedent-setting class with one other state, Massachusetts, that is attempting something similar, though there are other states, such as Maryland with its hospital rate-setting commission, that have pursued elements of this strategy.

The Board's emphasis on primary care is a bit more tested approach, but even here the focus on a specific patient-centered primary care home model (PCPCH) is pushing the envelope, as is the drive toward standardized reporting on key metrics across the marketplace.

In many states, the trail-blazing nature of these reforms would meet resistance from various stakeholders seeking more pedestrian approaches that had already been proven effective in other states. That is not the Oregon way. Indeed, Oregon has often been a national leader on health reform initiatives. But even in Oregon, there are trade-offs, and one of them is that none of the three primary strategies is yet defined enough to be translated into statutory or regulatory language this year. In each case, the next steps on the work plan involve collaborative work among stakeholders to refine the strategy before full implementation.

In sum, the Board is aiming high, taking on three fundamental challenges that go to the heart of what needs to change in our health care system, following in the footsteps of the state’s Medicaid waiver in pursuing alignment across the marketplace, and encouraging new levels of stakeholder collaboration on measuring outcomes, bending the cost curve, and expanding coordinated care models.

The rest of this memorandum summarizes the ways in which Oregon will be able to draw on research and action in other states to advance its public policy objectives.

#### **A. Measure the impact of aligning ACA implementation and Oregon’s state-specific health reform efforts**

Oregon’s efforts to align ACA implementation with its Medicaid waiver and other state –specific reform initiatives require collaboration across market segments and that collaboration will be impeded without a common measurement framework to assess progress and hold all parties accountable under a shared responsibility framework. The state has already laid significant groundwork for this effort with its all payer all claims database (APAC), which offers a strong starting point for developing a measurement framework that can assess progress in coverage, utilization, cost, and quality.

A number of states have invested in APAC databases, and at least 12 states have passed APAC legislation with comprehensive reporting requirements for claims data.<sup>1</sup> Other states that do not have APAC databases are considering legislation to establish them.<sup>2</sup> States with these databases are at various stages of development in using them to measure utilization and outcomes by analyzing claims data from a full range of services, including primary care, specialty care, outpatient services, inpatient stays, laboratory testing, dental services, and pharmacy data, across multiple payers.<sup>3</sup>

As Oregon capitalizes on its investment in its APAC database, the state will be able to draw on the experience of other states in developing a consensual measurement framework that crosses market sectors to assess progress in key areas of coverage, utilization, cost, and quality. Use of APAC databases is one area where the states already are laboratories of democracy, testing different approaches and learning from each other.

#### **B. Move the marketplace toward a sustainable and fixed rate of growth**

The Governor’s charge is clear in calling for “reasonable and predictable” growth rates in total health care spending, building on a core principle of the coordinated care model at the center of the state’s Medicaid waiver: to maintain costs at a sustainable fixed rate of growth (SRG). Extending SRG to the commercial sector presents a number of challenging issues, but failure to meet this

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<sup>1</sup> See <http://www.apcdouncil.org/sites/apcdouncil.org/files/All-Payer%20Claims%20Databases%20State%20Initiatives%20to%20Improve%20Health%20Care%20Transparency.pdf>

<sup>2</sup> *Id.*

<sup>3</sup> See [http://apcdouncil.org/sites/apcdouncil.org/files/APCD%20and%20Health%20Reform%20Fact%20Sheet\\_FINAL\\_0.pdf](http://apcdouncil.org/sites/apcdouncil.org/files/APCD%20and%20Health%20Reform%20Fact%20Sheet_FINAL_0.pdf)

challenge could lead to a new round of cost shifting in which cost reductions in Medicaid lead to cost increases for commercial payers, including insurers and self insured employers. Additionally, the Triple Aim demands systemic changes that hold down costs at the same time that care is enhanced and outcomes are improved.

Oregon's effort to develop an SRG methodology that constrains total health care spending is cutting edge, but not unprecedented. Massachusetts, the only state that has had an ACA-like exchange since 2006, has been exploring an overall limit on spending as an important complement to the coverage expansion achieved through the Massachusetts Connector. In 2012, Massachusetts enacted legislation that establishes a target health care cost growth rate, on a calendar year basis, for average total per person medical spending in the Commonwealth.<sup>4</sup> This target growth rate for total per capita medical expenditures includes all spending from public and private sources, all categories of medical expenses, all non-claims-related payments to providers, all patient cost-sharing amounts, and the net cost of private health insurance.<sup>5</sup>

The target health care cost growth rate is directly tied to growth in the Commonwealth's economy – specifically the potential gross state product (PGS). PGS is the highest level of economic growth that can be sustained over the long term without an increase in inflation; it is also equal to the economic output under full employment.<sup>6</sup> The target health care cost growth rate, as a percentage of PGS, is set forth under the legislation for each calendar year.

The legislation also creates the Health Policy Commission, whose responsibilities include (i) establishing an annual cost growth benchmark and monitoring progress through annual cost trends hearings and (ii) requiring clinics, hospitals, ambulatory surgical centers, physician organizations, accountable care organizations, and payers exceeding the growth rate in a given year to file performance improvement plans.

The market dynamics in Massachusetts are different than those in Oregon. For example, Oregon has a more competitive commercial insurance market, as well as different dynamics in its delivery system with respect to large hospital systems. These factors and others will make the Oregon solution different than the Massachusetts one, but Oregon will be able to learn from the Massachusetts approach as it moves forward at a pace that is a couple years ahead of Oregon's proposed work plan.

As the ACA brings major coverage gains in many states, it is likely that other states will also be looking at systemic approaches to cost containment. For example, Maryland, which operates the nation's only all-payer hospital rate regulation system, recently submitted a new federal waiver to allow the state to move away from fee-for-service reimbursement toward health care delivery that

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<sup>4</sup> See <https://malegislature.gov/Laws/SessionLaws/Acts/2012/Chapter224>; See also Blue Cross Blue Shield of Massachusetts Foundation summary of the Act at <http://bluecrossmafoundation.org/publication/summary-chapter-224-acts-2012>

<sup>5</sup> See A. Goslin and E. Rodman, "Summary of Chapter 224 of the Acts of 2012," Blue Cross Blue Shield of Massachusetts Foundation, September 2012, p. 2.

<sup>6</sup> *Id.*

emphasizes prevention, quality care, and value within a Triple Aim framework. Other states are sure to follow suit as ACA implementation requires new strategies for cost containment to make coverage expansions affordable.

### **C. Expand and improve primary and preventive care infrastructure**

Primary care services, including preventive care and chronic care management, are hallmarks of Oregon's current reform strategy. Studies suggest that preventive care<sup>7</sup> and chronic disease management services<sup>8</sup> may result in a healthier population and a decrease in overall utilization. For example, studies have indicated that an emphasis on primary care is essential to optimal preventive care and that effective primary care reduces unnecessary hospitalization and emergency room admissions.<sup>9</sup> Additionally, States with higher ratios of primary care physicians to population have better health outcomes, including decreased mortality from cancer, heart disease, or stroke.<sup>10</sup>

One approach for improving access to primary care services is through the medical home model. For example, both WellPoint and United Health have established medical home programs. WellPoint predicts that its new medical home program could reduce its projected medical costs in 2015 by up to 20 percent based on analysis of its current medical home pilot projects.<sup>11</sup> UnitedHealthcare estimates that its medical home program will result in savings equal to at least twice as much as the program's cost.<sup>12</sup>

Oregon has already taken several important steps toward supporting the patient-centered primary care home (PCPCH) model. PCPCH adoption is currently a metric in the Medicaid market and will

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<sup>7</sup> See, e.g., Andrea Klemes, DO, et. al., "Personalized Preventive Care Leads to Significant Reductions in Hospital Utilization," American Journal of Managed Care, December 18, 2012. Stating that:

The MDVIP model of personalized preventive care allows the physician to take a more proactive, rather than reactive, approach; we believe this increased physician interaction is the reason for the lower hospital utilization and ultimately lower healthcare costs seen here.

Found at: <http://www.ajmc.com/publications/issue/2012/2012-12-vol18-n12/Personalized-Preventive-Care-Leads-to-Significant-Reductions-in-Hospital-Utilization#sthash.0gmVVacD.dpuf>

<sup>8</sup> See, e.g., Niall Brennan, et. al., "Improving Quality and Value in the U.S. Health Care System," Brookings Institute, August 2009. Stating that:

A large body of evidence shows that [disease management] can improve quality of care. Evidence on the impact of [disease management] programs on overall health care costs varies depending on the targeted condition, the populations included, and the types of interventions used. While some programs have not proven cost-effective, other interventions have the potential to improve quality and reduce costs (page 10).

Found at: <http://www.brookings.edu/research/reports/2009/08/21-bpc-qualityreport>

<sup>9</sup> See [http://www.acponline.org/advocacy/current\\_policy\\_papers/assets/primary\\_shortage.pdf](http://www.acponline.org/advocacy/current_policy_papers/assets/primary_shortage.pdf)

<sup>10</sup> *Id.*

<sup>11</sup> See [http://www.pcpcc.org/sites/default/files/media/benefits\\_of\\_implementing\\_the\\_primary\\_care\\_pcmh.pdf](http://www.pcpcc.org/sites/default/files/media/benefits_of_implementing_the_primary_care_pcmh.pdf)

<sup>12</sup> *Id.*

be included in the soon to be released Public Employees' Benefit Board (PEBB) request for proposals. Further, the Oregon Health Authority (OHA) and the Oregon Health Leadership Council (OHLIC) have convened a series of meetings to develop a consensus-based strategy to support primary care homes in Oregon.

With research clearly linking access to primary care services with decreased utilization and improved health outcomes, Oregon's PCPCH program could serve as a model for a concerted effort across all markets to achieve the improved outcomes associated with the medical home model, especially if there also is flexibility for alternative approaches to be used as long as they can achieve similar outcomes on key metrics for preventive care and targeted, coordinated care for those with chronic conditions.

# Proposed Measurement Framework

## Overall State Dashboard

Quarterly display of trends in sentinel measures

### Utilization

1. Utilization per 1,000 members
  - Hospital Admissions
  - Inpatient Days
  - Outpatient Visits
  - Emergency Department Visits
  - Professional Claims
  - Rx Scripts
  - Ancillary Claims
2. Most Frequent Episode Treatment Groups
3. Primary Care Visits
4. Uninsured Hospital Admissions
5. Hospital Readmissions

### Enrollment

1. Coverage Enrollment by line of business
2. Medicaid newly eligible
3. Cover Oregon enrollment

### Access

1. Provider accepting new patients\*
2. Ability to get appointment\*
3. Medical debt\*
4. Uninsurance rates\*
5. Hospital uncompensated care
  - Bad debt
  - Charity care

### Cost

1. Per member per month
  - Total
    - Line of business
    - Paid & patient amount
  - Inpatient
  - Outpatient
  - Emergency Department
  - Professional
  - Prescription Drug
  - Ancillary
2. Most Expensive Episode Treatment Groups
3. Primary Care PMPM
4. Insurance Premium Increases
  - Member Share

### Quality

1. Selected PQIs and CCO Metrics
  - As determined by HB 2118 work group, OHA, and OID.
2. Health Status\*

### Satisfaction

1. Patient satisfaction measures\*

\*Measures updated annually or biennially.

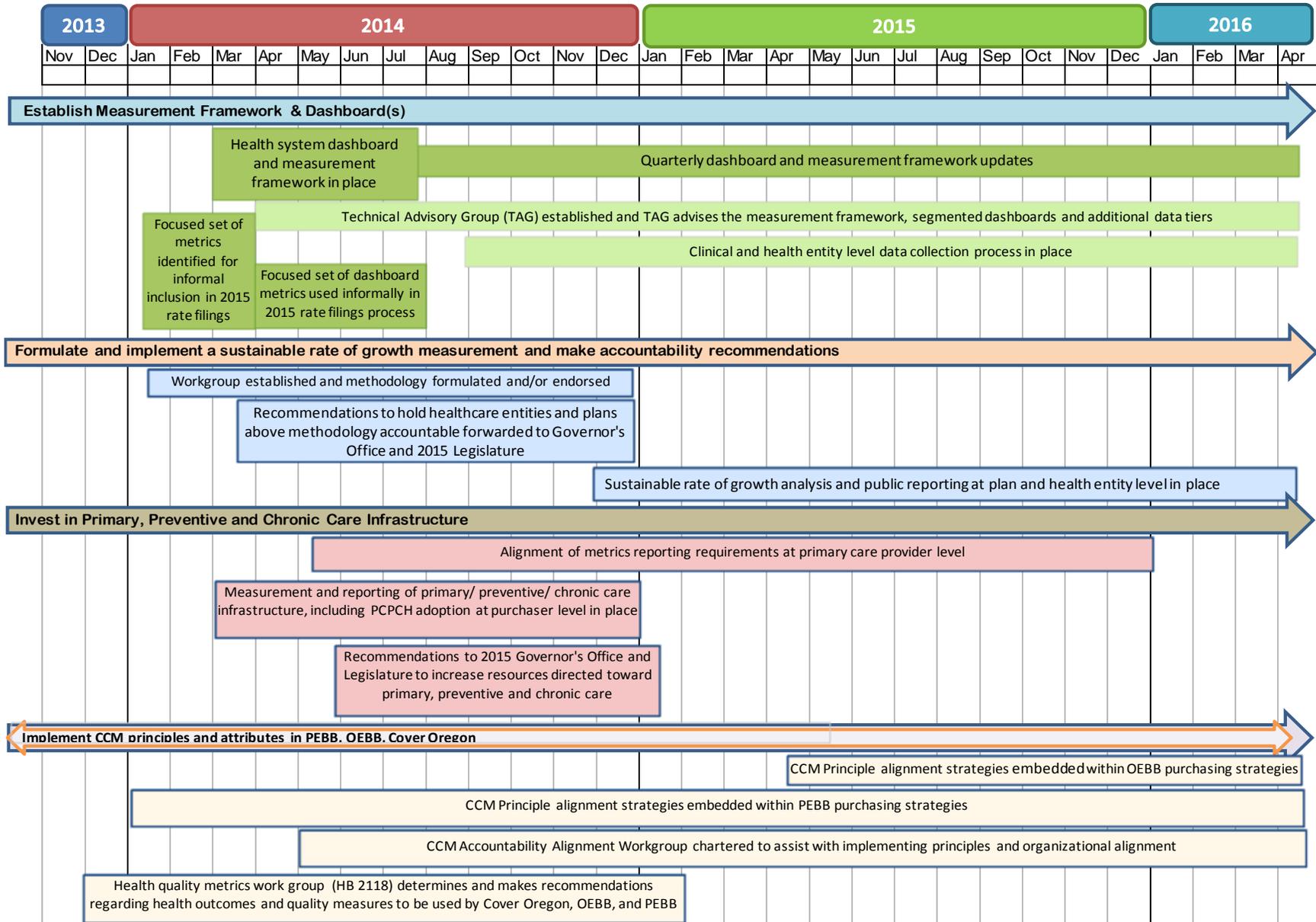


## Drill Down Dashboards & Additional Resources

Drill down displays of above measures broken out by available subcategories such as: line of business, gender, age, race and ethnicity, geography, income, category of service, market segment, plan, health care entity, and specific procedures.

Plus additional break outs of metrics and data not highlighted in the overall state dashboard.

# Recommended Strategies and Actions Timeline



# Attachment 1: Manatt Health Solutions and Georgetown Health Policy Institute Memorandum: Feasibility and Effectiveness of Cost Containment Strategies

**To:** Oregon Health Policy Board

**From:** Joel Ario, Manatt Health Solutions  
David Cusano, Georgetown Health Policy Institute

**Date:** September 26, 2013

**Re:** Feasibility and Effectiveness of Cost Containment Strategies

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During the Oregon Health Policy Board meeting held on September 10, 2013, the Board members discussed 10 draft elements for potential straw model development. The purpose of this memorandum is to provide an analysis of the effectiveness and feasibility of the 10 elements, plus one additional element that was raised at the meeting.

## A. Accountability & Measurement

1. Utilize All-Payer All-Claims (APAC) database to enhance transparency to stakeholders and the public through a “dashboard” with 10-12 key measures that provide an overall perspective on the impact of Oregon’s reforms and the Patient Protection and Affordable Care Act (ACA). Oregon could use its APAC database to identify cost shift and allow for future potential cost shift mitigation strategies and goals and track utilization metrics (e.g. ER utilization, readmission rates) in the individual and small group markets.

Effectiveness and feasibility: A number of States utilize an APAC database to develop a baseline capacity to measure utilization and outcomes.<sup>13</sup> Therefore, Oregon’s use of its APAC database for this purpose would be feasible and in line with the practice of other States. Most APAC databases are relatively new, so their effectiveness as a measurement tool that is capable of providing apples to apples comparisons is not fully established, but Oregon’s APAC database does appear to have the potential to be an effective accountability and measurement tool. A measurement framework built around Oregon’s APAC database would allow Oregon to accurately and effectively measure identified outcomes and set specific goals around them.

## B. Cost Containment

2. Decrease the total cost of care by increasing emphasis on evidence-based primary care.

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<sup>13</sup> See <http://www.apcdouncil.org/state/map>

3. Identify key outcomes and develop benchmarks that can be used to measure progress toward achieving those outcomes through PCPCH and/or other health home model expansion.

Effectiveness and feasibility: Primary care services include preventive care and chronic disease management and both are hallmarks of Oregon’s current reform strategy. Studies suggest that preventive care<sup>14</sup> and chronic disease management services<sup>15</sup> may result in a healthier population and a decrease in overall utilization. Therefore, an increased emphasis on primary care could prove to be an effective cost containment strategy.

Focusing resources on primary care would also be feasible because Oregon has already taken several important steps toward supporting the patient-centered primary care home (PCPCH) model. PCPCH adoption is currently a metric in the Medicaid market and will be included in the soon to be released Public Employees’ Benefit Board (PEBB) request for proposals. Further, the Oregon Health Authority (OHA) and the Oregon Health Leadership Council (OHL) have convened a series of meetings to develop a consensus-based strategy to support primary care homes in Oregon. The PCPCH program could serve as a model for increased emphasis on primary and chronic care services in the commercial market as it has with CCOs.

4. Promote wellness incentives and expand to individual market.

Effectiveness and feasibility: The promotion of wellness incentives is an important initiative, and has shown impressive results in the large group market, where insurers and the human resource departments of large employers work together to promote wellness programs. However, there are not clear models for how to effectively promote wellness programs in the small group and individual markets where there is no analog to the human resource department to ensure follow through. Given the importance of behavioral changes to improving health outcomes, there is every reason for Oregon to participate in experiments to expand wellness programs to the individual market, but the feasibility and effectiveness of such experiments is an open question.

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<sup>14</sup> See, e.g., Andrea Klemes, DO, et. al., “Personalized Preventive Care Leads to Significant Reductions in Hospital Utilization,” American Journal of Managed Care, December 18, 2012. Stating that:

The MDVIP model of personalized preventive care allows the physician to take a more proactive, rather than reactive, approach; we believe this increased physician interaction is the reason for the lower hospital utilization and ultimately lower healthcare costs seen here.

Found at: <http://www.ajmc.com/publications/issue/2012/2012-12-vol18-n12/Personalized-Preventive-Care-Leads-to-Significant-Reductions-in-Hospital-Utilization#sthash.0gmVVacD.dpuf>

<sup>15</sup> See, e.g., Niall Brennan, et. al., “Improving Quality and Value in the U.S. Health Care System,” Brookings Institute, August 2009. Stating that:

A large body of evidence shows that [disease management] can improve quality of care. Evidence on the impact of [disease management] programs on overall health care costs varies depending on the targeted condition, the populations included, and the types of interventions used. While some programs have not proven cost-effective, other interventions have the potential to improve quality and reduce costs (page 10).

Found at: <http://www.brookings.edu/research/reports/2009/08/21-bpc-qualityreport>  
Oregon Health Authority

5. Identify potentially unnecessary regulatory burdens and streamline and simplify rate review process through administrative simplification mechanisms.

Effectiveness and feasibility: Oregon has been a leader in regulatory streamlining and it makes eminent sense for the Insurance Division to be looking for opportunities to tie into other reporting elements and eliminate redundant processes and requirements as new more effective strategies are adopted. This will not support cost containment directly, but will free up regulatory and insurer resources for effective and feasible cost containment strategies.

6. Growth rates of total cost of care expenditures that are reasonable and predictable (moving toward a fixed rate of growth strategy).

Effectiveness and feasibility: The concept of maintaining healthcare costs at a sustainable fixed rate of growth is a centerpiece of Oregon's Health System Transformation and a key principle in Oregon's Coordinated Care Model. The strategy presents challenges for the commercial marketplace, though Massachusetts has enacted legislation charging the Massachusetts Health Policy Commission with establishing an annual cost growth benchmark and monitoring progress through annual cost trends hearings.<sup>16</sup> Health care entities that exceed the benchmark may be required to file and implement performance improvement plans. While the feasibility of this strategy has not been established, its potential effectiveness suggests that Oregon would be well served to explore whether there are feasible short term approaches that could measure and benchmark growth in the total cost of care. The challenge is identifying what to measure. A long term approach to consider could be developing guidelines for measuring the growth of total cost of care and evaluating how various levers for cost containment may be best utilized. To that end Oregon could be well served to establish a coordinated strategy with stakeholder input to determine the most effective, feasible and relevant related metrics. The concept has a high potential for effectiveness and given Oregon's history in healthcare innovation it's appropriate to consider varying mechanisms for making the concept more feasible.

### C. Transparency

7. Enhanced communication tools for consumers (e.g., rate comparison charts, pre-service pricing disclosure).

Effectiveness and feasibility: Oregon is a leader among the States in terms of the information available to consumers. However, studies have indicated that consumers may have difficulties with understanding complex data.<sup>17</sup> Therefore, health plans should continue to improve the information

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<sup>16</sup> See M.G.L. ch. 224, found at: <https://malegislature.gov/Laws/SessionLaws/Acts/2012/Chapter224>

<sup>17</sup> See, e.g., Alla Keselman et al, "Developing Informatics Tools and Strategies for Consumer-centered Health Communication," *Journal of the American Medical Informatics Association*, Vol. 15, Issue 4, 2008, pp. 473–483. Stating that:

[H]ealth literacy has emerged as a more fundamental barrier to providing Internet and other health resources to medically underserved and other audiences... About 50% of U.S. adults do not possess adequate health literacy skills required for many health communication and management tasks.

that is available and identify opportunities to distill that information into a format that is easily digestible for consumers.

8. Enhanced bad debt/charity care analysis and timely reporting.

Effectiveness and feasibility: The coverage provisions of the ACA will result in less uncompensated care in hospitals. Oregon could use the data obtained from its community benefit reports to effectively measure the impact of access to coverage on hospital revenues, bad debt and charity care. This data should be used within the measurement framework described in element #1 above. Using community benefit reports in this manner would be feasible to implement because these reports are publicly available today.

9. Enhanced disclosure of hospital and/or provider pricing.

Effectiveness and feasibility: The ACA requires disclosure of much new data, but it does not directly address provider pricing because the issues are tricky. A comparison of hospital and physician pricing can be difficult, and there is a fine line between using pricing data to promote competition versus engage in cost fixing. The commercial marketplace will continue to experiment with new pricing models and some of those will involve more transparency, but it is not clear that mandated disclosure is the most effective approach. In past experience, it also has proven time consuming to work out the details of disclosures. One approach could be to continue monitoring these pricing issues through the APAC.

#### **D. Quality Improvement**

10. Promote alternative payment methodologies (APMs) and collect relevant data to support APM development.

Effectiveness and feasibility: APMs are a fast-evolving concept, as public programs and the commercial marketplace experiment with new forms of risk sharing, from pay for performance to bundled payments to shared savings. There are not yet definitive studies on the effectiveness of particular APMs, and there will continue to be broad innovation with APMs, which may lead to better evidence about effective new payment methodologies.

11. Incent or set goals to promote value-based benefit designs.

Effectiveness and feasibility: Similar to APMs, value-based benefit designs (“VBDs”) are a fast evolving concept, with the ACA requiring first dollar coverage of preventive benefits and commercial insurers experimenting with new benefit designs. There are not yet definitive studies on the effectiveness of particular VBDs, and there will continue to be broad innovation with VBDs, which may lead to better evidence on what are the most effective new benefit designs.

# Attachment 2: Manatt Health Solutions Presentation of Recommendations to the Oregon Health Policy Board

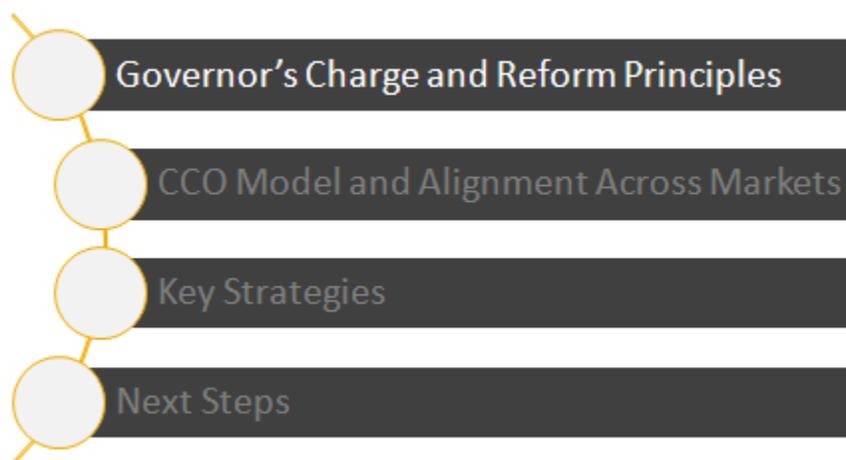
**Recommended Strategies for Advancing Health Reform**

Presentation to the Oregon Health Policy Board  
Joel Ario, Manatt Health Solutions  
November 5, 2013

Support for this resource provided through a grant from the Robert Wood Johnson Foundation's State Health Reform Assistance Network program



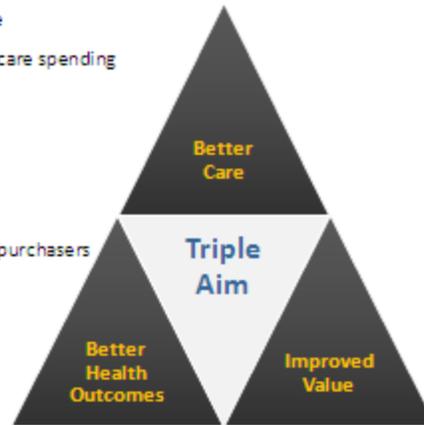
## Overview



## The Governor's Charge to the Oregon Health Policy Board

The Governor has asked the Board to recommend possible statutory and regulatory changes to align ACA implementation with current reform efforts and ensure **Triple Aim** goals are met across all markets, including strategies to:

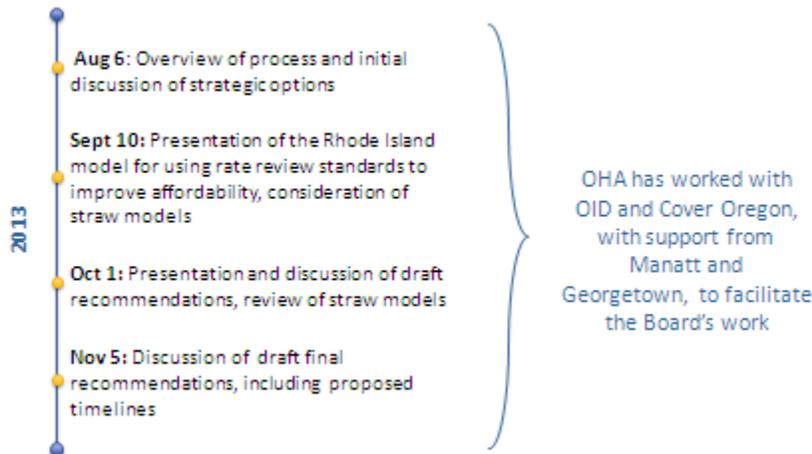
- Spread effective models of coordinated care
- Achieve predictable growth rates in health care spending
- Mitigate cost shifting
- Decrease health insurance premiums
- Increase transparency and accountability
- Enhance the rate review process
- Align care models across public and private purchasers



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## Review of Board's Process



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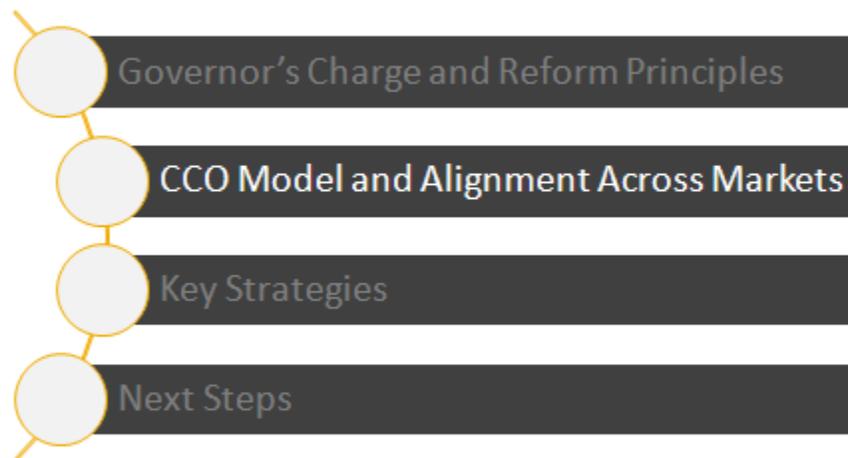
## Reform Principles

- 
-  Pursue alignment between CCO model and ACA implementation to leverage coordinated care model
  -  Enhance transparency in rate review and across health system
  -  Promote accountability with clear metrics and public reporting on results
  -  Regulations should focus on outcomes and not be overly prescriptive as to means
  -  Responsibility for expanded access, quality improvement and cost containment should be shared across all health entities

Oregon Health Policy Board



## Overview



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## Coordinated Care Model Principles

- Do what works. Use best practices.
- Have shared responsibility for health among providers, individuals, and health plans.
- Measure performance.
- Pay for outcomes and health.
- Provide information so that patients and providers know price and quality.
- Maintain costs at a sustainable fixed rate of growth.

Oregon Health Policy Board



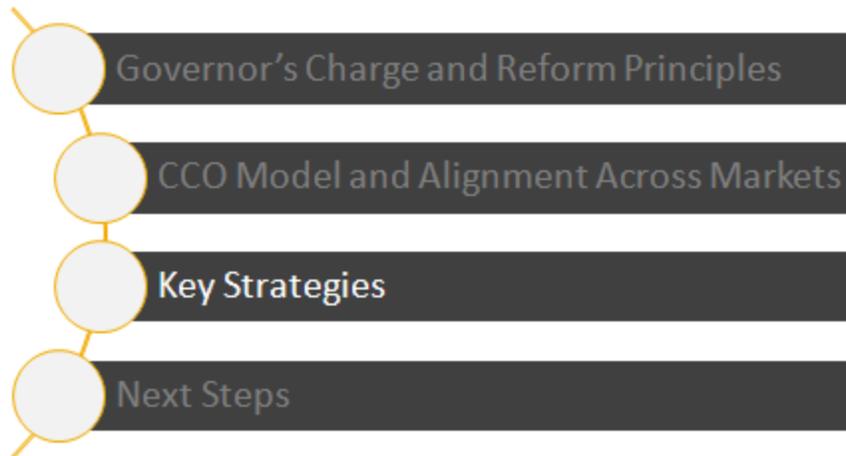
## Alignment of Purchasers and Market Segments



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## Overview



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## Transparency : Measurement Framework

- Oregon has invested in an all payers all claims database (APAC) that provides a starting point for developing a measurement framework to understand the evolving health care landscape and inform policies that enable consumers, providers, payers, and purchasers to pursue the Triple Aim.
- Measurement framework to include focused dashboard measures with clear metrics, periodic public reporting, and a focus on outcomes:
  - Coverage measures: enrollment #s for Oregon Health Plan, Cover Oregon, other insurance coverage; reduction in uninsured rate
  - Utilization measures: hospital utilization including trends with ER and uncompensated care; utilization patterns for benchmark services including trends with preventive care and high cost services
  - Cost measures: trends in PMPM expenditures, medical debt and bankruptcy
  - Quality measures: benchmarks for preventive and chronic care, patient access and satisfaction, health equity
- Goal is to develop consensual framework that crosses market sectors and encourages shared responsibility and accountability for improved outcomes

Oregon Health Policy Board



## Measurement Framework: How We Get There

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- OHA and OID create measurement framework, including a purchaser facing dashboard, to be populated with validated data at statewide, plan, and health care entity level by market segment, health care setting, geography, and other variables
- OHA and OID appoint technical advisory group with broad expertise to identify data gaps and data validation needs, and recommend technical specifications for measurement framework
- OHA and OID work with interested parties to explore and make recommendations for including specific metrics that will provide meaningful information on utilization, cost and quality at the health care and plan level
- OHA determines need for rulemaking or legislation, including authorization for data collection at the health entity and clinical level, that can be incorporated in measurement framework

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## Cost Containment: Sustainable Fixed Rate of Growth

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- Core principle of the coordinated care model is to maintain costs at a sustainable fixed rate of growth (SRG), and the Governor's charge to the Policy Board extends this principle by calling for "reasonable and predictable" growth rates in total health care spending
- Concept of a fixed rate of growth in the commercial sector is challenging, but failure to meet this challenge could lead to a new round of cost shifting in which cost reductions in Medicaid lead to cost increases for commercial payers, including insurers and self insured employers
- Triple Aim demands systemic changes that hold down costs at the same time that care is enhanced and outcomes are improved
- Goal is to develop a SRG methodology that will constrain total health care spending with shared responsibility and accountability across all health entities, including hospitals and insurers

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## Sustainable Fixed Rate of Growth: How We Get There

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- OHA and OID develop a timeline for formulating an SRG methodology that identifies and holds accountable health plans and other health entities that exceed SRG benchmarks
- Data collected through the measurement framework is used to develop a baseline for purposes of setting annual SRG benchmarks at the individual health entity and health plan premium level
- OHA and OID explore the benefits of and make recommendations for how to hold health plans and health care entities accountable, within a shared responsibility model, for maintaining costs within the SRG benchmarks

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## Quality Improvement: Primary and Preventive Care

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- Primary care services are critical to optimal preventive care and to effective coordination of chronic care, and the patient-centered primary care home model (PCPCH) is an important attribute of Oregon's coordinated care model
- The PCPCH and similar health home models emphasize three care strategies that promote the Triple Aim
  - Primary care: coordinating care through a medical home that can address the patient's full range of health needs in the context of their life situation
  - Preventive care: ensuring that patients receive cost effective preventive services that can reduce the need for more invasive and expensive interventions
  - Chronic care: identifying and effectively treating patients with chronic conditions requiring sustained and coordinated treatment
- The health care system will benefit from concerted across-the-board efforts to achieve the improved outcomes associated with the PCPCH model and similar initiatives that emphasize preventive care and targeted, coordinated care for those with chronic conditions
- Goal is to utilize metrics and the measurement framework to promote primary, preventive and chronic care while also leaving flexibility for pursuing the same outcomes in alternative ways

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## Primary and Preventive Care: How We Get There

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- OHA develops a timeline and process to establish baselines for primary, preventive, and chronic care, including PCPCH adoption at the plan level
- OHA and OID explore the benefit of and make recommendations for how to increase the share of health care resources devoted to primary, preventive, and chronic care infrastructure, including PCPCH or similar health home model adoption
- OHA develops an initiative to facilitate standardized reporting on key metrics at the primary care provider level

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## Enhanced Transparency for Consumers

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- The new measurement framework will bring opportunities for administrative simplification and enhanced communication with consumers
  - Administrative simplification: eliminating current data requirements that are redundant or no longer relevant under the new framework
  - Enhanced communication: working with stakeholders to identify new and better ways to communicate information in a timely and effective manner
- The rate review process has changed significantly in response to Oregon legislation and the Affordable Care Act (ACA), imposing new requirements on insurers that could be offset by eliminating redundant requirements



### How We Get There

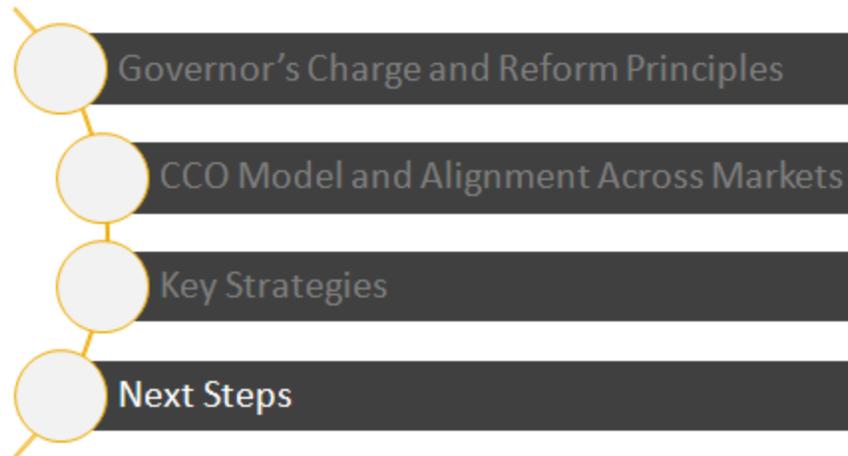
- OID identifies opportunities for administrative simplification in the rate review process
- OID engages stakeholders in a process to identify and implement enhanced communications tools and outreach strategies for consumers and insurers

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## Overview

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## Next Steps

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## Attachment 3: Memorandum RE: Metrics Alignment

### Transparency and Alignment in Oregon's Health System Transformation

#### Background

Implementation of Oregon's health system transformation is taking place in an extraordinarily dynamic environment. Implementation of Coordinated Care Organizations in the Medicaid delivery system and of key elements of the Affordable Care Act (ACA)—expansion of the Medicaid program; creation of the health insurance exchange, Cover Oregon; and rate oversight in a changing commercial health insurance market—are occurring simultaneously. Each includes performance metrics and transparency efforts as key characteristics. There are five major measurement-related initiatives or programs that should be closely coordinated in order to minimize duplication and prevent a proliferation of measures. The five are:

- The Oregon Health Policy Board's (OHPB's) recommendations in response to the Governor's letter, dated June 3, 2013, asking the Board to make recommendations for aligning public and private purchasers toward models of coordinated care and achieving sustainable rates of growth for total health care expenditures.
- The Oregon Insurance Division's (OID's) rate review process to increase transparency of quality improvement and cost containment efforts by commercial health insurers across the market as well as general transparency of underlying health care costs.
- Oregon Health Authority's (OHA's) Metrics and Scoring Committee, established in 2012 by Senate Bill 1580 for the purpose of recommending outcome and quality measures for Coordinated Care Organizations (CCOs). The committee is responsible for identifying measures of outcome and quality for ambulatory care, chemical dependency and mental health treatment, oral health care and all other health services provided by CCOs.
- HB 2118, which creates a health plan quality metrics work group to make recommendations to the Legislature for appropriate health outcomes and quality measures to be used by Cover Oregon, the OHA, PEBB and OEBB.
- Multi-Payer Strategy Workgroup, convened by the OHA and the Oregon Health Leadership Council to develop a statewide, multi-payer strategy to support primary care.

***This memo outlines how these initiatives relate to each other and how they will be coordinated.***

#### Governor Kitzhaber's Request to the Oregon Health Policy Board

Governor Kitzhaber's June 3, 2013 letter to the Oregon Health Policy Board charged the Board with recommending possible statutory and regulatory changes necessary to ensure that the goals of the triple aim (better health, better healthcare and lower costs) are met, including strategies to mitigate cost shifting, decrease health insurance premiums and increase overall transparency and accountability. In that letter he states, "...I believe there is an immediate need to focus on how to better align the Affordable Care Act (ACA) goals of lower costs, better care and better health across all markets are achieved. To that end, concurrent with the ACA, we have an opportunity to create an environment for the commercial market place in Oregon that moves toward one characterized by models of coordinated care and growth rates of total health expenditures that are reasonable and predictable."

There is broad agreement that we need a shared assessment of how these efforts are progressing and what policies should be considered to improve Oregon's ability to create a health care system that meets the triple aim.

One of the key strategies emerging from the Board's work is a recommendation that OHA and OID create a measurement framework, including a purchaser-facing dashboard that consists of a focused set of measures of utilization, cost, enrollment, access and quality. The selected measures will be focused, actionable, and serve as key indicators of the impact of Oregon's health system transformation and implementation of the ACA.

### **OID Rate Review**

Facilitated by House Bill 2009 (2009), OID has established one of the most robust commercial health insurance rate review programs in the country. OID must review and approve all health insurance rates in the individual and small group markets (both inside and outside of Cover Oregon) and may consider a number of factors in evaluating proposed rates, including changes in insurers' cost containment and quality improvement efforts. Currently, insurers provide general information about key cost containment and quality improvement strategies with varying levels of quantitative detail.

In addition to the work cited above, stemming from OHPB's forthcoming recommendations, OID will consider identifying a handful of initial metrics for inclusion in 2015 rate filings as a "test run" of the broader public-facing dashboard. The initial metrics should be drawn from the draft dashboard and represent key drivers of health care costs. For the purposes of the test run, these metrics will be used for informational purposes to promote market-wide transparency and alignment, but they will not be tied to rate decisions. The information gathered during the 2015 rate review process, along with results from the other concurrent work streams, will help OID shape and enhance the process in future years. In the coming months, OID will also be initiating additional work to increase health care cost transparency, as supported by Cycle III of the U.S. Department of Health and Human Services' Health Insurance Rate Review Grant, and will seek alignment wherever possible.

### **OHA Metrics and Scoring Committee**

Senate Bill 1560 created a permanent nine-member committee to recommend outcome and quality metrics to assess the performance of Coordinated Care Organizations within the Medicaid program. The Committee, in partnership with the Centers for Medicare and Medicaid Services (CMS), identified 33 measures of access and quality that are included in Oregon's Medicaid 1115 demonstration agreement with CMS. The state will incur financial penalties if no improvement is shown within the 33 items. Also, 2% of global budget is at risk for performance on 17 of the 33 metrics.

### **House Bill 2118 Quality Metrics Work Group**

In 2011, Senate Bill 99 was enacted, creating the state's health insurance exchange, Cover Oregon. House Bill 2118 creates a health plan quality metrics work group tasked with recommending health outcomes and quality measures to be used by Cover Oregon, OHA, OEBB and PEBB. The work group will recommend health and outcome measures that further the goals of the Oregon Integrated and Coordinated Health Care Delivery System while recognizing the unique needs and goals of the organizations affected. The recommendations are due to the Legislative Assembly by the end of May 2014.

## **Multi-Payer Strategy Work Group**

A broad coalition of public and commercial payers, professional associations and providers was convened by OHA and the Oregon Health Leadership Council in late summer 2013 to develop a strategy to support primary care in Oregon. Participants all agreed that effective primary care will improve patient care and the provider experience, and is critical to sustainable, high quality health care for all Oregonians. There is also agreement on the need to reduce the administrative waste and inefficiency for both plans and providers that comes from differing standards for primary care.

To this end, the coalition has finalized an agreement to coordinate their efforts to support patient centered primary care homes (PCPCH) in Oregon. As part of this agreement, *nearly all* commercial and public payers in Oregon (excluding Medicare FFS) will offer structured payments to support PCPCH and the advancement to higher functioning levels. Payers will individually establish the amount and type of payment with the providers in their networks. As part of next steps, OHA's Patient-Centered Primary Care Home (PCPCH) program has convened a work group to establish common metrics. These measures will also support the OHPB measurement framework.

## **Proposed Approach for Aligning These Parallel Efforts**

- **Purchaser dashboard:** The HB 2118 Work Group will focus on recommending a small number of core health plan quality metrics that will serve as a common core across Cover Oregon, Medicaid, PEBB, and OEBB. The work group will focus on metrics that are meaningful across payer types. Further, the work group will base its work in the criteria developed by the OHPB Health Incentives and Outcomes Committee, the OHA Metrics and Scoring Committee and the Medicaid metrics required by the state's Medicaid waiver. The work group will prioritize use of existing and accessible data sources. Recommendations are due May 2014.
- **Health care system dashboard:** In creating the measurement framework recommended by OHPB, OHA and OID will select a focused set of system-wide metrics for utilization, cost, enrollment and access. Quality metrics to be included in the measurement framework will include, but not necessarily be limited to the core metrics identified by the HB 2118 work group. OHA and OID will engage a technical advisory group to develop/adopt definitions and specifications. The goal is to have a version of a dashboard available in March 2014, and a dynamic version that allows views by selected segments (e.g., payer, plan, geography) by December 2014. OID will draw from the dashboard and work with its existing technical advisory group to identify initial metrics for inclusion in 2015 rate review "test run," which will occur in the second quarter of 2014.

**Primary care common metrics:** OHA's Patient-Centered Primary Care Home program has identified and convened a sub-committee of the strategy work group to examine the potential for common metrics. The original timeline was that a recommended set would be completed in November 2013. The time line for this work should be adjusted to align with the May deliverable of the HB 2118 group. The work of this group should inform both the purchaser dashboard under the HB 2118 workgroup and the health care system dashboard.

**Attachment 4: Coordinated Care Model Alignment Workgroup  
Report**

# Coordinated Care Model Alignment Workgroup

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Recommendations for the  
Oregon Health Policy Board

11/5/2013

**Background:**

In a letter to the Oregon Health Policy Board (OHPB) dated June 3, 2013, Governor John Kitzhaber, M.D. requested recommendations for aligning the Oregon’s coordinated care model (CCM) principles to the Public Employees’ Benefit Board (PEBB), the Oregon Educators’ Benefit Board (OEBB), Cover Oregon (CO) and the broader market. This request builds on the success of Oregon’s broader health system transformation by using the state’s purchasing and purchasing facilitation lever to signal to the delivery system that there are higher expectations for enhanced care coordination and innovative methods for reducing costs, reducing disparities, and improving quality of care. To develop recommendations in response to the Governor’s request the OHPB approved a chartered workgroup, the Coordinated Care Model Alignment (CCMA) workgroup, and charged it with developing recommendations detailing specific CCM principles and attributes for adoption as well as timelines and outcomes which facilitate alignment within their respective organizations.

The Director of the Oregon Health Authority (OHA) Bruce Goldberg, M.D. appointed two board members from PEBB, OEBB and Cover Oregon as members of the workgroup. Workgroup membership is listed below.

Sean Kolmer (Chair), <i>PEBB</i>	Steve McNannay, <i>OEBB</i>	Gretchen Peterson, <i>Cover Oregon</i>
Paul McKenna, <i>PEBB</i>	Alison Little, <i>OEBB</i>	Ken Allen, <i>Cover Oregon</i>

Cover Oregon is Oregon’s state-based health insurance marketplace where individuals, families, and small employers (1-50 employees) can shop for, compare and enroll in health insurance plans and access financial assistance to help pay for coverage. In 2016, Cover Oregon is expected to expand to employers with 51-100 employees. Cover Oregon operates at no cost to the state. It is funded by federal grant dollars through 2014; after that, it will be self-sustaining through an administrative fee charged to insurance carriers. It is anticipated that over 200,000 Oregonians will purchase health insurance through Cover Oregon.

PEBB designs, contracts and administers medical, dental, vision, life, accident, disability and long-term care insurance, flexible spending accounts, and an employee assistance program for state employees and their dependents. The Board also offers benefit plan options for retirees not yet eligible for Medicare and for individuals in other participating groups, such as certain self-pay groups and semi-independent state agencies. PEBB’s total membership is approximately 127,000 individuals. PEBB’s Benefit Budget for the 2013-2015 biennium is \$1,531,997,391. These funds are used to pay for all the covered benefit plans offered by PEBB for eligible members.

OEBB was created in 2007 and, similar to PEBB, provides medical, dental, vision, life, accident, disability and long term care insurance, flexible spending accounts and an employee assistance program for 240 of Oregon’s educational employees, including employees at K-12 grade school

districts, education service districts (ESDs), community colleges and some charter schools. OEGB also offers a health savings account. Currently, 145,785 individuals are eligible to enroll in OEGB. OEGB's Benefit Budget for the 2013-2015 biennium is \$1,628,294,000. These funds are used to pay premiums for all the various benefit plan options offered by OEGB for members or educational entities that make selections on behalf of members.

Membership for OEGB and PEBB could expand in January of 2014 and 2015, respectively, as a result of Oregon House Bill 2279 (2013). HB 2279 amends PEBB's and OEGB's governing statutes to allow local governments or local government employees to voluntarily participate in the benefit plans offered by PEBB or OEGB. There are nearly 900 city, county, or special districts that are eligible to participate, with an estimated 50,000 employees.

To date, OEGB has received notice from Josephine County that they will join OEGB and begin offering benefits to their employees and their families effective January 1, 2014. OEGB anticipates this would be approximately 700 additional members eligible to enroll in benefit plans offered through OEGB. An employee group within Clatsop County has expressed interest in joining OEGB in January 2014, but there is no firm commitment at this time. PEBB will be able to enroll local government groups in its benefit plans beginning January 2015 and expects to know more about these groups' level of interest over the next six to nine months.

PEBB, OEGB, and Cover Oregon are responsible for offering high-quality and affordable health insurance plans to a vast number of Oregonians in all regions of the state. Increasing alignment and collaboration among these organizations creates a significant opportunity to positively impact the delivery system statewide.

**Recommendation 1: Each entity should adopt the principles of the coordinated care model.**

The overarching goal of each state purchaser and purchaser facilitator in the CCMA workgroup is to improve the health of those they serve, improve the quality of care delivered and control costs. Similarly the workgroup recognizes that spreading the coordinated care model principles into their respective organizations is a vital "next step" in Oregon's Health System Transformation (see CCM principles below). Spreading the coordinated care model will help PEBB, OEGB, and Cover Oregon better meet the triple aim by identifying appropriate coordinated care model attributes for adoption and determining detailed opportunities for implementing those attributes within their respective organizations. The workgroup understands the need to help members improve their health through best practice care models such as those that emphasize preventive and primary care as well as the potential for their respective organizations to hold health plans and providers accountable for the money they spend by paying for and measuring achievement and process-related health outcomes. The group's work establishes a higher standard of care for health plans and providers that prioritizes efficiency, coordination, and patient-centered care for the members for whom they facilitate the purchase of or purchase health coverage for. By jointly establishing common priorities in purchasing health care while simultaneously increasing active

engagement and collaboration across agencies, these organizations will help build a sustainable healthcare delivery system and a healthier Oregon.

By adopting principles of the coordinated care model throughout PEBB, OEBB, and Cover Oregon contracts with health insurers, a large percentage of commercial purchasing will be coordinated and aligned for the delivery system to begin changing its business model to achieve better health, better care and lower costs. For example, in the future, successful bids and definitions for request for proposals, qualified health plans or other contract relationships would demonstrate adoption of model features, such as fixed rates of growth that encourage flexibility and are outcome-based, delivery system integration and coordination, and performance measurement.

The coordinated care principles are below and can be implemented in different ways through different levers in each organization.

1. Do what works. Use best practices to manage and coordinate care.

Coordinating care through evidence-based best practices can support providers in attaining the highest quality of care in the most efficient manner.

2. Share responsibility for health among providers, individuals and health plans.

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 of accountability for individual health behaviors.

3. Measure performance.

Strengthening performance measurement alignment across purchasers eases the burden of reporting for providers and establishes an accurate picture of health and performance outcomes.

4. Pay for outcomes and health.

Alternative payment methodologies (APMs) such as value-based payments, shared savings, and offering incentives for quality outcomes instead of volume-based fee methodologies supports better care and better quality of care while providing flexibility without compromising access to care or services.

5. 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.

6. Maintain costs at a sustainable fixed 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.

**Recommendation 2: Each Board should adopt a shared timeline with accountabilities for implementation of coordinated care model alignment.**

Alignment with the principles of the coordinated care model will not be instantaneous, sequential nor happen in the exact same way across these entities. PEBB, OEBC, and Cover Oregon should begin to incorporate these principles in RFP development, contracts, renewals, and other means, where appropriate. These organizations' respective boards are responsible for alignment and should begin their respective conversations using the timeline in Appendix C as a framework, which reflects key dates and opportunities for alignment over the course of the next four years.

**Recommendation 3: PEBB, OEBC, and Cover Oregon should jointly charter a group to oversee continued alignment between the three organizations.**

It is essential that PEBB, OEBC, and Cover Oregon continue these alignment efforts following the completion of this workgroup. Actively coordinating and connecting this work across organizations will further enhance the sustainability and efficiency of the model while ensuring that best practices are shared. The following actions are recommended:

1. Ensure that alignment across metrics is addressed by establishing it as the first priority for the jointly chartered group.
2. Support collaborative and coordinated procurements among PEBB, OEBC, and Cover Oregon to allow these groups to explore where there might be efficiencies gained from undergoing joint or parallel processes for obtaining similar categories of professional services (e.g., contract one data analytic company to examine claims data for all three organizations).
3. Convene staff and board leadership from PEBB, OEBC, Cover Oregon and the broader market through learning collaboratives, potentially through the OHA Transformation Center, where these organizations can continue to share opportunities, challenges, and innovative ideas for coordinated care model alignment in purchasing and purchasing-related issues.

**Recommendation 4: To the extent practical, alignment efforts in the future should consider the role of the Oregon Insurance Division as the regulator for the individual and small group markets in Oregon, which includes plans certified through Cover Oregon.**

The Oregon Insurance Division can facilitate the creation of a statewide health insurance market that is committed to the coordinated care model.

Additional background information and analysis supporting these recommendations is available in the following attachments:

*Appendix B:* The Coordinated Care Model Alignment work group charter

*Appendix C:* Proposed contracting timelines for PEBB, OEBC, and Cover Oregon

*Appendix D:* Expanded definitions, attributes, and examples of the Coordinated Care Model principles

*Appendix E:* Crosswalk of current Coordinated Care Model alignment across PEBB, OEBC, and Cover Oregon

*Appendix F:* Comparison of quality measures to be reported by PEBB, OEBC, Cover Oregon QHPs, and CCOs

# Oregon Health Policy Board Coordinated Care Model Alignment Work Group Charter

Approved by OHPB on 2 July 2013

## I. Authority

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The Oregon Health Authority (OHA), under Governor Kitzhaber's June 2013 letter to the Oregon Health Policy Board (Board), is establishing a public process to inform healthcare cost containment strategies and recommend delivery system alignment actions.

The goal is a sustainable, affordable, coordinated and high quality health care delivery system.

The Oregon Health Plan (OHP), Oregon's coordinated care delivery model, delivers care through a fixed global budget and maintains costs at a sustainable level. Under this model healthcare is coordinated across the delivery spectrum through locally accountable Coordinated Care Organizations (CCOs). Flexibility to innovate, alternative payment methodologies, and shared responsibility among local providers, patients and health plans are other key aspects of the model. CCOs are charged with delivering healthy outcomes and their ability to meet this charge is measured quarterly through performance data.

As the policy-making and oversight body for OHA, the Board establishes the Coordinated Care Model Alignment Work Group to provide input on potential regulatory delivery system alignment improvements. The Work Group will be guided by Governor Kitzhaber's June 2013 letter to the Board, the Board's 2010 report *Oregon's Action Plan for Health*, and by Oregon's health system transformation goals:

- improving the lifelong health of all Oregonians;
- improving the quality, availability and reliability of care for all Oregonians, and;
- lowering or containing the cost of health care so that it is affordable for everyone.

This charter shall expire on November 30, 2013 or when the Board determines that the charter has been fulfilled, whichever is sooner.

## II. Scope

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The Coordinated Care Model Alignment Workgroup is charged with providing draft recommendations and implementation actions for the consideration of the Oregon Health Policy Board.

Purchasers to be covered in recommendations include but are not limited to:

- PEBB (to include currently underway RFP process for 2015 services)
- OEBC
- Cover Oregon
- Other public and private organizations

OHA staff will provide workgroup members materials in advance of scheduled meetings in order to ensure adequate review time and meaningful input.

The work group will not be asked to approve the final Board recommendations to the Legislature.

## III. Deliverables

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The workgroup will submit recommendations in a report to the Board before November 1, 2013.

## IV. Timing/Schedule

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The Workgroup will complete its work by November 2013; it will meet monthly at a location to be determined. The workgroup will meet at the discretion of the Board.

## V. Staff Resources

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Chairs: TBD

Staff: TBD, Jeff Scroggin

## VI. Work Group Membership

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Workgroup members are appointed by Director Bruce Goldberg. The workgroup will have a chair that will represent the group and present at Board meetings.

Membership: TBD

		<b>PEBB</b>	<b>OEBB</b>	<b>Cover Oregon</b>
2013	Sep	Med/Pharmacy RFP issued for 2015		Enrollment period for 2014 plans
	Oct			
	Nov	RFP closes, PEBB reviews proposals		
	Dec			
2014	Jan	Competitive proposals selected and interviewed	Med/Dental contract renewal period for Oct 2014 to Sept 2015 plan year	
	Feb	Final awards		
	Mar	Contract negotiations		
	Apr			
	May	Contracts signed by 6/1	Complete contract renewals for Med/Dental for Oct 2014 to Sept 2015 plan year	
	Jun	Open enrollment planning		
	Jul			
	Aug			
	Sep	Enrollment period for 2015 plans	Enrollment for Aug 2014-Sept 2015 plans	
	Oct			
	Nov			
	Dec			RFA released for carriers for plan benefit year 2016
2015	Jan	Contract initial plan year begins; initial 2016 renewal letters sent*	Med/Dental contract renewal period for Oct 2015 to Sept 2016 plan year	Response to RFA due
	Feb	2016 renewal responses due; reviewed by Board for approval of plan designs/rates		CO reviews RFA responses for approval by early April
	Mar			Approved carriers file plans/rates with DCBS
	Apr			
	May	Contract amendment and member handbook update period	Begin design process for med/dental/vision RFPs for Oct 2016 to Sept 2017 plan year	Cover Oregon certifies plans
	Jun		Complete contract renewals for med/dental plans for Oct 2015 to Sept 2016 plan year	
	Jul		Enrollment for Aug 2015-Sept 2016 plans	
	Aug			
	Sep	Complete contract renewals for 2016 plan year		2016 plans publicly available
	Oct			
	Nov			
Dec		Release RFPs for med/dental/ vision for Oct 2016 to Sept 2017		
2016	Jan		Selection process for med/dental/vision plans for Oct 2016 to Sept 2017	
	Feb			
	Mar			
	Apr			
	May			
	June			
	July			
	Aug		Contracts signed for Oct 2016 to Sept 2017 plan year& Enrollment period for 2016-17 plans	
	Sep			

Note: PEBB and OEBB will jointly release an actuary RFP during mid-2014. PEBB may also release a wellness RFP in 2014

\*Timeline for PEBB contract renewals for subsequent plan year (2016) are modeled after the PEBB 2013 contract renewal timeline

# Principles of Oregon's Coordinated Care Model

## Coordinated Care Model Alignment Work Group

### Examples and Descriptions

#### 1. Use best practices to manage and coordinate care

Coordinating care through evidence-based best practices can support providers and health care facilities in attaining the highest quality of care in the most efficient manner.

##### Examples:

- Single point of accountability
- Patient and family-centered care (e.g., patient-centered primary care homes PCPCH)
- Increased coordinated care around long term care services and support (LTSS)
- Team-based care across appropriate disciplines
- Cost containment and quality improvement plans for managing care for 20 percent of population driving 80 percent of costs
- Plans for prevention and wellness, including addressing disparities among population served
- Broad adoption and use of electronic health records

##### Contract examples:

"PHP agrees to continue developing and implementing the medical home concept and providing PEBB with data and findings related to the success or challenges learned from the implementation of medical home pilots. Programs will include: Asthma, Diabetes, Coronary Disease, Chronic Obstructive Pulmonary Disease, Heart Failure." *PEBB January 2013 contract*

#### 2. 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 of accountability for individual health behaviors.

##### Examples:

- Shared decision-making for care among patients and providers
- Providers can increase education for consumers/patients on care management, personal health behaviors, treatment options, etc.
  - Payer can ensure screenings, well-child visits, other preventive care measures, supportive chronic care management techniques are incentivized

- Payers can support patients/consumers in becoming accountable for personal health behaviors through evidence-based wellness incentives (e.g., gym membership subsidies, smoking cessation programs, weight loss programs, etc.), payment for preventive primary care, etc.

Contract example:

“Health Engagement Model. PHP will provide health tools that will allow PEBB members to comply with the required components of PEBB’s Health Engagement Model. HEM tools accessible through the online portal must include an Online Personal Health Assessment (PHA), Health Conversation modules, and other supporting information as required by PEBB.” *PEBB January 2013 contract*

### 3. Measure performance

Strengthening performance measurement alignment across purchasers eases the burden of reporting for providers and establishes an accurate picture of health and performance outcomes.

Examples:

- Demonstrated understanding of population served can improve health outcomes at all levels and establishes a baseline dataset
- Establish shared metrics with clear targets
- Performance measurement should include metrics related to health care workforce issues with a demonstrated connection to health care quality, such as staff turnover rates, existence of labor-management partnerships, and availability of protection for whistleblowers.
- Share strategies for improvement on quality, cost and access metrics
- Using data from metrics can ensure adequate provider supply in needed areas is supported.
- Utilize aligned metrics across purchasers

Contract example:

“Cover Oregon will identify a list of quality measures to be used to evaluate Carrier’s QHP performance and effectiveness and assign a QHP grade. The measures chosen will be measures already established by nationally or locally recognized entities such as NCQA, CMS, and Oregon Health Care Quality Corporation (Quality Corp). Cover Oregon will work with an independent contractor, Quality Corp, to collect all data necessary to assign a quality rating for each QHP. Carrier will join the Quality Corp measurement and reporting initiative and will submit its administrative claims data to Quality Corp on a regular schedule, at minimum biannually.” *Cover Oregon Final Medical Contract 2013*

#### 4. Pay for outcomes and health

Alternative payment methodologies (APMs) such as value-based payments, shared savings, and offering incentives for quality outcomes instead of volume based fee methodologies supports better care and better quality of care while providing flexibility without compromising access to care or services.

##### Examples:

- Global budgets (e.g., CCOs are in part defined by a new payment model that holds them accountable for the total cost of care (behavioral, physical and dental health care) for enrolled members)
- Tiered payments for PCPCHs
- Value-based payments that providers are incentivized to provide high-quality, efficient care.

##### Contract example:

“PEBB endorses innovative payment models that move away from fee-for-service reimbursement and reward for cost and quality outcomes. PHP will develop and implement payment models that may include (but are not limited to) withhold, global budgets, capitation, and other reimbursement methods based on Patient Centered Primary Care Home Standards and Measurements as developed from time to time by the Oregon Health Authority.” *PEBB January 2013 Contract*

#### 5. 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.

##### Examples:

- Providing information to consumers that explains enrollment options and plan choice
- Providers and plans working together to provide consumers with an estimated quote for a medical procedure in advance of treatment
- Plans and providers sharing data back and forth on quality outcomes and price

##### Contract examples:

“Price and Quality Transparency: These innovations provide useful and easily accessible cost and

quality information to guide enrollees in understanding their own out-of-pocket costs for services, and in comparing the quality and safety of providers. They may include decision-support tools to help enrollees understand the availability and potential risks of treatment options for their disease.” *OEBB RFP Scope of Work 2009*

## **6. 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.

### Examples:

- Improving care coordination at all points in the system
- Integrating health system delivery budgets across the spectrum
- Testing, acceleration, and spread of effective delivery system & payment innovations

### Contract example:

“The Contractor shall deliver to OEBB enrollees a care management process that fully integrates medical, behavioral, acute, chronic care and patient education into a seamless experience. Contractor’s program shall help enrollees manage their chronic conditions and diseases to achieve optimum health. Such a delivery model shall, to the extent possible, be evidence-based and produce clinical outcomes and financial impacts that can be measured quarterly and annually.”  
*OEBB Contract 2009.*

**PEBB, OEBC, and Cover Oregon Alignment with the Coordinated Care Model Principles:  
November 2013**

The information below provides a picture of PEBB, OEBC, and Cover Oregon activities, programs, contract language and operations that already align under the Coordinated Care Model (CCM) principles, as well as opportunities for future alignment.

Items indicated for PEBB are reflected in PEBB’s current medical contracts and should be furthered through its current Medical Request for Proposals (RFP) process. Items for OEBC were extracted from its current 2013-2014 medical contracts. Cover Oregon items were gathered from the generic medical contract for the 2014 plan year and for the Request For Applications (RFA) put out in 2013.

Items were included based on whether the activity/program furthered the effort toward alignment with a CCM principle. Since many items can impact multiple CCM principles, the right-hand column indicates additional CCM principles that may be applicable to the item. For example, chronic disease case management is primarily a best practice for managing care (CCM Principle #1), but also can help share responsibility for health (CCM Principle #2), and may contribute to maintaining costs at a sustainable fixed rate of growth (CCM Principle #6).

<b>Coordinated Care Model Principle</b>	<b>Program or Operation</b>	<b>PEBB</b>	<b>OEBC</b>	<b>Cover Oregon</b>	<b>Notes, Contract Language, and Examples</b>	<b>Other applicable CCM Principles</b>
<b>1. Do what works. Use best practices to manage and coordinate care</b>	Quality Improvement program or strategies	X	X	X	E.g., Aligning Forces for Quality, e-value8, Leap Frog. To participate in the Exchange, carriers are required to implement and report on a quality improvement strategy or strategies consistent with §1311(g) of the Affordable Care Act (ACA). Under §1311(g), a strategy is a payment structure that provides increased reimbursement or other incentives for improving care coordination, chronic disease management, prevention of hospital readmissions, improvement of patient safety, implementation of wellness programs, or reduction of health care disparities.	3, 6
	PCPCHs or Medical Homes	X	X	X	Including adoption of the Patient-Centered Primary Care	3, 4, 6

Coordinated Care Model Principle	Program or Operation	PEBB	OEBC	Cover Oregon	Notes, Contract Language, and Examples	Other applicable CCM Principles
					Home Standards and Measurements developed by OHA	
<b>1. Do what works. Use best practices to manage and coordinate care</b>	Use of Electronic Medical Records and Health Information Exchange (HIE)	X	X	X	Contractor agrees to make commercially reasonable efforts to request its providers to adopt and demonstrate the meaningful use of certified EMRs and promote health information exchange.	
	E-prescribing	X	X		Contractor supports the implementation of e-prescribing access for all providers	
	Case management or chronic disease management programs	X	X	X	E.g., congestive heart failure, cardiovascular disease, asthma, diabetes and maternity management.	2, 6
	Behavioral and Physical Health Integration				Develop and implement a health care delivery model that integrates mental health and physical health care and addictions. This should specifically address the needs of individuals with severe and persistent mental illness.	
	Telehealth programs for members	X	X		<p>For PEBB: PHP, through Providence Health eXpress, will establish and maintain telehealth stations in state buildings for active PEBB Members enrolled in either a Providence Health Plan (PHP) or Kaiser medical plan. A “telehealth station” is defined as a confined and private room with a videoconferencing unit for the encounter and with a direct connection to a PHP intake specialist.</p> <p>For OEBC: Covered medical services, delivered through a 2-way video communication that allows a professional provider to interact with a member who is at an originating site, are covered. For OEBC: Covered medical services, delivered through a 2-way video communication that allows a professional provider to interact with a member who is at an originating site, are covered.</p>	2

Coordinated Care Model Principle	Program or Operation	PEBB	OEBB	Cover Oregon	Notes, Contract Language, and Examples	Other applicable CCM Principles
<b>1. Do what works. Use best practices to manage and coordinate care</b>	Administrative simplification	X	X		From OEBB and PEBB contracts: Contractor acknowledges that there are significant opportunities to improve the efficiency and timeliness of administrative processes and transactions between providers and health plans. Therefore, Contractor shall: (a) Continue its active participation in administrative simplification efforts undertaken by the OHA, DCBS and the Oregon Health Leadership Council;(b) Comply with the rules of DCBS requiring uniform standards for insurers; and, (c) Use commercially reasonable means, to include language in all its contracts with professional and institutional providers, as those contracts requiring them to conduct all administrative transactions electronically in accordance with standards...	
	Language and cultural considerations for members			X	From Cover Oregon RFA: How do you communicate important information about your health benefit plans and company policies in a culturally and linguistically appropriate manner with members?	
	Provider diversity and cultural competence				E.g., cultural competence training for providers; provider composition reflects Member diversity; non-traditional health care workers composition reflects member diversity	1,2
<b>2. Share responsibility for health among patients, providers, and plans</b>	Health Risk Assessment, with incentives for members who participate	X	X		E.g., Health Engagement Model (PEBB) and Health Futures (OEBB)	5, 6
	Wellness program or activities for members	X	X		E.g., weight management program, smoking cessation program, diabetes management program, MoodHelper, etc.	1, 5, 6

<b>Coordinated Care Model Principle</b>	<b>Program or Operation</b>	<b>PEBB</b>	<b>OEBB</b>	<b>Cover Oregon</b>	<b>Notes, Contract Language, and Examples</b>	<b>Other applicable CCM Principles</b>
	Online team-based Worksite Wellness program	X	X		E.g., Healthy Team, Healthy U	1, 5, 6
<b>2. Share responsibility for health among patients, providers, and plans</b>	Fitness Facility Subsidy program	X			Provides partial reimbursement of fitness facility membership costs for participants that meet defined minimum attendance requirements for attending the qualifying fitness facility where they have a membership. New to PEBB in October 2013.	
	Inclusion of preventive services at no-cost or low-cost to members	X	X	X	E.g., annual physical exams, mammograms, well-baby or well-child visits, immunizations, colorectal cancer screenings, etc.	1, 6
	Shared decision-making tools	X	X		E.g., online tools for members and providers including health trackers, medical libraries, E-DOC, evidence-based information that can help members compare treatment options for common chronic conditions (e.g., low back pain or hypertension).	5
	Value-Tier medications	X	X		OEBB and PEBB instituted value tier medications for 5 chronic conditions: diabetes, asthma, heart conditions, high blood pressure and cholesterol.  PEBB offers barrier-free prescription drugs for some mental health and behavioral health conditions	4, 6
	Community Health Assessment and Improvement				Providers and plans can incorporate information from community health assessments and community health improvement plans, including those developed by Coordinated Care Organizations, as part of a strategic population health and health care system service plan for the community served by the plan and providers	

<b>Coordinated Care Model Principle</b>	<b>Program or Operation</b>	<b>PEBB</b>	<b>OEBB</b>	<b>Cover Oregon</b>	<b>Notes, Contract Language, and Examples</b>	<b>Other applicable CCM Principles</b>
<b>3. Measure performance</b>	C-Section goal	X	X	X	Attempt to use reasonable measures to reduce purely elective inductions and primary and repeat cesarean deliveries at <39 weeks of gestation.	4, 6
	Readmission goals	X	X	X	Contractor shall provide a goal of reducing re-admissions and report on its efforts to decrease re-admission rates	4, 6
	HEDIS Reports	X	X		Report OEBB-specific and commercial book of business scores for selected HEDIS measures	
	Large Claims Reports	X	X		Large Claims Report by case with diagnosis of aggregate claims over a \$100,000 threshold by month for the Plan Year	
<b>3. Measure performance</b>	Enrollee Satisfaction surveys	X	X	X		2
	Metrics to be reported	X	X	X	E.g., Cover Oregon proposed metrics: Breast cancer screenings; Comprehensive diabetes screenings; Cholesterol management (LDL test) for patients with cardiovascular conditions; Flu shots; Annual monitoring for patients on persistent medications; Inpatient utilization – general hospital/acute care (IPU); Initiation and engagement of alcohol and other drug (AOD) treatment (IET); Antidepressant medication management; Prenatal and postpartum care; Well-child visits in the first 15 months of life, six or more; Getting needed care without delay; Overall rating of health care quality; and Overall rating of health plan.	5
	Strategies and Evidence-based Outcomes Workgroup		X		OEBB Strategies and Evidence-based Outcomes Workgroup (SEOW) in place to review data and make recommendations on benefit changes to improve cost and quality (not specifically in contract but all reports are reviewed by this group)	
<b>4. Pay for outcomes and health</b>	Tiered payment for Patient-Centered Primary Care Homes (PCPCHs)	X	X		PEBB and OEBB provide an age-adjusted, per-member-per-month incentive payment to Tier 2 or Tier 3 recognized PCPCHs	1, 2

<b>Coordinated Care Model Principle</b>	<b>Program or Operation</b>	<b>PEBB</b>	<b>OEBB</b>	<b>Cover Oregon</b>	<b>Notes, Contract Language, and Examples</b>	<b>Other applicable CCM Principles</b>
	Innovative Payment Reforms or Alternative Payment Methodologies (APMs)	X	X	X	Endorses innovative payment models that move away from fee-for-service reimbursement and reward for cost and quality outcomes. Contractor will develop and implement payment models that may include (but are not limited to) withhold, global budgets, capitation, reference pricing, bundled service payments, blended rates, pay-for-performance, and other reimbursement methods	1, 6
	Patient Safety Reporting	X	X	X	Requires that contractor uses commercially reasonable means to include specific language in contracts with hospitals, such as requiring Adverse Events Reporting programs, surgical checklists, participation in Non-Payment for Serious Adverse Events, etc.	1, 5
<b>4. Pay for outcomes and health</b>	Additional Cost Tier Co-Pays (ACT)	X	X		ACT increases member cost-sharing for certain services often considered to be preference sensitive. Members are encouraged to start a dialogue with their provider and to explore less invasive treatment alternatives if possible. There is a \$100 or \$500 copayment for Additional Cost Tier procedures, plus the applicable deductible & copayment still apply (in contract benefit summaries and member handbook).	1, 2,5,6
<b>5. Provide information so that patients and providers know price and quality data</b>	Web portal access for members	X	X	X	Website dedicated to members with targeted communication and outreach	
	Specific Treatment Cost Navigator and Prescription pricing tool		X		Cost calculators that OEBB members can enter a procedure or prescriptions into and find out the estimated cost	2

Coordinated Care Model Principle	Program or Operation	PEBB	OEBC	Cover Oregon	Notes, Contract Language, and Examples	Other applicable CCM Principles
	Plan comparison available to members		X	X	<p>Individuals will use Cover Oregon to make meaningful comparisons of QHPs. Carriers offering QHPs through Cover Oregon will report on networks, care coordination efforts, and quality measures. Individuals can view QHP performance in these areas to help them make choices among Carriers and QHPs.</p> <p>OEBC has partnered with Truven Health Analytics and MIT to implement and evaluate an informed decision making enrollment tool focusing on cost. Offered at open enrollment.</p>	
<b>6. Maintain costs at a sustainable fixed rate of growth</b>	2013-2015 budget	X			Caps PEBB expenditure growth Per Employee Per Month at 4.4% for 2013, 3.4% for 2014, and 3.4% for 2015	

## Overlap Among 2014 Quality Measures: OHA CCO, Cover Oregon and PEBB

Measure	NQF Number	CCO <sup>1</sup>	Cover Oregon <sup>2</sup>	PEBB/OEBB <sup>3</sup>
<b>MENTAL HEALTH, ALCOHOL AND DRUG USE</b>				
Adherence to antipsychotics for individual with schizophrenia	Unspecified	X		
Alcohol and drug misuse, screening, brief intervention, and referral for treatment	Unspecified	X		X
Alcohol and drug treatment success rate	Unspecified			X
Antidepressant medication management	0105	X	X	
Follow-up after hospitalization for mental illness	0576	X		X
Follow-up care for children prescribed attention deficit hyperactivity disorder medication	0108	X		
Initiation and engagement of alcohol and other drug dependence treatment	0004	X	X	X
Penetration rate for mental health and chemical dependence treatment	Unspecified			X
Screening for clinical depression and follow-up plan	0418	X		X
<b>PREGNANCY, CHILDREN, AND ADOLESCENTS</b>				
Adolescent well child visits	Unspecified	X		X
Annual pediatric hemoglobin A1c testing	0060	X		
Antenatal steroids	0476	X		
Appropriate testing for children with pharyngitis	0002	X		
Childhood immunization status	0038	X		X
Cesarean rate for nulliparous singleton vertex	0471			X

Measure	NQF Number	CCO <sup>1</sup>	Cover Oregon <sup>2</sup>	PEBB/OEBB <sup>3</sup>
Developmental screening, first 36 months of life	1448	X		X
Elective delivery	0469	X		
Immunization for adolescents	1407	X		
Oral health screening for children under 3 years	Unspecified			X
Pediatric central-line associated bloodstream infections, neonatal and pediatric intensive care units	Unspecified	X		
Percentage of live births with low birth weight	0278, 1382	X		X
Prenatal and postpartum care: postpartum care rate	1391	X		
Prenatal and postpartum care: timeliness of prenatal care	1517	X	X	
Prevalence of early childhood caries	Unspecified			X
Child and adolescent BMI assessment	Unspecified	X		
Well-child visits, first 15 months of life	1392	X	X	
Well-child visits, 3rd, 4th, 5th, and 6th years of life	1516	X		
<b>SCREENINGS AND PREVENTIVE CARE</b>				
Adult BMI assessment	Unspecified	X		X
Annual HIV/AIDS medical visit	0403	X		
Annual monitoring for patients on persistent medications	0021			
Breast cancer screening	0031	X	X	X
Breast feeding exclusivity at 6 months	Unspecified			X
Cervical cancer screening	0032	X		X
Chlamydia screening in women age 21-24	0033	X		X
Colorectal cancer screening	Unspecified	X		X
Comprehensive diabetes screening	Unspecified	X	X	X
Controlling high blood pressure	0018	X	X	X

Measure	NQF Number	CCO <sup>1</sup>	Cover Oregon <sup>2</sup>	PEBB/OEBB <sup>3</sup>
Dental visits	Unspecified			X
Fall risk screening	Unspecified			X
Flu shots for adults ages 50-64	0039	X	X	X
Preventive service utilization	Unspecified			X
Medical assistance with smoking and tobacco cessation	0027	X		X
Total eligibles age 1-20 who received preventive dental services	Unspecified	X		
<b>MEMBER HEALTH STATUS</b>				
Effective contraceptive use among women who do not desire pregnancy	Unspecified	X		
Functional status improvement	Unspecified			X
Health status improvement	Unspecified			X
Member health status, adults	Unspecified	X		
Rate of obesity among CCO enrollees (state measure)	Unspecified	X		X
Rate of tobacco use among CCO enrollees	Unspecified	X		X
Skin injuries: stage 3 or 4 pressure ulcers acquired after admission to healthcare facility	Unspecified			X
<b>HOSPITAL RELATED</b>				
All-cause readmissions	1789	X		X
Ambulatory care: hospital admissions	See Note 3	X	X	X
Annual percentage of asthma patients age 2-20 with one or more asthma-related emergency department visit	1381	X		
Hospital acquired infection rates	Unspecified			X
Hospital process of care	Unspecified			X
Potentially avoidable emergency department visits	Unspecified	X		X
<b>CUSTOMER SERVICE</b>				
Chronic disease self-management support	Unspecified			X

Measure	NQF Number	CCO <sup>1</sup>	Cover Oregon <sup>2</sup>	PEBB/OEBB <sup>3</sup>
Customer Service: information	Unspecified	X	X	
Customer service: courtesy and respect	Unspecified	X	X	
Getting needed care and getting care quickly	Unspecified	X	X	X
Overall rating of health care	Unspecified		X	X
Primary provider or provider team	Unspecified			X
Shared decision making or participation in care planning	Unspecified			X
Wait time for dental visit	Unspecified			X
<b>OTHER</b>				
Advanced directives: percentage of members who have an advanced directive	Unspecified			X
Care transition: transition record transmitted to health care professional	1391	X		
Child and adolescent access to primary care practitioners	Unspecified	X		
Coordination with long term care (for example, percentage of dual eligible discharged from acute care to home or community-based settings)	Unspecified			X
Electronic health record adoption	Unspecified	X		
End-of-life care preferences	Unspecified			X
Falls: patient death or serious physical injury associated with a fall while being cared for in a healthcare facility	Unspecified			X
Healthy eating: for example, percentage of adults and children who eat recommended number of fruit and vegetable servings	Unspecified			X

Measure	NQF Number	CCO <sup>1</sup>	Cover Oregon <sup>2</sup>	PEBB/OEBB <sup>3</sup>
Improvement in employment status or school attendance for individuals with behavioral health diagnosis	Unspecified			X
Improvement in housing status for individuals with behavioral health diagnosis	Unspecified			X
Kindergarten readiness	Unspecified			X
Medication errors	Unspecified			X
Medication reconciliation post-discharge	0554	X		X
Mental and physical health assessment within 60 days for children in DHS custody (state measure)	Unspecified	X		
Patient-centered primary care home enrollment (state measure)	Unspecified	X		
Physical activity: percentage of adults and children who meet recommendations for physical activity	Unspecified			X
Physician Orders for Life-Sustaining Treatment (POLST) forms: percentage of members who have a POLST form on file	Unspecified			X
Physician Orders for Life-Sustaining Treatment (POLST) forms: percentage of members whose end-of-life care matches preferences in POLST registry	Unspecified			X
Service engagement: Percentage of members who received no health services at all in a given period	Unspecified			X
Use of imaging studies for low back pain	Unspecified			X

Measure	NQF Number	CCO <sup>1</sup>	Cover Oregon <sup>2</sup>	PEBB/OEBB <sup>3</sup>
Use of palliative or hospice care at the end of life	Unspecified			X

<sup>1</sup> Oregon Health Authority. January 2013. *Oregon Measurement Strategy*. Accessed January 23, 2013 from <http://www.oregon.gov/oha/Documents/MeasurementStrategy.pdf>

<sup>2</sup> Oregon Health Care Quality Corporation. October 2013. *Cover Oregon Year One Measure Specifications*.

<sup>3</sup> Potential CCO Performance Measures by Category, PEBB & OEBB Alignment Discussion

## Attachment 5: Governor's Letter to Oregon Health Policy Board



JOHN A. KITZHABER, MD  
Governor

June 3, 2013

Oregon Health Policy Board  
Chair Eric Parsons  
Vice-Chair Lillian Shirley

Dear Chair Parsons and Vice-Chair Shirley:

As you and the Board are well aware, beginning in 2014, the Affordable Care Act (ACA) will significantly expand coverage to thousands of currently uninsured Oregonians and alter the regulations governing the individual and small group markets. While the ACA makes historic, nationwide changes in coverage expansion and the regulation of the individual and small group markets, I believe there is an immediate need to focus on how to better align ACA implementation activities with our current reform efforts. I want to ensure that our triple aim goals of lower costs, better care and better health across all markets are achieved. To that end, concurrent with the ACA, we have an opportunity to create an environment for the commercial marketplace in Oregon that moves toward one characterized by models of coordinated care and growth rates of total health care expenditures that are reasonable and predictable.

For this to occur, I am asking that by the end of this year, the Oregon Health Policy Board take on the task of recommending to me and the Legislature, possible statutory and regulatory changes necessary to ensure our triple aim goals are met. I would anticipate that such recommendations would include, but not be limited to:

- strategies to mitigate cost shifting, decrease health insurance premiums and increase overall transparency and accountability;
- opportunities to enhance the Oregon Insurance Division's rate review process;
- alignment of care model attributes within PEBB and OEBB contracts;
- alignment of care model attributes within Cover Oregon's qualified health plans.

Thanks to all of your hard work and leadership over the past several years, Oregon has made significant progress in reforming its health care delivery system. Across the state, communities have begun transforming to deliver more effective, efficient care. Critical partnerships are developing to reward quality care, promote prevention and wellness and manage chronic diseases and are building new networks, products and contracting models.

Oregon Health Policy Board  
June 3, 2013  
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We have an amazing opportunity to leverage all of your great work with the implementation of the ACA and I look forward to working with you to achieve further success.

Sincerely,

A handwritten signature in black ink, appearing to read "John A. Kitzhaber". The signature is fluid and cursive, with the first name "John" being the most prominent.

John A. Kitzhaber, M.D.  
Governor

MJB/smg