

Oregon Health Policy Board

AGENDA

January 18, 2011

Double Tree Hotel Portland

1000 NE Multnomah Street

Portland, OR 97232

Weidler/Broadway Rooms

9:00 AM to 4:00 PM

#	Time	Item	Presenter	Action Item
1	9:00	Welcome, call to order and roll Action item: Consent agenda 12/14/10 minutes	Chair	X
2	9:05	Director's Report	Bruce Goldberg	
3	9:15	Legislative Update	Amy Fauver	
4	9:45	Medicaid 101	Jeanene Smith	
	10:15	Break		
5	10:30	Strategic Planning for 2011: Where we've been Where we're going How we're getting there	Tina Edlund	
	12:00	Break for lunch		
6	1:00	2011-2013 Budget Issues	Bruce Goldberg	
7	1:30	Using the State's Purchasing Power: Coordinating with PEBB, OEBC, Medicaid	Chair Group breakout discussions	
8	3:30	Summary and Next Steps	Chair	
9	4:00	Adjourn	Chair	

Next meeting:

February 8, 2011

1 pm to 4:30 pm

Market Square Building

Oregon Health Policy Board
DRAFT Minutes
December 14, 2010
Market Square Building
1515 SW 5th Avenue, 9th floor
Noon – 5:00pm

Item

Welcome and Call To Order

Chair Eric Parsons called the Oregon Health Policy Board (OHPB) meeting to order. All Board members were present. Oregon Health Authority (OHA) staff members present were Bruce Goldberg and Tina Edlund.

Consent agenda –

Minutes from November 9 and 16, 2011 Meetings

The November 9 and 16, 2010 minutes were reviewed.

Reports

Incentives and Outcomes Committee Report
Medical Liability Taskforce Report
Public Employers Health Purchasing Committee Report
Workforce Committee Report

All items on the consent agenda were approved by unanimous voice vote.

The Chair noted that the next meeting was planned for January 11, 2011, which creates a conflict for some Board members and January 18, 2011 was suggested as an alternative.

Director's Report – Dr. Bruce Goldberg

- Dr. Goldberg reported that OHA has been busy with the governor's transition, as well as the transition to two agencies.
- The budget continues to require attention.
 - ❖ The quarterly rebalance is due to the Legislature, and at this point, the OHA budget is very close to balanced.
 - ❖ Staff numbers continue to diminish through attrition and the hope is that soon the hiring freeze will be lifted.
- The Board asked that the Director's Report include revenues and expenditures on a monthly or quarterly basis in 2011.

Value-Based Benefits Package: Focus Group Results Presentation – Carol Foley and Jeanene Smith

- This study was designed to explore the feasibility of implementing value-based benefit design to see if there is interest from consumers and to explore the best way to communicate concept to employers and consumers.
 - ❖ Overall, the package was appealing to consumers. They liked the emphasis on wellness and wanted greater emphasis on diet and nutrition.
 - ❖ The benefits and tiers were seen as complicated and the group felt that significant education and communication would be required.
 - ❖ Although participants had reservations about features, they were very interested in a program that reduced costs.
- For insurers, the interest has so far been low. Structuring tiers by procedure or diagnosis is manageable, but together would be a complicated design to administer. The administrative impact is thought to be significant.

This presentation can be found [here](#).

- The Board asked about the public's level of understanding of the idea of value-based benefits packages. Carol replied that most people felt that a chance incident, like a broken arm, would act

as a penalty because it would require a higher tier treatment. They could not reconcile that the benefit of lower tier preventive treatments outweighed the risk of possibly requiring a higher tier treatment because of an accident or cancer.

- The Board felt that the burden of education should fall to the insurers.
- The Board asked if anyone was currently offering value-based benefit plans. Jeanene replied that OEBC rolled one out in October and hadn't had as much dissent as they thought there would be. ODS is offering a less complex design to their employees.

Discussion on the Health Insurance Exchange: Legislative Concepts and Direction – Nora Leibowitz and Barney Speight

- Areas of prior OHPB Agreement
 - ❖ Specify measures to ensure Exchange is accountable
 - ❖ Organization with a strong public mission
 - ❖ Exchange should have a governing board

This presentation can be found [here](#).

- The make up of the governing board was of concern to the Board.
 - ❖ They wanted to make sure that people with valuable experience were not excluded because they worked for a company that would benefit from the exchange.
 - ❖ They also wanted to be sure that they provided clear guidance to the Legislature, who will ultimately decide the make up of the governing board.

The Board unanimously voted to adopt the legislative concept.

The Health Insurance Exchange: Business Plan for a Sole Market Scenario – Bill Kramer and Nora Leibowitz

- Original analysis of the Health Insurance Exchange assumed a dual market; this analysis assumes a single market.

This presentation can be found [here](#).

- The Board asked about the possibility of unintended consequences of a dual versus single market exchange.
- Nora answered that when they assembled a panel of experts, the experts said that it could be difficult to ensure quality plans are offered in the Exchange if it is only a single market. If insurance companies can offer plans outside the Exchange, it is easier to turn them away from the Exchange because their plans are not good enough. If all insurance is offered through the exchange, it becomes politically difficult for a government to turn away a provider because they have no other opportunity to present their plans to consumers.
- Bill recommended setting up the Exchange as a sole market because he felt it would be stronger and be a more effective vehicle for institutional change than a dual market.

Break

Discussion on the Oregon Health Action Plan, For Review and Approval – Gretchen Morley

- Foundational Strategies for Action
 - ❖ Spend health care dollars in a better way to lower costs.
 - ❖ Focus on prevention.
 - ❖ Improve health equity.
 - ❖ Make it easier for Oregonians to get affordable health insurance and quality care.
 - ❖ Reduce barriers to health care.
 - ❖ Set standards for safe and effective care.
 - ❖ Involve everyone in health system improvements.
 - ❖ Measure progress.

This presentation can be found [here](#).

- The Board requested changes to the document, including putting the scorecard back in and rewording language to make it clearer.

The Board unanimously voted to adopt the Action Plan with the proposed changes.

Budget Discussion and Follow-Up On Governor-Elect Kitzhaber's Comments – Bruce Goldberg

- Dr. Goldberg presented information on what has taken place since the Governor-Elect came before the Board and what's occurring in the transition, particularly around the health care budget.
- The biggest change is that we must live within the dollars that are available and change what we do with them rather than doing less.
- The approach to the budget is to manage the Triple Aim, manage to a fixed budget, integrate services, and enforce regional accountability for cost and outcome.

This presentation can be found [here](#).

- The Board emphasized their desire to look out ten years into the future instead of just a biennium. Dr. Goldberg responded that we must set up something in the next biennium that can be sustained into the future.

Public Testimony

Betty Johnson – Mid-Valley Health Care Advocates

Ms. Johnson advocated for a public health plan as a way to motivate major changes to the quality and cost of health care in Oregon.

Jim Hauser – Co-Owner, Hawthorne Auto Clinic and Co-Chair of Oregon Small Business Council

Mr. Hauser spoke of the challenges small businesses face in providing health insurance to their employees. He urged the Board to empower the Exchange to enable combined purchasing power of small employers.

Sandra Hernandez and Maria Lasso – THE-TREE Institute

Ms. Hernandez urged the Board to enable the Exchange to include everyone in Oregon, regardless of documentation status, particularly children.

David Green – Member, Oregon Consumer Survival Coalition

Mr. Green spoke of the need for simpler information for those in the addictions and mental health community, as well as more conversation between consumers and survivors and OHA and the Addictions and Mental Health Division.

Adjourn 4:45pm

Next meeting:

January 18, 2011

8:00am – 5:00pm

Double Tree Hotel

1000 NE Multnomah Street, Weidler/Broadway Room

Portland, OR 97232

**Monthly Report to
Oregon Health Policy Board
January 18, 2011**

Bruce Goldberg, M.D.

PROGRAM AND KEY ISSUE UPDATES

Governor Kitzhaber Sworn into Office

On Monday, January 10 Governor John Kitzhaber was sworn into office for his third term. The Governor has already put together a Health Care Budget Transition Team, co-chaired by myself and the Health Policy Board's Mike Bonetto. The Team has been asked to develop recommendations for ways to reduce the size of the state health care "cut" in order to sustain our system in the first year of the biennium, as well as constructing strategies to develop and implement a more efficient and effective system in the second year of the biennium and beyond. Lot's more about this on Tuesday.

Healthy Kids Program

Enrollment

Through December, just over **73,000** more children have been enrolled into Healthy Kids.

- This is 91% of our goal of 80,000 more children and a 27% increase in enrollment since June 2009 (baseline).
- Just over 3,400 children are now enrolled in Healthy KidsConnect.
- See the chart below for a more detailed look at Healthy Kids enrollment.

Federal Performance Bonus Award

- Oregon was awarded a \$15 million performance bonus for streamlining its application and eligibility process and exceeding federal targets for Medicaid enrollment in FFY 2010.
- Out of 15 states that received an award, Oregon's was the fourth highest, which given our small population size is a significant achievement.

New Application

- The new application, developed with the Center for Health Literacy, has now rolled out across the state.
- The new application simplified the form's language as well as incorporating recent policy changes. It also includes an easy-to-read checklist of materials and paperwork that is required upon submittal, along with aesthetic upgrades.
- Anecdotal reports from eligibility staff indicate that the new application and policy changes should significantly reduce the rate of pended applications (those put on hold pending further information).

OHP Standard

- As of November 15, 2010, total enrollment in OHP Standard is now **56,505**. Total enrollment in all OHP/Medicaid programs is 585, 617.
- The 2009/2011 biennial goal is to have an enrollment of 60,000 people in the OHP Standard program by June 30, 2011.
- There have now been fourteen random drawings to date. The last drawing was on December 15, 2010 for 10,000 names. The next drawing will be on January 12, 2011, for 2,000 names.

Thank You

I want to take this opportunity to give a huge thank you to Board Members and to all of the Committee and Task Force members that have played such a vital role in this process. Their effort and deliberation on a wide range of health policy issues is what enabled the Health Policy Board to take clear, decisive, and timely action on this huge step towards health care reform in Oregon.

We begin planning our work for the new year on Tuesday.

Upcoming

Next OHPB meeting:

Tuesday, February 8, 2011

Location: Market Square Building

Healthy Kids Progress Toward Enrollment Goals

	OHP Net Enrollment	HKC Net Enrollment	Total Net Enrollment	Increase Over Baseline	Monthly net enrollment change	% of Goal Achieved
Jul-09	271,493	0	271,493	3,648	3,648	5%
Aug-09	276,712	0	276,712	8,867	5,219	11%
Sep-09	281,374	0	281,374	13,529	4,662	17%
Oct-09	289,015	0	289,015	21,170	7,641	26%
Nov-09	294,459	0	294,459	26,614	5,444	33%
Dec-09	298,600	0	298,600	30,755	4,141	38%
Jan-10	303,026	0	303,026	35,181	4,426	44%
Feb-10	305,785	205	305,990	38,145	2,964	48%
Mar-10	309,047	549	309,596	41,751	3,606	52%
Apr-10	312,191	923	313,114	45,269	3,518	57%
May-10	314,933	1,133	316,066	48,221	2,952	60%
Jun-10	316,891	1,338	318,229	50,384	2,163	63%
Jul-10	319,878	1,662	321,540	53,695	3,311	67%
Aug-10	322,694	1,948	324,642	56,797	3,102	71%
Sep-10	326,545	2,335	328,880	61,035	4,238	76%
Oct-10	331,837	2,700	334,537	66,692	5,657	83%
Nov-10	334,120	3,046	337,166	69,321	2,629	87%
Dec-10	337,498	3,441	340,939	73,094	3,773	91%

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Oregon's Action Plan for Health

Key Recommendations for 2011 Legislature

Align purchasing

- **Bill # TBA:** Standardize certain provider payments to Medicare methodology (not rates) to set stage for future payment reform.

Reduce administrative costs in health care

- **SB 94:** Create authority to extend standards to clearinghouses and third-party administrators.

Mission-driven public corporation as legal entity for Oregon Health Insurance Exchange

- **SB 99*:** Establish corporation board and Exchange.

Build the health care workforce

- Fund loan repayment program to attract and retain primary care providers in rural and underserved areas.
- **SB 96:** Extend requirement to participate in Oregon's health care workforce database to all health professional licensing boards.

Expand use of health information technology (HIT) and exchange (HIE)

- **HB 2101:** Establish a public-private state-designated entity to connect local, regional, and statewide HIE.

Strengthen medical liability system

- **SB 95*:** (1) Prevent liability insurers from canceling coverage or refusing to defend insurers to disclose errors.
(2) Amend Oregon's "apology" law to clarify that statements of regret or apology may not be used to prove negligence.

* This bill will be amended to reflect the Board's full recommendation.

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Medicaid in Oregon

Oregon Health Policy Board Meeting

January 18, 2011

The logo for the Oregon Health Authority. It features the word "Oregon" in a smaller, orange, sans-serif font above the word "Health" in a large, blue, serif font. A thin blue horizontal line is positioned below "Health", and the word "Authority" is written in a smaller, orange, sans-serif font to the right of this line.

Oregon
Health
Authority

In Oregon, Medicaid touches almost 600,000 lives

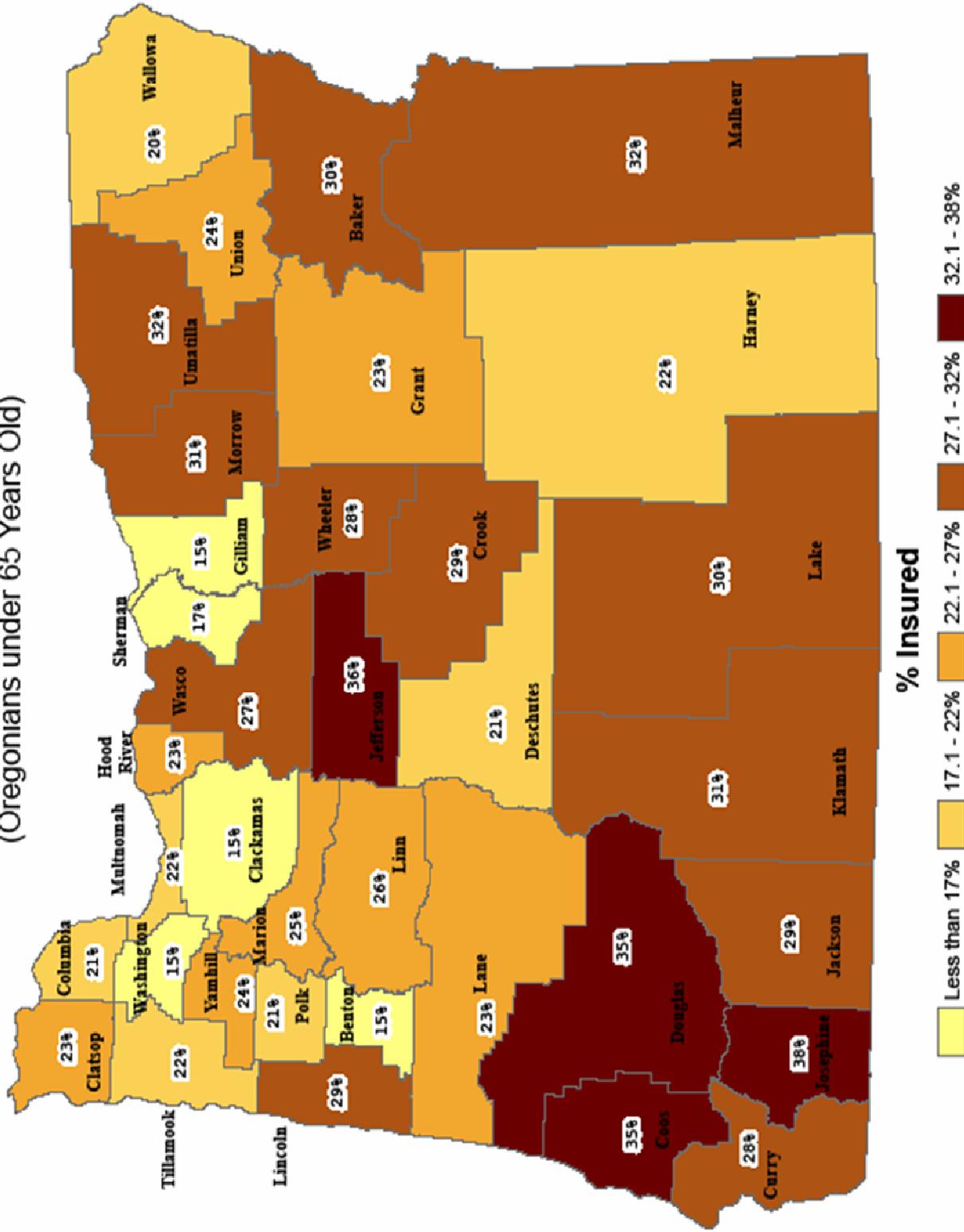
- Medical and some dental services under OHP Plus and Standard
- Addiction and mental health services for Medicaid-eligible clients
- Family Health Insurance Assistance Program
- Smaller programs for specific services or populations (e.g. family planning, CAWEM program)
- In-home services, community-based care, and nursing homes for Medicaid eligible seniors and people with disabilities
- Some case management services

Oregon Health Plan's Reach

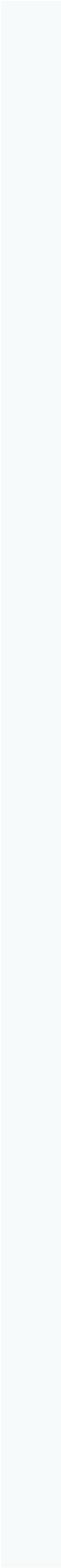
- About 2 million people have had their health care covered by OHP since it began in 1994 (unduplicated count)
- Nearly one in three of all Oregonians have been on OHP at some point in their lives
- Today, OHP is the health insurance provider for approximately 15 percent of all Oregonians and almost 38 percent of all Oregon children
- Approximately 40 percent of Oregon's births in 2007 were covered under OHP

Oregon Health Plan (OHP) as Percent of Total Insured

(Oregonians under 65 Years Old)

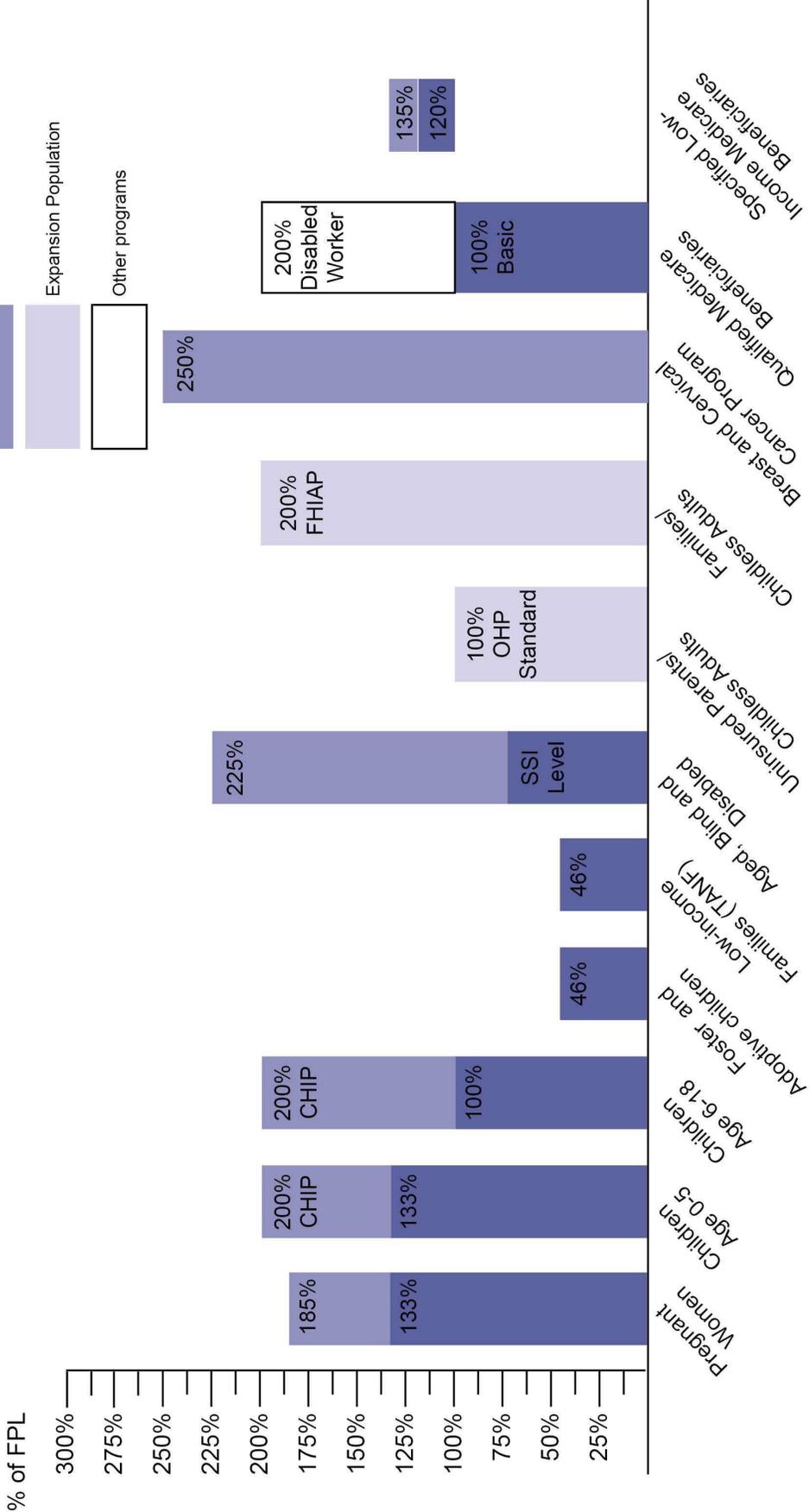


Data were provided by: DHS website, http://www.oregon.gov/DHS/healthplan/data_pubs/enrollment/2010/110/main.shtml;
Oregon population statistics provided by Portland State University.



Eligibility is fragmented...

Approximate Federal Poverty Levels (FPL) for Medical Eligibility Groups



- ♦ Aged, blind, and disabled populations meeting long-term care criteria are eligible up to 300% of the SSI level (which is equivalent to approximately 225% of the FPL); otherwise, these populations are eligible up to the SSI level.
- * The Family Health Insurance Assistance Program (FHIAP) subsidizes private health insurance coverage for low-income families and individuals. All OHP populations have the option to elect FHIAP coverage rather than direct state coverage. Parents and childless adults up to 100% of the FPL must enroll in FHIAP if they have employer-sponsored insurance. Parents and childless adults over 100% of the FPL are not eligible for direct state coverage but may be eligible for FHIAP if enrollment limits have not been met.

OHP Programs

- **OHP Plus** covers about 490,000 people (mandatory Medicaid)
 - Low-income elderly, blind & disabled; families receiving Temporary Assistance for Needy Families (TANF); low-income foster children; low-income children; low-income pregnant women
 - About 65% are under age 19
 - Supported by General Fund with federal match
- **OHP Standard** covers about 57,000 clients (expansion population)
 - Parents and childless adults under 100% FPL
 - Supported by hospital tax with federal match

Premium Assistance Programs

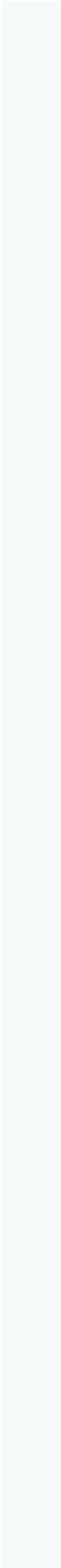
- **Family Health Insurance Assistance Program** (FHIAP) helps about 7,000 low-income adults and families purchase private insurance
- About 3,500 kids are enrolled in **Healthy KidsConnect**
- Oregon uses Medicaid match to support its investment in these programs

Other Programs

- 470 women receive treatment through the Breast and Cervical Cancer Program (**BCCP**)
- Approximately 24,000 get emergency medical, prenatal care, and labor/delivery services through the Citizen Alien Waived Emergency Medical (**CAWEM**) benefit package
- 77,000 low-income women receive family planning services (**CCare**)

Also.....

- Oregon Youth Authority clients – behavioral rehabilitative services
- Some Addictions and Mental Health Division community services - rehabilitative services, personal care and a few State Hospital services
- DHS Children, Adults and Families Division – targeted case management and behavioral rehabilitative services



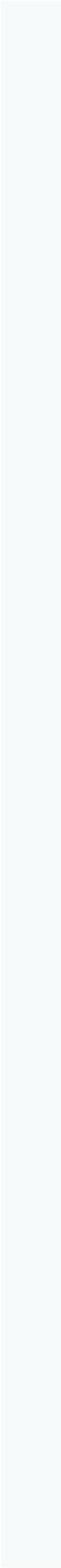
**And the Delivery System is
Fragmented....**

Managing Care in OHP

- Approximately 83% of OHP clients are enrolled in physical health managed care.
- Nearly 95% of OHP clients are enrolled in managed dental care, and more than 90 percent are enrolled in managed mental health care.
- Clients not enrolled in managed care receive services on a Fee-for-Service (FFS) arrangement –providers bill the state directly for their services based on a set fee schedule
- Some providers receiving FFS also get a case management fee (in areas where there are no managed care plans)

Managing Care in OHP (2)

- The state has contracts with:
 - 14 Fully Capitated Health Plans (physical health) (FCHPs)
 - 1 Physician Care Organization (physical health) (PCO)
 - 8 Dental Care Organizations (DHOs)
 - 10 Mental Health Organizations (MHOs)
- Each contracted organization receives a monthly capitation payment for each enrolled client



Medicaid and Medicare linkages

Dual Eligibles

- Approximately 59,000 very low-income seniors and younger people with disabilities are enrolled in both Medicare and Medicaid
- In 2007, dual eligibles accounted for 40% of Medicaid spending in Oregon but represented only 17% of Medicaid enrollment
- 73% of that spending was for long-term care services

Medicaid dollars augment Medicare coverage for some

- Medicare Part A/B premiums:
 - Pays Medicare premiums, deductibles and copayments for certain qualified Medicare beneficiaries
 - About 16,000 Qualified Medicare Beneficiaries in Oregon

Medicaid Long-term Care

- Medicaid long-term care provides long-term care services and supports:
 - In nursing facilities;
 - And as alternative to nursing facilities:
 - Community-based facilities (assisted living and residential care)
 - Increasingly at home, to support an individual's goal to remain in his or her own home

Medicaid Long-term Care

- In FFY 2010, 37% of Oregon's Medicaid spending was for long-term care (national figure is 34%)
- Oregon ranks 2nd only to New Mexico in proportion of Medicaid long-term care dollars spent in home and community-based settings rather than institutions (71% in FFY 2008)

Medicaid Opportunities under Reform

- ACA expands Medicaid eligibility up to 133% of FPL and provides enhanced federal funding for new eligibles
 - 100% federal funding in 2014-16; phases down to 90% in 2020 and after
- Oregon's Medicaid enrollment expected to increase by almost 60% by 2019
- Opportunities for reform and innovation within Medicaid, such as:
 - Integration of care for dual eligibles
 - Patient-centered primary care homes
 - Bundled payments for episodes of care
 - Pediatric accountable care organizations

Oregon Health Authority

MEMORANDUM

To: Oregon Health Policy Board
From: Jeremy Vandehey
Date: January 13, 2011
Re: Revisiting input received in 2010 for 2011 planning

I recently reviewed some notes of conversations I've had with stakeholders, partners, and advocates throughout 2010. I thought this would be a good opportunity to summarize some themes I've heard around the state for you to consider when setting your 2011 agenda and strategy. I realize that some of this may seem redundant after just finishing the Action Plan.

Behavioral health integration is important and can yield real savings, particularly in communities with mental health provider shortages.

- New reimbursement models could integrate care delivery so physical and behavioral health providers can work together to keep people out of emergency departments.
- The way mental health services are currently provided with contracted mental health organizations creates provider shortages in communities where mental health providers cannot survive on the private market alone.
- With expansion of community health center funding in federal reform, the state should look into integration of behavioral health with FQHCs.

Focus on **primary care, prevention, and improve population health** to yield the greatest savings and improved quality.

- Oregon must address the current access to primary care issues, including primary care provider workforce shortages.
- The state should quantify the value of preventive services, attach that value to reimbursement rates, and require reimbursement for those services in OHA contracts. A method for doing this could be to create reimbursement rates for licensed, skilled "preventive care" providers.
- In communities with a hospital, residents know they can go to the emergency room. Patients need to be retrained about where they access care.
- Improving **chronic care management** will yield the largest savings in payments to hospitals, but there needs to be a way to bill for successful chronic care management to encourage its use.
- Patient responsibility and finding ways to encourage patients to follow-through should be considered in any new payment models which pay for outcomes.
- Improved population health will occur over a generation, not immediately. There needs to be longer term metrics for measuring progress that provide incentives to hospitals and providers to improve health.

While **managed care organizations** may be a successful model, there still should be some competition.

- There should be at least two Medicaid insurers in a region to drive innovation and ensure consumer satisfaction.
- Capitated payments will require some oversight to ensure they do not result in underserved clients and ensure consumer satisfaction.

Reducing duplicative and unnecessary services will yield large savings in small communities.

The overuse of **medical technology** must be addressed, including creating some protection for providers against **malpractice** when they decline to use technology based on evidence.

Long-term care in hospitals can be problematic. Staff are reimbursed at hospital rates, which is higher than they would be in a long-term care facility. If there are empty beds, that cost is subsidized by other hospital revenue.

The board should address all **workforce shortages**, including dentists, physical therapists, behavioral health, and pharmacists.

One size does not fit all.

- Rural and smaller communities will always have higher costs because they cannot reach the same economies of scale as higher populated areas.
- Variations between communities require local solutions. Requirements of local communities should be to meet the board's general principles, but in a way that addresses unique local needs.
- Create vehicles for communities to **share innovative ideas** and replicate work that is improving quality, lowering costs, and improving health in other parts of the state.
- To save start-up costs and time for integration and regionalization, OHPB should build off of models across the state that are working rather than reinventing the wheel.
- There is innovative work going on across the state. OHA should ensure that pilot opportunities include communities outside I-5 corridor.

The state should look into **streamlining reporting** requirements to the state. There is a direct cost shift between state mandated administrative requirements and increased costs, particularly at critical access hospitals and in smaller health departments.

OHA and OHPB need to have continual communication with local partners, particularly about new priorities and expectations so they can integrate them into their work locally early on.