Straw Comprehensive Plan: System Transformation

Barney Speight

July 24, 2008

The Board's Vision

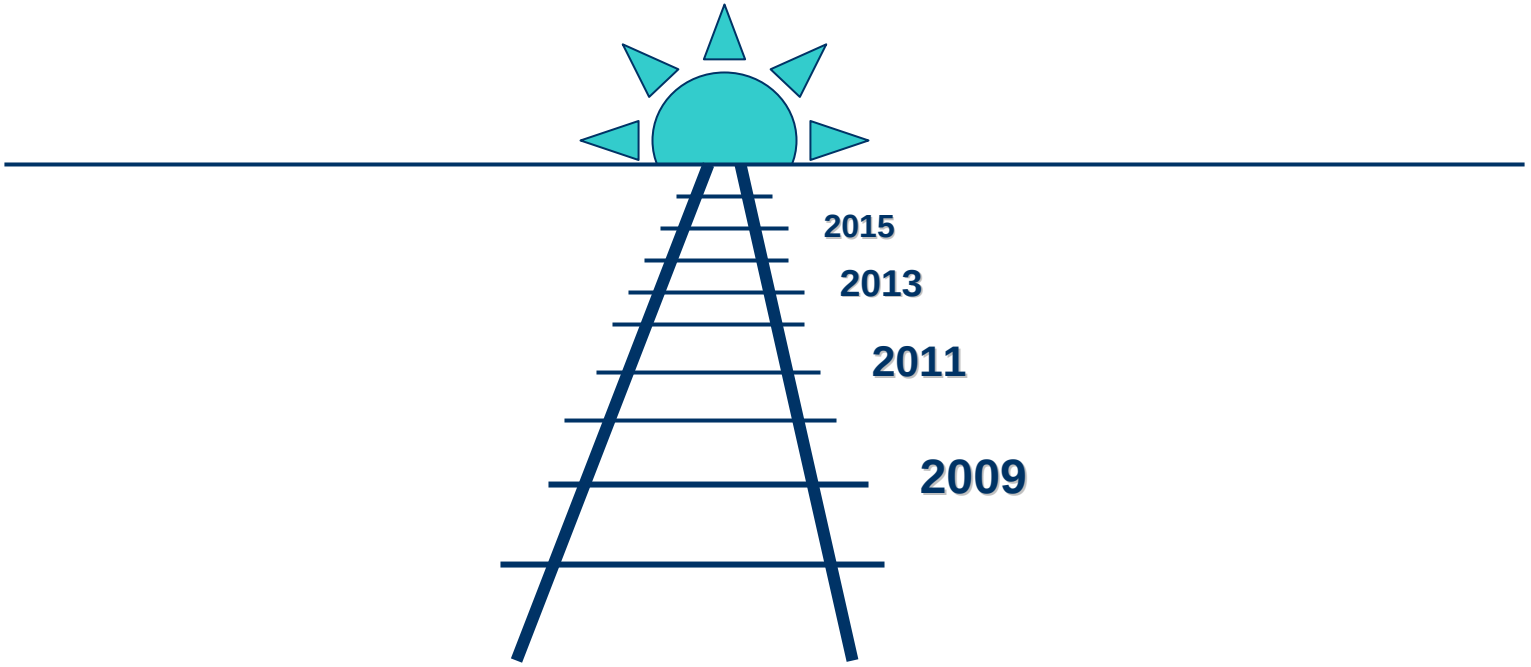
A Healthy Oregon:

Quality, Affordable Health Care for All Oregonians

Our Goals

- **ACCESS – Get everyone in the tent**
- **SYSTEM TRANSFORMATION – Reform Oregon's delivery & payment systems to improve quality and contain costs**

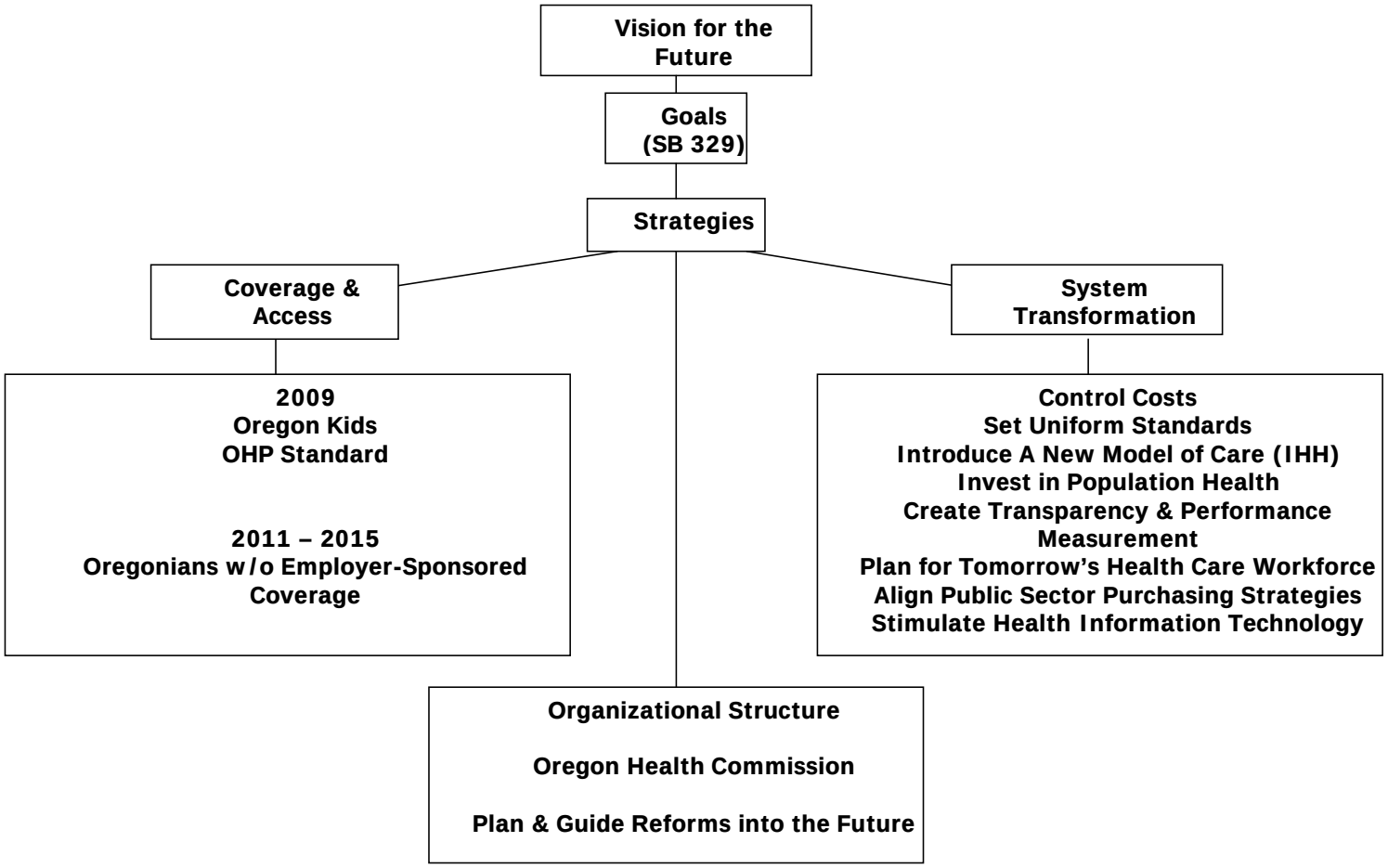
Parallel Tracks To the Future



Affordable Coverage For All Oregonians

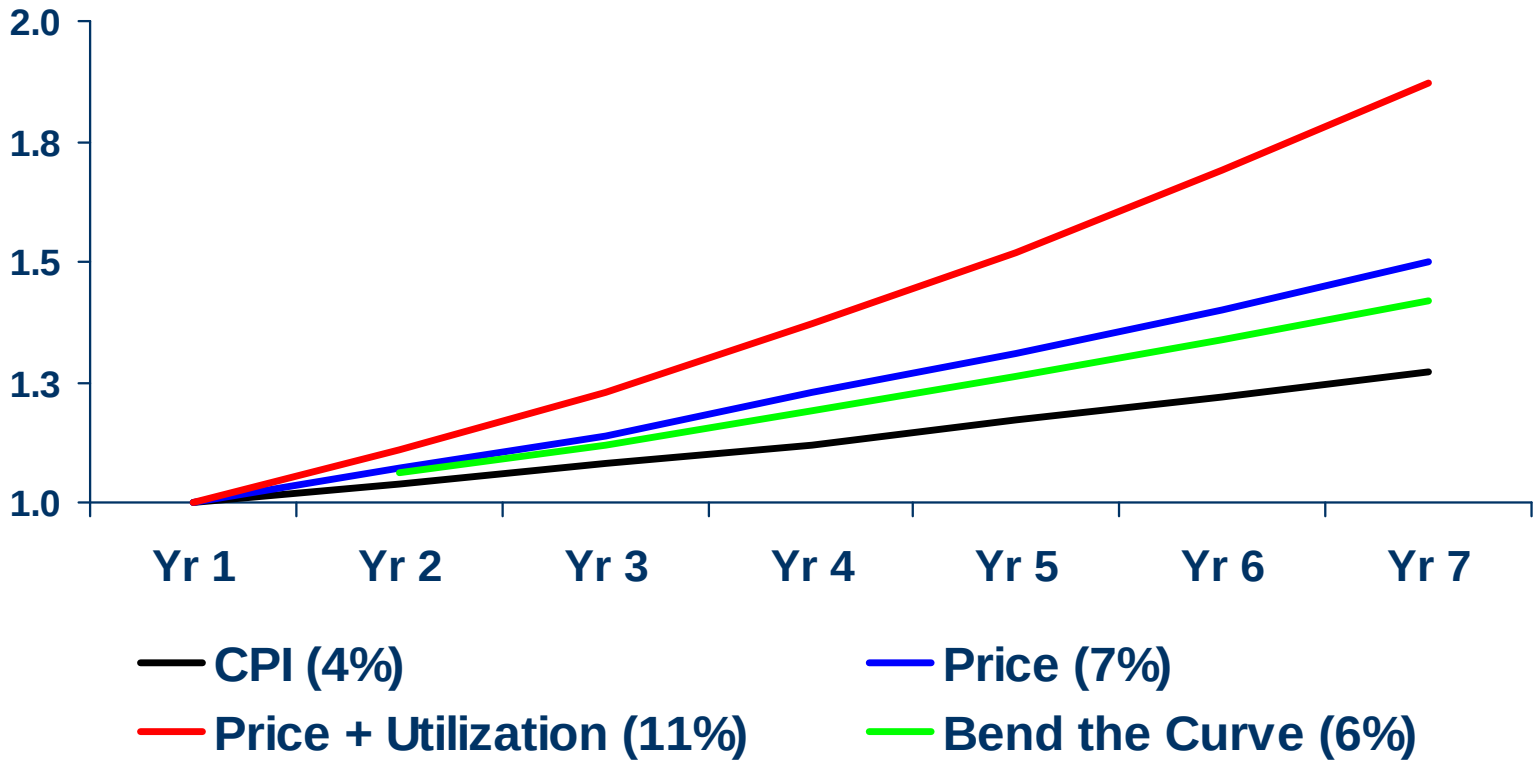
Transform Oregon's Health Delivery System

Components of A Plan

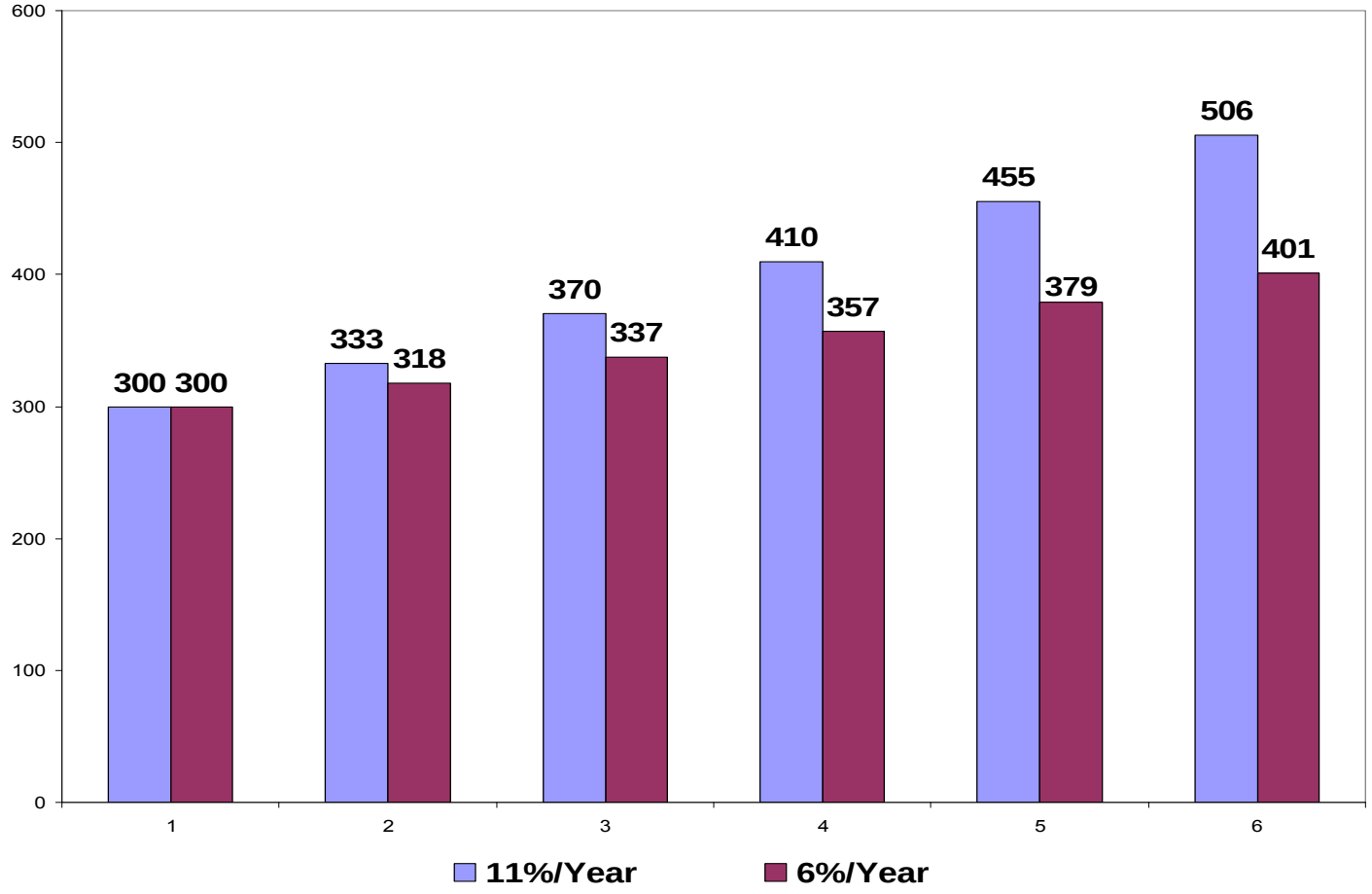


SYSTEM TRANSFORMATION: CONTROL COSTS

Unsustainable Increases



Bending The Curve: 11% vs. 6%yr



5-Year Savings - Group of 25 Employees

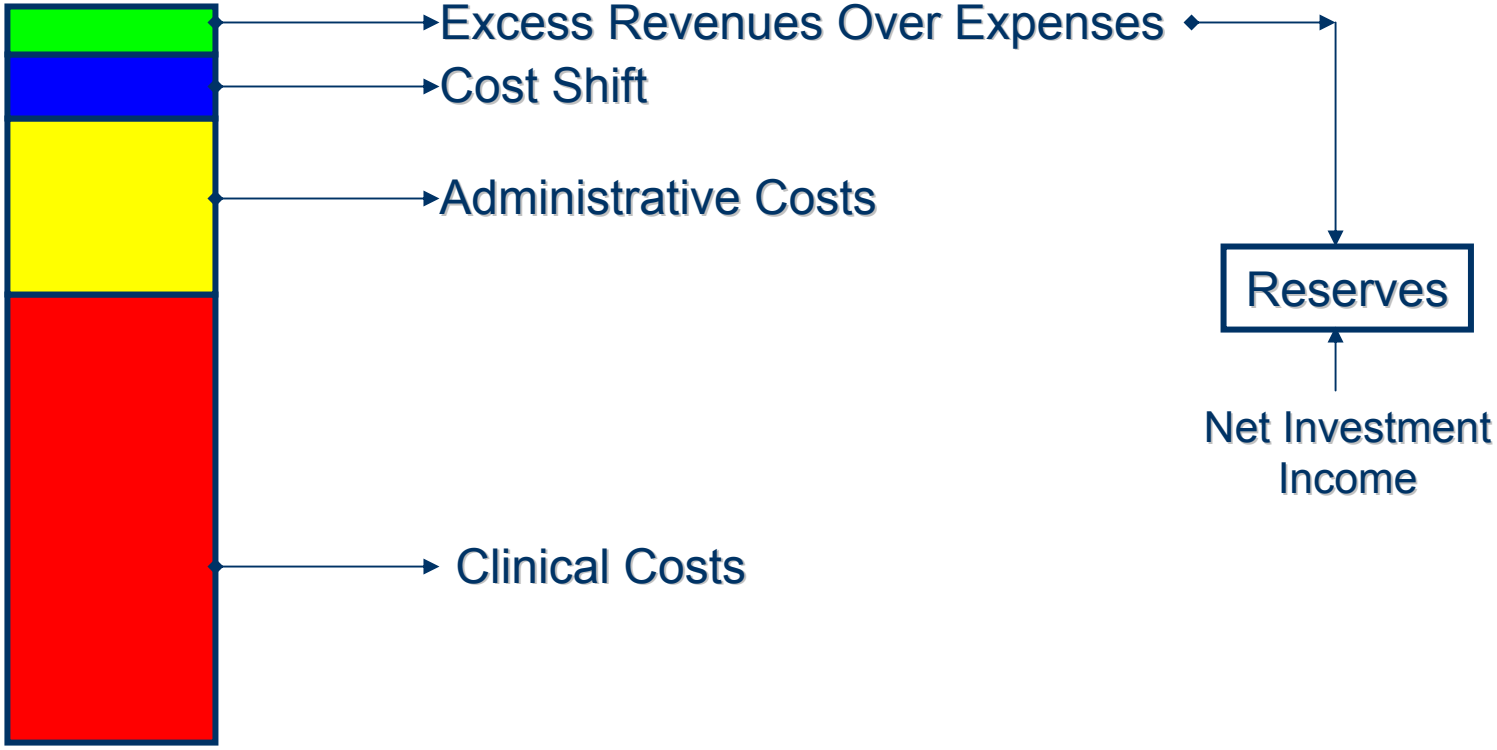
	Year 1	Year 2	Year 3	Year 4	Year 5
Annual	$4,500	9,900	15,900	22,800	31,500
Cumulative	$4,500	14,400	30,300	53,100	84,600

5-Year savings for Oregon's insured & self-insured market = $ 6 to 7 Billion

SYSTEM TRANSFORMATION: CONTROL COSTS

PROVIDER PRICES
&
INSURER PREMIUMS

Components of Provider "Price"



Addressing The Cost Shift

- Reduce Uncompensated / Charity Care
  - Expand Oregon Health Plan
  - Stabilize & Expand Private-Sponsored Coverage
- Medicaid Deductions From Revenue
  - Improve Payment in Oregon Health Plan
- Medicare Deductions From Revenue
  - Expand Medicare Advantage HMOs + PPOs
  - Payment Reform for “Low-Reimbursed” States

Addressing Administrative Costs

- Administrative Simplification
  - Standardize Practices Among Insurers
    - Eligibility, Billing, Remittance and Related Functions
      - Drive HIPAA standardization deeper
    - More uniform clinical guidelines for coverage
      - First Target ? → Services with high variation in use or questionable clinical efficacy
- Information Technology
  - Move more information (clinical + administrative) without paper & with fewer people

Addressing Clinical Costs

- Setting quality standards & measuring performance
  - e.g., Readmissions, Infection rates, etc.
- Target preventable hospitalizations
  - Data + Analysis
  - Transform ambulatory delivery system
- Information Technology
  - Maximize clinical time, minimize administrative time
  - Reduce duplication of services with “on-time” information
  - Reduce errors
- Employ “best practice” clinical protocols

Addressing “Profit”

- Reasonable “profit” is necessary
  - Rebuild infrastructure, invest in new technologies, meet new community needs, lower capital costs
- Public disclosure is the current approach

(“Profits” = Excess Revenues Over Expenses for not-for-profit entities)

Addressing Total "Price"

- Three Options
  1. Disclosure, analysis & reporting (see slides 16 & 17)
     - Broad public awareness
  2. Aggregate local purchasing power to a scale larger than the most dominant payer (see slides 18 & 19)
     - Purchasing Cooperative ("Purchasing Exchange")
     - Start with Public employers (PEBB, OEBB, Cities, Counties, Special Districts, etc.)?
     - Others can join? (insurers, self-insured employers)
     - Negotiate unit price, not premiums; e.g., Centers of Excellence
  3. State sets price ceilings on providers (see slide 20)
     - Some providers or all providers?

Payer Contracts Reporting Option

- DCBS requires regulated carriers + TPAs to send provider contract information to private actuarial firm
  - Information is protected from public disclosure
- Contractor reports % change in prices by facility, professional group (or specialty)
- Distributed widely to purchaser community & general public

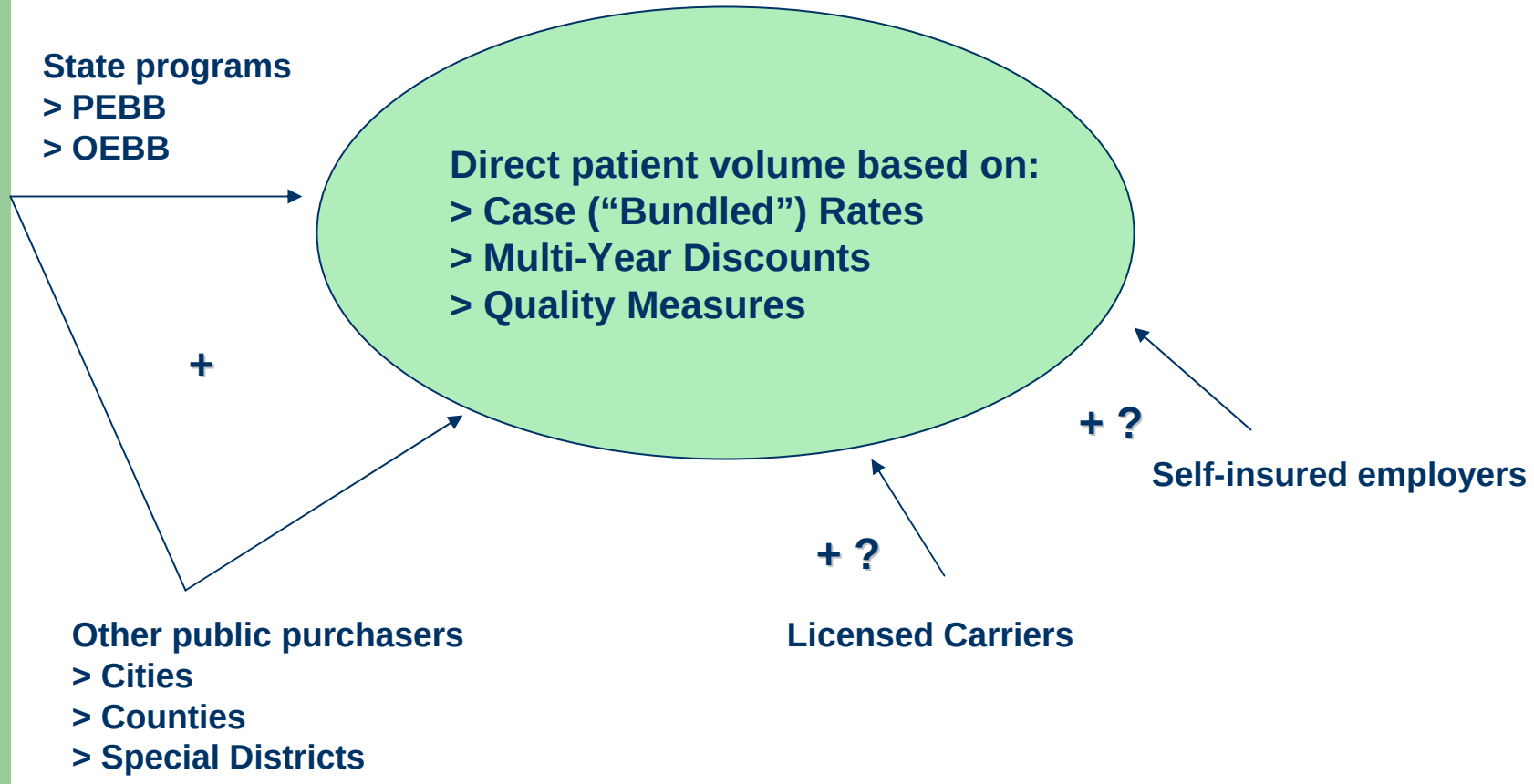
Payer Contracts Reporting Option

- Necessary for:
  - Improving “line of sight” from unit price increases & subsequent premium increases for purchasers
  - Potential “engagement” of local purchasers & providers on pricing trends
  - Comparing Oregon local prices to other markets

Purchasing Cooperative Option

- "Government should take the lead either in setting prices or coordinating payers to create monopsony power." (emphasis added)
  - **Joseph White, Case Western University, "Markets and Medical Care: The United States, 1993 – 2005"**

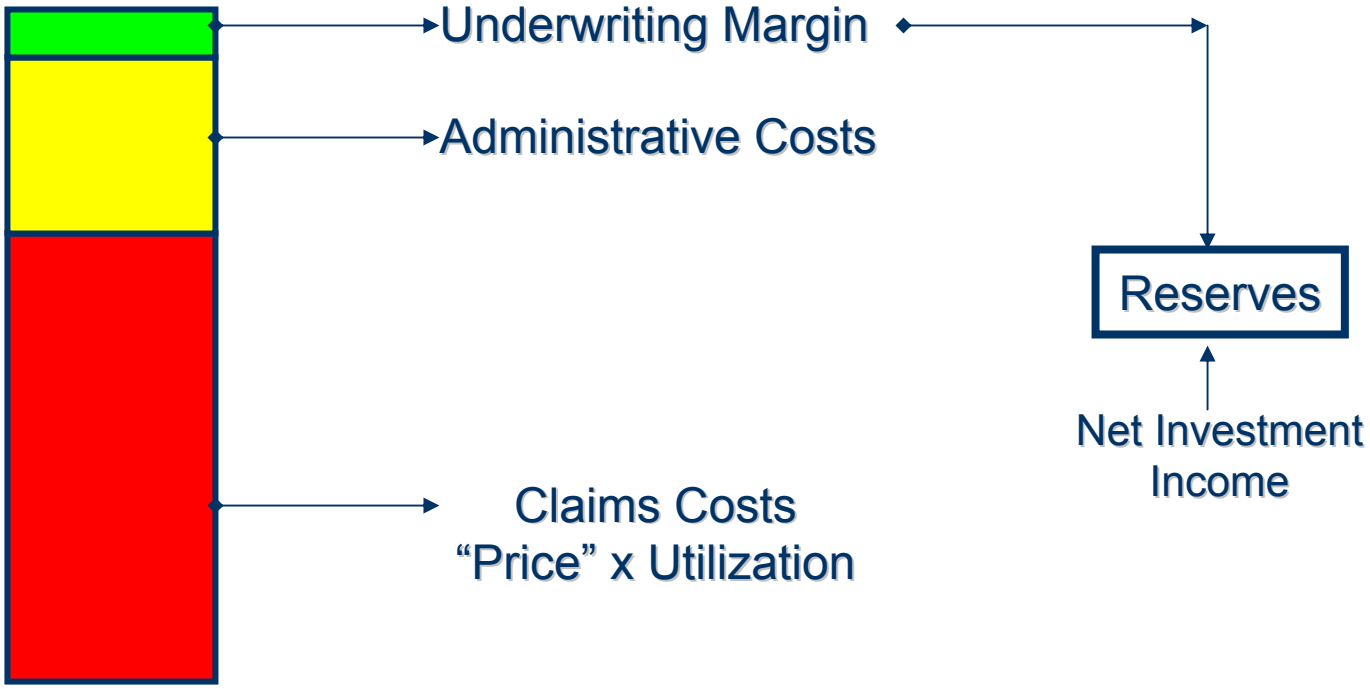
Purchasing Cooperative Option



Price Ceiling Option

- State establishes price ceilings on services
- Options:
  - A fixed % increase (CPI + x%) from base year
  - A multiple (e.g., 130%) of Medicare reimbursement rates (DRG, APG, RBRVS)

Components of Insurer's "Premium"



Current Rate Regulation of Insurers

- Rates must be approved by Insurance Division
  - Individual Market
  - Small Group Market (2-26)
  - Medium Group Market (26-50)
- Rates in Large Group Market are negotiated between insurer and group

- Small Group & Medium Group markets are now merged into Small Group, defined as 2-50.

Addressing Claims Costs

- “Price”
  - See previous slides
- Utilization
  - Traditional tool is benefit design
  - Uniform clinical guidelines across industry
    - Who creates?
      - Private, public/private, government?
    - Some Voluntary, Some Mandated?

Addressing Administrative Costs

- Administrative Simplification
  - More industry-wide administrative policies & processes
    - Developed & implemented by voluntary action?
    - Drive HIPAA-like standards of administration “deeper” into industry
- Regulatory review & approval by DCBS?
  - Evaluated against CPI, not medical CPI
    - Sales, marketing & general administration cost increases no more than CPI + *x* ?

Addressing Margins & Reserves

- Underwriting Margin (+/-) is arithmetic
  - Premium minus (Claims Cost + Admin Expense)
- Minimum Medical Loss Ratios
- Reserves fluctuate (+/-) based positive or negative Underwriting Margins & Net Investment Gains

Medical Loss Ratios (2006)

Company Name	Medical Loss Ratio Individual	Medical Loss Ratio 2 – 25	Medical Loss Ratio 26 – 50	Medical Loss Ratio Over 50
Health Net	101.60	75.00	80.80	84.30
Kaiser	96.00	96.00	96.60	96.00
LifeWise	73.40	81.50	78.90	79.80
ODS Health Plan	74.30	85.10	91.30	84.70
PacificSource	84.00	86.40	83.10	85.50
PacifiCare	82.40	77.80	77.80	85.80
Providence	65.90	87.40	87.60	84.10
Regence BCBS	97.00	77.30	84.80	87.10
Total – above 8	**90.03**	**84.06**	**85.68**	**88.73**
Total – all companies	**83.95**	**84.14**	**85.23**	**88.56**

Addressing Reserves

Surplus to Minimum Required Surplus (2006)								
	Regence	Kaiser	Pacific Source	Health Net	Providence	Life Wise	ODS	PacifiCare
	4.1	5.7	3.0	2.2	5.6	3.7	2.1	2.8
Total Surplus (2006)								
(in millions)	$ 533.5	$ 430.0	$ 123.5	$ 59.8	$ 285.6	$ 74.9	$ 37.8	$ 50.9

Aggregate surplus for 8 insurers = $ 1,596M on Earned Premium of $ 4,083M

Between 2001 & 2006 aggregate surplus increased at avg. annual rate of 19.7%

SYSTEM TRANSFORMATION: SETTING UNIFORM STANDARDS

VALUE-BASED PURCHASING

Possible Common Contract Standards

- Quality measurement & performance
- Integrated Health Home (IHH) criteria
  - Case management payment policy
  - Incentives for managing vulnerable populations (DHS)
- Evidence-based practice guidelines
- Comparative effectiveness guidelines
- Payment strategies for administrative services

Users of Common Contract Standards

- Initially applicable to:
  - Oregon Health Plan (MCO + FFS)
  - PEBB
- Available to:
  - OEBB
  - City/County and other public employers
  - Private businesses and organizations

Other Coordinated Activities

- Identify, test & evaluate patient decision aids for select patient-sensitive care
- Require health plans under contract with state-sponsored health programs to provide pharmacy benefit through Oregon Prescription Drug Program (OPDP) unless they can demonstrate greater savings through alternative PBM arrangement

Setting Standards for…

- Clinical quality measures
- Evidence-based practice guidelines
- Comparative effectiveness standards
- End-of-Life care
- Administrative Simplification

Clinical Quality Standards

- The State shall develop a standardized set of measures to assess the quality of health care services provided in Oregon
  - Uniform definitions, measures & forms for data submission
  - Aligned with nationally accepted measures
  - Initially based on existing quality indicators used by quality measurement organizations (e.g., Q Corp)
  - Measures should include:
    - Hospital & physician services
    - Initial focus on preventive services & 5 major chronic diseases (asthma, CAD, CHF, depression & diabetes)

Clinical Quality Standards

- Organizational Options
  - Create Quality Institute for Oregon (QIO) that is publicly-chartered & financed
    - See Quality Institute Work Group Report for role, financing, structure & Governance
    - Coordinates work with OHA
  - Existing agency/commission plays the role of QIO with specialized committees
  - Create public-private partnership

Clinical Quality Standards

- Implementation
  - After January 1, 20xx, all health plans in Oregon shall use the standardized quality measures
  - Providers shall not be required to use & report on any other quality measures.

Evidence-Based Practice Standards

- Health Services Commission charged to develop EBPGs
  - Use advisory committees comprised of health plan medical directors & leaders of Oregon medicine
  - Review & endorse existing guidelines from other reputable national & state organizations
- Implementation Options
  - All state sponsored health plans
  - Voluntary in private sector
  - All regulated health plans

Comparative Effectiveness Standards

- Health Resources Commission charged to develop coverage guidelines for emerging treatments, procedures & services
  - Use advisory committees comprised of health plan medical directors & leaders of Oregon medicine
  - Review & endorse existing guidelines from other reputable national & state organizations (meta-analysis)
  - Contract with national evidence-based practice centers where appropriate
- Implementation Options
  - All state sponsored health plans
  - Voluntary in private sector
  - All regulated health plans

End-of-Life Care Standards

- Implement a statewide electronic Physician Orders for Life-Sustaining Treatment (POLST) registry to guide emergency responders & other providers

Administrative Standards

- Standardize administrative policies & processes across insurers
- DCBS leads provider/carrier work group to standardize industry policies, processes, forms & data requirements for eligibility, claims, payment & related functions
  - Drive HIPAA-like standards of administration “deeper” into industry

SYSTEM TRANSFORMATION: NEW MODELS OF CARE

Integrated Health Homes (IHH)

- Establish standards for reimbursing designated IHHs
- IHH designation includes reporting requirements on process, outcome and quality metrics
- Evaluate the impact of IHH model on a biennial basis for 6 years

Building Integrated Health Homes

- State Action:
  - Develops standard requirements with contracted health plans including
    - Reimbursement for case management services performed by IHHs
    - Incentives to enrolled members to utilize IHHs, especially those with chronic diseases
- Implementation of IHHs in Oregon Health Plan shall begin no later than 1-1-2010 ?

Expanding Integrated Health Homes

- PEBB, OEBB, other public employers & regulated carriers are encouraged to incorporate designated IHHs in their plan networks.
  - Benefit packages offer incentives (i.e., reduced cost sharing) for members with chronic diseases to seek care from contracted IHHs

Integrated Health Homes and Learning Collaboratives

- Establish a learning collaborative for all designated IHHs
  - Share information on best clinical practices & quality improvement processes
- IHHs serving OHP clients are required to participate
- State may contract with a state or national organization specializing in quality improvement to facilitate the collaborative

Community-based Innovation

- Support Community Collaboratives
  - Performance-based grants
- Create Accountable Health Communities
  - Virtual or Real

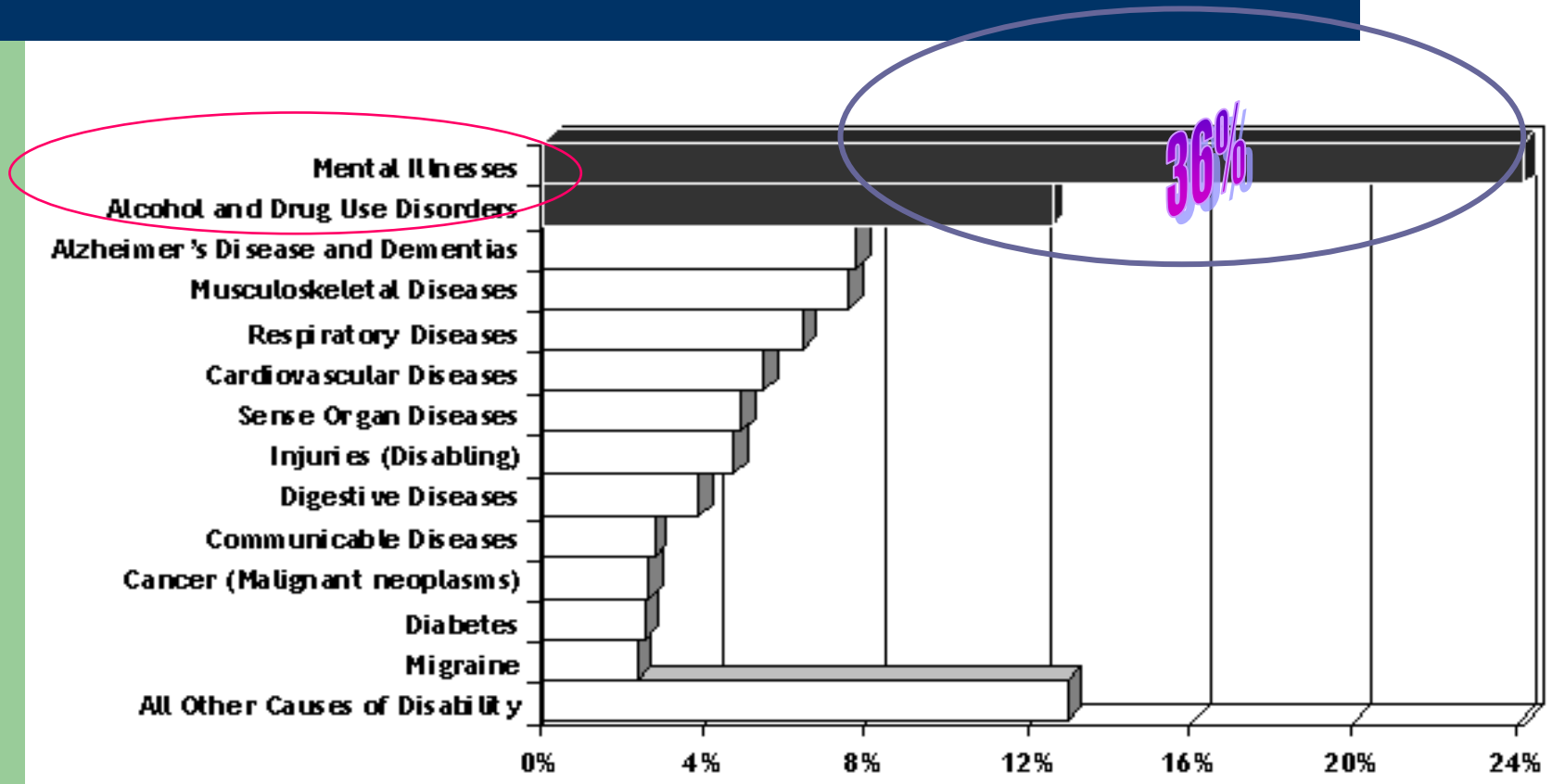
Grants for Community Collaboratives

- Pursue innovation/coordination in local communities based on Triple Aim principles
  - Performance and financial measures
  - Waive administrative rules under conditions that stimulate & reward community-based innovation
  - Special focus on multi-cultural communities
  - Grants available for exceptional pilot projects

Health & Prevention Areas of Focus

- Integrated Health Homes (IHH)
- Public health and wellness programs
- Integration of behavioral health services
- Eliminating health inequities

Behavioral Health Conditions the Leading Cause of Disability



Integration of Behavioral Health Services

- DHS should develop policies & incentives to encourage contracted plans (physical & behavioral) to develop effective care integration strategies for enrollees.

Health Equities

- Community-centered public health initiatives should include culturally-specific approaches to disease prevention & health promotion.
- DHS should develop policies that incent the partnership of health care provider organizations with community-based organizations to support culturally-specific disease management.

SYSTEM TRANSFORMATION: INVEST IN POPULATION HEALTH

Public Health & Wellness

- Develop “stretch” goals for Oregon relating to:
  - Reduction in tobacco use
  - Obesity
  - Other behavioral risk factors related to chronic disease
- Develop strategic plan to achieve “stretch” goals working with schools, employers & community organizations

Public Health and Wellness

- Establish & fund a Community-Centered Health Initiative program aimed at reducing:
  - Tobacco use & obesity
- Establish conditions for grants to local communities:
  - Evidence-based programs
  - Community matching funds
  - $$ conditioned on meeting explicit performance targets

SYSTEM TRANSFORMATION: PLAN FOR TOMORROW'S WORKFORCE

Health Care Workforce Strategy

- Collect, analyze & report on work force statistics
- Identify long-term needs
- Develop recommendations for training programs
  - Coordination, expansion, etc.
- Develop recommendations for incentives to recruit & retain providers
- Develop training & licensure strategies for a 21st Century health care workforce
- Advocacy for improved federal work force policies & funding

SYSTEM TRANSFORMATION: PUBLIC DATA AND TRANSPARENCY

Potential Activities

- Uniform health care data collection program
- Payer contracts reporting (see slides 17 & 18)
- Monitor the “health” of the insurance market
- Facility capital expenditure reporting

Health Care Data Collection

- Essential activity for compliance & sustainability
- Regulated carriers, OHP plans, Medicaid FFS, Medicare, TPAs (?)
- All lines: group, individual
- All health care services
  - Hospital IP & OP, Professional, Rx, etc.
- Submitted pursuant to DCBS & DHS rule + agreement with CMS
- Contract with experienced vendor
  - Data analysis conducted by OHPR staff + consultants

Health Care Data Collection

- Necessary to know what we're paying for:
  - Report on statewide, regional, community level
  - Longitudinal + comparative analysis
  - Determine performance baselines
  - Create virtual or real Accountable Health Communities (AHCs)
  - Link w/quality and population health data sets
  - Analyze episodes of care (efficiency)

Monitor Insured Market by Community

- DCBS requires insurers to submit annually membership by zip code
  - By line of business (individual, 2 – 50, >50)
  - Aggregate across carriers to community level
  - Track growth or contraction of local insured markets

Capital Expenditure Reporting

- Hospitals + ASCs required to hold community meeting(s) to disclose:
  - Proposed capital expenditures > $ *x* million
- Community meeting requirements developed by DHS - Health Division

What's the Role of State Government?

- Establishing a Vision
- Purchaser / Sponsor (OHP, PEBB, OEBB)
- Setting Goals & Standards
- Measuring Performance & Public Reporting
- Stimulating Community-Based Innovation & Learning
- Collaborating with public & private sector
- Financial Support for Local Programs
- Regulator

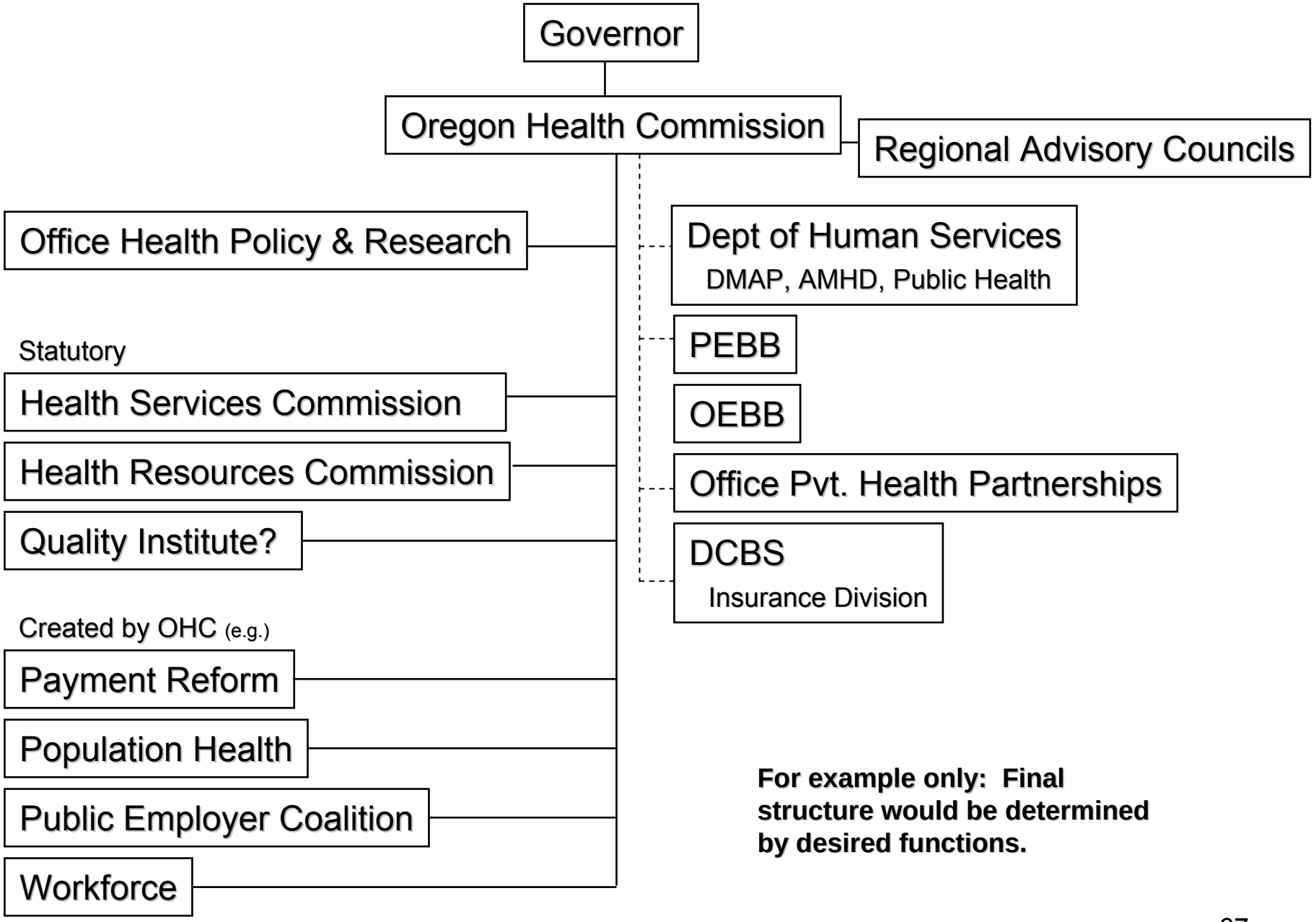
So Who Does What Now?

- Background
  - Purchasing/funding
    - DHS, PEBB, OEBB, OPHP, Corrections
  - Regulation
    - DHS for institutional providers
    - Licensing agencies for health care professionals
    - DCBS (Insurance Division) for insurers, TPAs, OMIP
  - Multiple health policy entities
    - OHFB (sunsets 1-2-10)
    - Health Policy Commission, Health Services Commission, Health Resources Commission, Medicaid Advisory Committee, Patient Safety Commission, Public Health Advisory Commission, etc.

DO WE NEED AN INTEGRATOR/COORDINATOR?

Oregon Health Commission (OHC)

- A robust state entity with broad authority
- Analogous to:
  - Transportation Commission
  - Board of Education
  - Board of Higher Education
- Strong citizen board
- Competent professional staff & appropriate financing
- Objectivity & credibility to rise above politics of the moment & act in the best interests of Oregonians

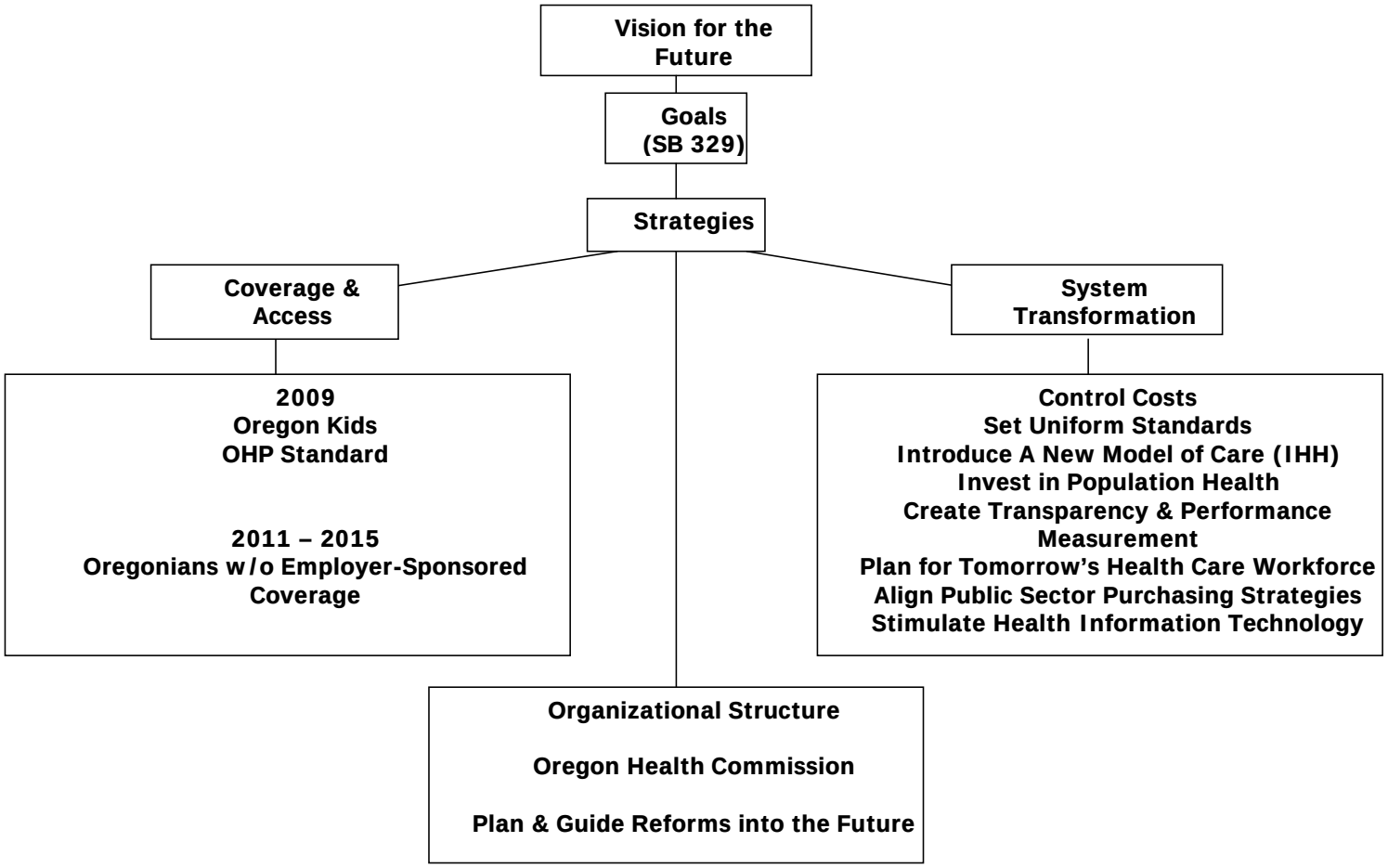


For example only: Final structure would be determined by desired functions.

OHC Functions / Authority: Examples

- Set standards
- Coordinate state health care purchasing policy
  - Recommend contract requirements
- Develop recommendations on payment reform
- Oversee data collection program & transparency reporting system
- Coordinate/align activities of other health-related commissions
- Establish population health goals & monitor performance

OHC Functions / Authority: Examples

- Promote community-based innovation & knowledge transfer
- Develop & implement public employer coalition/cooperative
- Develop strategies for health care workforce
- Develop strategic plan for Phase II Coverage Expansions
- Meet regularly with Governor & Legislative leadership on health care policy
- Carry out other duties assigned by statute

Components of A Plan